University Health | COMMUNITY FIRST HEALTH PLANS

THINKING BEYOND TO SERVE OUR COMMUNITY

SUMMARY OF BENEFITS

University Family Care Plan 2026

Effective Date 01/01/2026

As permitted by the Patient Protection and Affordable Care Act (the Affordable Care Act), a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. This group health plan believes this coverage is a "grandfathered health plan" under the Affordable Care Act.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Human Resources at 210 - 358-2275. You may contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act. You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

ADMINISTERED BY
COMMUNITY FIRST HEALTH PLANS
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249
TELEPHONE 210-358-6090
Or
1-800-434-2347

University Health | COMMUNITY FIRST HEALTH PLANS

THINKING BEYOND TO SERVE OUR COMMUNITY

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Community First for information or to file a complaint at 210- 358-6090 Local San Antonio Area 1-800-434-2347 Toll Free

CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should first contact Community First.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar a Community First para informacion o para someter una queja al

210-358-6090 Local San Antonio Area 1-800-434-2347 Toll Free

DISPUTAS SOBRE SU PREMIO O RECLAMOS:

Si tiene una disputa concerniente a su premio o a un reclamo, debe comunicarse con Community First primero.

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THE UNIVERSITY HEALTH (UH)
EMPLOYEE HEALTH BENEFIT PLAN (PLAN)

- **COMMUNITY FIRST HEALTH PLANS, INC. (COMMUNITY FIRST)** certifies that it will administer the Plan to you and your dependents, in accordance with the terms of the Plan Administrator Agreement.

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Covered Employee:	You are eligible to become covered if you are in the "Covered Classes" shown below and meet the requirements in the "Who is Eligible to Become Covered" section. The "When You Become Covered" section states how and when you may become covered. Your Coverage will end when the rules in the "When Your Coverage Ends" section so provide.
Plan Sponsor:	University Health
Group Contract No.:	004012-0006, 004012-0007, 004012-0008, 04012-0009, 004012-00010, 004012-0011
Effective Date:	**January 1, 2026** This Summary of Benefits describes the benefits under the Employee Health Benefit Plan.
Covered Classes:	All eligible employees who live, work, or reside in the service area.
Limiting Age for Dependent(s)	Up to age 26 for children. However, this age limitation does not apply to a child who is medically certified as disabled and dependent on the parent. **See Dependent Coverage for more details.**
Service Area	**Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina and Wilson County. The expanded network "PPO Network" is now available n a t i o n wide.**
Administrator	**Community First Health Plan's, Inc.** Mailing Address: 12238 Silicon Drive, Suite 100, San Antonio, Texas 78249 Physical Address: 12238 Silicon Drive, Suite 100, San Antonio, Texas 78249
Community First's Telephone Number:	210-358-6090

Member Services Number: 210-358-6090 or 1-800-434-2347

I. WHO IS ELIGIBLE TO BECOME COVERED

A. FOR EMPLOYEE COVERAGE

1. **You are eligible for Employee Coverage** while:

- You are an Eligible Retiree.
- You are an Eligible Employee.
- You are in the Covered Classes; and have completed any employment waiting period required by the Employer.

UH determines the covered classes. This will be done under its rules, on dates it sets. UH will not discriminate among persons in like situations and cannot exclude you from a covered class based on a health status related factor.

2. **You are not eligible for Employee Coverage** if your coverage under any Community First group health care coverage was terminated for cause, as described in the "When Your Coverage Ends" section.

B. FOR DEPENDENT COVERAGE

1. **You are eligible for Dependent Coverage while:**

- You are an eligible employee; and
- You have a qualified dependent.

2. **Dependents eligible for coverage:**

- Your legal spouse.
- Your common law spouse.
- Your eligible children. The definition of an eligible child includes:
  - Your natural born child.
  - Your stepchild.
  - Your adopted child or a child placed with you for adoption;
  - A dependent covered under a Qualified Medical Child Support Order.
  - A child for whom you are an appointed legal guardian.
    - Court ordered dependents that reside outside of the service area may be covered under the UFCP plan but must obtain care through the UFCP or UFCP Expanded Network (applicable out of pocket costs will apply such as deductible and coinsurance. Services obtained outside of the UFCP or

UFCP Expanded Network without a prior authorization will be the member's responsibility.

- Plus one Qualifying Adult. The definition of Plus one Qualifying Adult includes:
  - Must have resided together in the same residence for at least 12 months and must continue to do so for the Plus One Qualifying Adult to remain eligible for benefits.
  - Must be 18 years of age or older.
  - Must be financially interdependent with the University Health employee, sharing common financial obligations as evidenced by 3 or more of the following documents:

    All 3 Evidenced Items Must be turned in and Certified before Benefits are Effective
    - Joint Deed or mortgage agreement to demonstrate common ownership of real property or a common leasehold interest in real property.
    - A title or vehicle registration showing common ownership of a motor vehicle.
    - Proof of joint bank accounts or credit accounts.
    - Proof of designation as the primary beneficiary for life insurance or retirement benefits.
    - Assignment of a durable property power of attorney or health care power of attorney.
    - Out of State Marriage License or Civil Certificate.

Please note that the following individuals are not eligible for designation as a Plus One Qualifying Adult:

- Parents
- Parents' other descendants
- Grandparents and other descendants
- Step relatives
- Renters, boarders, tenants
- Employees of University Health cannot be added as a Plus One (spouse or domestic partner) if they separately enrolled in the UFCP

Qualifying Children:

- Medical - Up to age 26.

3. **Exception(s)**

   a. Children who have a behavioral or physical disability are eligible to continue coverage after they have attained these age limits provided that they are incapable of self-sustaining employment because of the disability and are chiefly dependent on you for financial support and maintenance. Contact Human Resources for additional information.

   b. Your spouse or child does not qualify as your dependent while covered under the Plan as an employee.

   c. Grandchildren are not covered unless the qualifications are met as listed above in Dependents eligible for coverage.

4. **A child will not be considered a Dependent** of more than one Employee.

5. **You are not eligible for Dependent Coverage** if your coverage under any Community First group health care coverage was terminated for cause, as described in the "When Your Coverage Ends" section.

6. **Your Dependent Coverage becomes effective** as described in the "When You Become Covered" section.

II. AUDIT PROCESS

A. Dependent Verification Process

The purpose of the Dependent Verification Process is to ensure UH provides high-quality, cost-effective healthcare coverage to eligible employees and their dependents.

B. Documentation Required When Enrolling a New Dependent

Dependents added to coverage must complete an eligibility verification process. When a participant enrolls a new dependent, they will receive a notice from the UH Human Resources department and will be required to submit appropriate documentation. Participants electing and/or adding dependent coverage have 30 days as a new enrollee, 31 days for a qualifying event and the entire annual open enrollment period to return the appropriate documentation. If verification is not completed by the deadline, UH will retroactively drop the dependent as of the coverage effective date.

C. Random Dependent Eligibility Audits

UH conducts random checks to ensure only eligible dependents are covered. Severe penalties, including the loss of coverage and liability for repayment, could apply if you knowingly attempt to cover or continue to cover anyone who is not eligible.

During the random check process, UH will select participants covering any type of dependent and require them to submit documentation of eligibility (includes spouse, common law spouse, dependent child).

Participants must submit the required documentation by the deadline indicated by UH (see section II.B). If a participant does not respond by the date indicated, the dependent will be dropped from all coverages.

If a participant was previously selected for the audit but did not provide appropriate documentation and was dropped from coverage, they must provide the documentation before adding the dependent to coverage during annual open enrollment.

III. WHEN YOU BECOME COVERED

You may only enroll yourself or your dependents during the enrollment periods described below:

A. INITIAL ENROLLMENT PERIOD

1. **General Rule: When You Become an Eligible Employee** You may enroll yourself and your dependents within 30 days after first becoming an eligible employee. Coverage will not begin sooner than the first day of the month following the end of the waiting period.

2. **General Rule: Acquiring New Dependents** You may enroll a qualified dependent within 31 days after you acquire the dependent through marriage, birth or adoption.

3. **Default Health Care Coverage** UH requires all eligible employees, as a condition of employment, to carry health care coverage, whether under a component plan or a plan or policy not provided by UHS. Employees who fail to carry health care coverage shall be automatically enrolled in a default plan, as identified by UH. If UH becomes aware of an employee's lack of health care coverage by the date that compensation reduction contributions would otherwise begin, UH shall automatically withhold premiums for the employee's default coverage on a pre-tax basis under this Plan. If UH becomes aware of an employee's lack of health care coverage at any other time, the premiums will be withheld on an after-

tax basis for the remainder of the plan year of the employee's hire, or until a special election period begins, if sooner. Default health care coverage is provided for the employee only and the employee shall be allowed to add family members only during the next open enrollment period unless access to health care coverage is required under HIPAA or other applicable law.

4. **Special Dependent Coverage Rules for Newborn and Adopted Children** If a child is born to you or adopted by you while you are covered for employee coverage, your child will be covered from the date of the child's birth, or date the child becomes the subject of a suit for adoption. Coverage for the child is subject to the "*When Your Coverage Ends*" section and to the following provisions:

   a. the coverage for the child will not end during the (31) day period starting with the child's birth or adoption because you fail to pay any required contribution for that coverage.

   b. The coverage for the child will not continue beyond the end of that (31) day period unless, before the end of that period, you have notified the UH Human Resources department of the birth and paid any additional premium you owe for the added dependent coverage. **If you do not provide notice of the birth, coverage for the child terminates on the 32nd day after the birth even if you do not owe additional premium for the child.**

   c. If your dependent becomes pregnant during the plan year, coverage is limited to prenatal care and delivery only. The dependents dependent is not eligible for coverage unless the child meets the eligibility requirements listed under I. Who is Eligible to Become Covered, B. For Dependent Coverage.

B. OPEN ENROLLMENT PERIODS

1. During the open enrollment period, you may elect to cover yourself and qualified dependents if:

   a. You and your qualified dependents are covered under other health care coverage, and you wish to switch coverage to the Plan; or

   b. You first become eligible for employee coverage during the open enrollment period; or

   c. You were previously eligible to enroll for employee coverage but did not enroll or are no longer enrolled.

2. If you elect for yourself and your dependents to become covered under the Plan during the open enrollment period, your or your dependent's coverage will begin on the open enrollment date established by UH, if all the conditions below are met on that date:

   a. You are eligible for employee coverage.

   b. You have enrolled for the coverage via the UH online website or completed the benefits enrollment form and, agreed to pay the required contributions.

   c. You reside, live or work in the Service Area.

C. SPECIAL ENROLLMENT PERIODS.

1. **Special Enrollment Period for Employees and Dependents Who Lose Coverage** Eligible employees and dependents that lose other coverage shall have 31 days to enroll in the Plan, if the following conditions are met:

   a. The eligible employee or dependent is eligible for coverage and he or she failed to enroll when first eligible; and

   b. When enrollment was previously offered and declined, the eligible employee or dependent had other coverage; and

   c. When enrollment was declined, the eligible employee stated in writing that he or she was declining coverage because he or she or the dependent had other coverage; and

   When enrollment was declined:

   (1) The eligible employee or dependent was covered under COBRA or state continuation periods and the continuation period has since been exhausted; or

   (2) When enrollment was declined, the eligible employee had coverage other than COBRA or state continuation coverage that has since terminated due to loss of eligibility or because the employer ceased contributions to the plan.

   Loss of eligibility includes a loss of coverage as a result of a legal separation, divorce, death, termination of employment, reduction in hours, and any loss of eligibility.

(3) A special enrollment period is not available to an eligible person and/or dependents if previous coverage was terminated for cause or failure to timely pay premiums.

2. **Special Enrollment Period for Court-Ordered Coverage of a Spouse or Child**

a. **Coverage automatic for 30 days If** UH receives a medical support order or notice of a medical support order requiring you to enroll your spouse or child for coverage, the Plan shall cover the spouse or child for 30 days after receipt of the order or notice.

b. **Enrollment Required to Continue Coverage** Coverage for such spouse or child will end unless you or another person authorized applies for enrollment of the spouse or child and pays any additional premium by the last day of the month in which the 30-day automatic coverage period expires.

c. **Removal of Court Order Coverage** Coverage of spouse or child cannot be removed or canceled until UH HR receives a court order expressing that the respective UH employee is no longer mandated by the court to sustain coverage for their spouse/child.

3. **Special Enrollment Period for Changes in Family Circumstances**

a. **Enrollment of Eligible Employee An** eligible employee may enroll in the Plan outside of the open enrollment period if the employee:

(1) Is eligible for the Plan.
(2) Is not enrolled because he or she previously declined enrollment; and
(3) Applies for enrollment and pays the required contribution to premium within 31 days after either:
- Acquiring a new dependent through marriage, birth, adoption, or placement for adoption; or
- UH receives a medical support order or notice of a medical support order requiring the Employee to cover his or her spouse or child.

b. **Enrollment of Spouse of Eligible Employee An** eligible employee may enroll his or her spouse in the Plan outside of the open enrollment period if:

(1) The eligible employee and his or her spouse have a child

who becomes a dependent through birth or adoption; and

(2) The eligible employee applies for enrollment and pays the required contribution for his or her spouse within 31 days after the child is born or adopted.

D. NOTICE OF CHANGE IN FAMILY STATUS

It is important that you inform the UH Human Resources Department promptly when:

- You first acquire a qualified dependent.
- A new qualified dependent becomes eligible; or
- A qualified dependent becomes ineligible.

E. SPECIAL COVERAGE RULES IN CASE OF AN INPATIENT CONFINEMENT

Confined as an Inpatient If ***you or your dependent are confined in a hospital or other facility on the date that you or your dependent become enrolled in the Plan,*** you must notify the facility and Community First within (2) days or as soon as reasonably possible and authorize Community First to assume responsibility to arrange for the confined persons' health care.

If you fail to notify Community First of the hospitalization or to allow Community First to coordinate your care, the Plan will not be obligated to pay for any expenses related to your hospitalization following the first two (2) days after your coverage begins.

The services are not covered if you or your dependent are covered by another health plan on that date and the other health plan is responsible for the cost of services. The Plan will not cover any service that is not a covered benefit under the Plan. To be covered, you must utilize participating providers and are subject to all the terms and conditions set forth in the Plan.

Community First may transfer you or your dependent to a participating provider and/or a participating hospital if the Medical Director, in consultation with your physician, determines that it is medically safe to do so.

IV. HEALTH CARE COVERAGE

A. FOR YOU AND YOUR DEPENDENTS

1. **In General** This coverage provides benefits for many of the services and supplies needed for care and treatment of you or your qualified dependents' illnesses and injuries, or to maintain your or your qualified dependents' good health, as determined by your PCP. Not all services and

supplies are eligible; some are eligible only to a limited extent.

2. **Primary Care Physician (PCP) Selection** Your next choice is to select who will provide the majority of you and your qualified dependents' health care services. Your PCP will be the one you call when you need medical advice, when you are ill and need preventive care such as immunizations. Each covered participant may select his or her own PCP from the participating provider directory. Primary medical care includes the following medical specialties: internal medicine, general, pediatrics and family practice.

   Should you have a chronic, disabling, or life-threatening illness, you may apply to Community First's Medical Director to utilize a participating specialty physician as a PCP, provided that (1) the request includes information specified by Community First, including certification of medical need, and is signed by you and participating specialty physician interested in serving as the PCP; (2) the participating specialty physician meets, and agrees to abide by the Community First requirements for PCP; and (3) the participating specialty physician is willing to accept the coordination of all of your health care needs.

   If such request is denied, you may appeal the decision through Community First's established Complaint and Appeals process. Should such request be approved, the new designation shall not be retroactive and shall in no way reduce the amount of compensation owed to the original PCP prior to the date of the new designation.

3. **OB/GYN Selection A** female participant entitled to coverage shall be permitted direct access without a referral by the female participant's PCP or preauthorization to receive health care services from a participating obstetrician or gynecologist.

4. **Changing Your PCP** A strong PCP/participant relationship is critical. However, we also realize that there may be a need for a participant to change his/her PCP. If you must change your PCP, you may do so by calling Community First's Member Services Department. Requests for changes received will take effect on the first day of the following month.

B. COVERED SERVICES AND SUPPLIES

1. **In General** The Plan will arrange or provide for benefits for the covered services and supplies set forth in this section. You will need a referral from your PCP in order for the Plan to cover most covered services and supplies rendered by other participating providers. Some services, such as hospital confinements, also require Preauthorization by Community First.

However, you will not need a referral or preauthorization for:

- Emergency Care.
- Female participant to have direct access to health care services of a participating obstetrician or gynecologist.
- Behavioral Health with participating providers.

All covered services rendered by non-participating providers, except in the case of a medical emergency, require preauthorization by the Community First. Preauthorization is granted on the condition that the participant is eligible for covered services at the time the covered services are received. Preauthorization will be denied if the requested supply or service is not a covered service or supply. If you have any questions about whether a covered service or supply requires preauthorization, contact your PCP or Community First's Member Services Department.

Covered Services are those services and supplies furnished to participants as described in the paragraph below. Some covered services and/or supplies below may require medical review for medical necessity and/or appropriateness prior to preauthorization.

a. Covered Services: All covered services must be furnished to a participant:

(1) by a PCP.
(2) by another participating provider and authorized by a PCP or Community First.
(3) by a non-participating provider and authorized by Community First.
(4) by a participating specialty care physician approved by Community First's Medical Director to perform the services of a PCP pursuant to a request of a participant with a chronic, disabling or life-threatening illness; or
(5) by a participating obstetrician or gynecologist or a participating behavioral health provider.

It is your responsibility to obtain a referral from your PCP to see a specialty care physician. Preauthorization may be required to obtain specific services or supplies from a specialty care physician or prior to undergoing hospitalization, outpatient surgery or diagnostic procedures.

Referral A referral is a recommendation by a participant's PCP or other treating provider for a patient to be evaluated or treated by another physician or provider. This does not apply to OB/GYN or Behavioral Health providers.

Authorization Certain services and supplies under this Plan may require authorization by us to determine if they are covered benefits under this Plan. Your physician must obtain an approval for certain services. Benefits are payable only when we determine the care is clinically appropriate to treat your condition. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan.

If medically necessary covered services are not available through a participating provider, Community First will, at the request of a participating provider, and within a reasonable time period, allow referral to a non-participating provider and reimburse the non-participating provider at the usual and customary rate or at a negotiated rate. Before such a requested referral can be denied, Community First may have the request reviewed by a specialist of the same or similar specialty as the physician or provider to whom the referral is requested.

b. After Hours Care: Illnesses and injuries often do not happen during normal office hours. If your call is placed after your PCP's office hours, you will be assisted by an answering service that will notify the physician on call and advise you on how to proceed. Additionally, participants may call NurseLink, Community First's 24-hour nurse advice/triage service. You may reach this service by calling 210-358-3000 or 1-800-434-2347.

c. Urgent Care: In the event of an urgent situation (illness or injury) that is severe or painful enough to require assessment and/or treatment within 24 hours, you should contact your PCP who will direct you based on the symptoms. You may also visit the University Health's Express Med Clinic. Additionally, participants may call NurseLink, Community First's 24-hour nurse advice/triage service. You may reach this service by calling 210-358-3000 or 1-800-434-2347.

An urgent care situation is not as serious as an emergency. Urgent care includes services other than those for an emergency that result from an acute injury or illness that is severe or painful enough to lead a person with an average knowledge of medicine and health to believe that the condition, illness or injury is such that failure to get treatment within a reasonable period of time would cause serious deterioration of his or her health.

Any urgent care provided by a facility other than a University Health Express Med Urgent Care Clinic will be processed under

the Expanded Network, and corresponding deductible/coinsurance would be applied to these claims. If a provider is not currently contracted with the Expanded Network, you will be responsible for all billed charges.

d. Medical Emergency: Services for a medical emergency are covered anywhere in the world 24 hours a day. If a medical emergency occurs, you should go to the nearest participating or non-participating medical facility. Community First will have preauthorization staff on duty at phones during regular business hours.

Emergent care includes, but is not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing his or her health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement; or
- Serious jeopardy to the health of the fetus in the case of a pregnant woman

A University Hospital emergency room visit will be processed as an in-network provider. An emergency room visit provided by a facility under the First Health Network (Expanded Network) will be processed at a 30% coinsurance after annual deductible is met. Hospitals outside of the First Health Network (Expanded Network), will be processed as an out of network provider and will be reimbursed at the reasonable and customary rate according to the emergency diagnosis submitted on the claim.

For Necessary emergency care services **within the country**, a non-participating provider will usually submit claim and the member will pay any applicable copays to provider at time of service. A non-participating provider will receive Usual and Customary from Community First Health Plans as payment.

For Necessary emergency care services **out of the country**, members will be required to pay out of pocket for cost of services rendered and submit a claim or receipts for services paid.
Community First Health Plans will review and reimburse the member at the Usual and Customary Rate. The member may not

be reimbursed in full. Claims will be paid at the current rate of exchange.

Necessary emergency care services will be provided to participants, including the treatment and stabilization of a medical emergency, and any medical screening examination or other evaluation required by state or federal law necessary to determine if a medical emergency exists.

If it is determined that a medical emergency does exist, the Plan will pay for medically necessary emergency care services required to evaluate and stabilize the medical condition performed by participating or non-participating providers. Non-participating providers will be reimbursed at negotiated or usual and customary rates for the services performed. Community First will approve or deny coverage of post-stabilization care, as requested by a treating provider, within the timeframe appropriate to the circumstances, but in no case to exceed one hour.

If you have received emergency care and the provider who treated you indicates that you will need follow-up care to complete the treatment, the follow-up care must be rendered by the participant's PCP or the appropriate specialist, not by the provider who treated you for the medical emergency. The participant, or someone acting on the participant's behalf, should contact the participant's PCP or the appropriate specialist within 24 hours, or as soon as reasonably possible, so that he or she may arrange for follow-up care.

Participants should not use the emergency room or urgent care facility for routine or non-emergent services. If you choose to use the emergency room or urgent care facilities for routine or non-emergent services, then you will be responsible for all billed charges relating to the services. You can use Community First's Complaint and Appeals Process to resolve a dispute regarding emergency care.

If you have any questions regarding whether a situation constitutes a medical emergency, please contact your PCP. Additionally, participants may call Community First's 24-hour nurse advice/triage service, NurseLink. You can reach this service by calling 210-358-3000 or 1-800-434-2347.

2. Participant's Authorization and Financial Responsibility

a. Authorization: Participants hereby authorize licensed physician, hospital, pharmacy, clinic, health care facility, insurance company,

employer, or organization to release to University Health or its agents any information regarding the participant or any enrolled dependents' medical history, treatment, and/or disability that is reasonably necessary for the purpose of utilization review, coordination of benefits, or payment of a claim.

The authorization shall cease to be effective at such time when participants' coverage under the Plan terminates. In the event that participant or dependents have any outstanding claims at time of termination, the authorization will continue to apply until all the claims have been settled. Participant understands that UH will automatically deduct from participants' wages the amount of any co-pays the participant or any dependents incur as a result of receiving medical services or supplies from UH under any UH-sponsored health plan. See Section X. Health Insurance Portability and Accountability Act (HIPAA).

b. Accessing Authorized Covered Services: When accessing authorized covered services from a participating provider, you will only owe a copayment to that provider. It is the participant's responsibility to ensure that the providers from whom you receive services are contracted with Community First. A preauthorization will be required prior to services being rendered outside of the UFCP network should a specific service or specialty not be available within the UFCP network.

All services received from a non-participating provider require preauthorization except for emergency care. All out-of-network services require a preauthorization. You will be liable for all charges if services are not preauthorized. If you receive preauthorized services from a non-participating provider, and that provider has not agreed to a negotiated rate from Community First, then Community First may pay the usual and customary charge for the services provided, and you may be responsible for the difference between the amount paid by Community First and the amount of the full charge billed by the non-participating provider.

If you pay up front and seek reimbursement for the preauthorized services you received from a non-participating provider, you will be reimbursed the usual and customary charge or negotiated rate less the copayment.

c. Accessing UFCP Expanded Network: If member chooses to utilize the First Health Expanded benefit, the member will be subject to the expanded network out-of-pocket costs such as deductible and coinsurance. UFCP Expanded Network is

available Nationwide.

d. Contract Status of Providers: You should ask about the contract status of the providers from whom you receive treatment, especially when you are referred by your PCP to a specialty care physician and when you receive services at a participating hospital as some facility based physicians or other health care practitioners such as anesthesiologist, pathologist, neonatologist, emergency room physicians and radiologist may not be included in Community First's network and may balance bill you for amounts not paid by Community First. Diagnostic and lab fees are covered only if testing is performed at UH facilities. If you receive services from a non-participating provider, and that provider has not agreed to a negotiated rate from Community First, then Community First may pay the usual and customary charge for the services provided. The non-participating providers will be reimbursed usual and customary charges even if the services are rendered at a participating facility. Member will be responsible for any remaining balances.

If you receive a bill from any participating provider asking you to pay for something other than a copayment or applicable deductible and/or coinsurance for Expanded Network services, please notify Community First's Member Services Department immediately.

e. Premiums: Participants may pay a premium for Plan coverage. The premium amount and payment arrangements are made through UH. UH will determine the fixed price per participant and will determine how much of that cost to pass along to you.

f. Copayments**:** In addition to any payroll deduction UH may impose; you will be responsible for appropriate copayments. The copayments that apply to certain covered services and are described in the Schedule of Copayments attached to and made a part of this Plan. Participating providers will look only to the Plan and not to you for payment of covered services, except for payment of applicable copayments.

g. Services or Supplies that are Not Covered under this Plan**:** If you receive health care services or supplies that are not covered services and supplies, you will be financially responsible for the entire cost of service.

h. Unauthorized Services**:** You will be held financially responsible for the entire cost of services if you:

- Obtain health care services, in circumstances other than a medical emergency, from a non-participating provider without preauthorization.
- Obtain services from a participating provider who is not your PCP without a referral from your PCP, except for the following services, which do not require a referral or preauthorization:
    - Accessing care from a participating provider
    - who is an obstetrician or gynecologist.
    - Accessing care from a participating Behavioral health provider.
    - Emergency care.

3. **Covered Services**: The covered services are those that are in the list below. Section C ("Limitations") describes any modification of these covered services for certain illnesses. A service or supply is not a covered service or supply if excluded. It is excluded to the extent it falls outside any limits described in Section C ("Limitations") or is described in Section D ("Exclusions"). Some covered services and/or supplies below may require medical review for medical necessity and/or appropriateness prior to preauthorization.

Acquired Brain Injury Cognitive rehabilitation therapy, cognitive communication therapy neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment, neurofeedback therapy, and remediation. Post-acute transition services, community reintegration services, including outpatient day treatment services, or other post-acute treatment services. Medically necessary treatment and services can be obtained at a hospital including an acute or post-acute rehabilitation hospital or an assisted living facility regulated under Chapter 247, Health and Safety Code.

Also covered is reasonable expenses related to periodic reevaluation of the care provided to a participant who has incurred an acquired brain injury, has been unresponsive to treatment and becomes responsive to treatment at a later date.

Alcohol/Chemical Dependency Medically necessary care and treatment of alcohol/chemical dependency will be covered the same as any other physical illness. See Schedule of Benefits and Copayments.

Allergy and Treatment Medically necessary allergy testing including food allergy to evaluate and determine the cause of allergy and appropriate allergy treatments including injections and serum. See Schedule of Benefits and Copayments.

Ambulance Services Emergency ground or air ambulance transportation when medically necessary. Community First will pay up to $1,500 of the usual and customary charge for the services provided, and you will be responsible for the difference between the amount paid by Community First and the amount of the full charge billed by the non-participating provider for ground transportation. Per the No Surprises Act Members cannot be balance billed for air medical transportation. Please be advised that currently, there are no contracted ambulance service providers. See Exclusions.

Amino Acid-Based Elemental Formula is covered if medically necessary for the treatment of the following:

(1) Milk or soy protein allergies/intolerance

(2) Multiple food protein intolerance

(3) Food protein allergy induced: Eosinophilic esophagitis and gastroesophageal reflux disease

(4) Other medical conditions requiring an amino acid-based diet, such as: short bowel syndrome and transition from parenteral to enteral nutrition

Alzheimer's Disease Demonstrable proof of organic disease or other proof is required before Community First Health Plans will authorize payment of benefits for Alzheimer's disease. That proof requirement is satisfied by a clinical diagnosis of Alzheimer's disease made by a physician licensed in this state, including a history and physical, neurological, and psychological or psychiatric evaluations, and laboratory studies.

Anesthetics and their administration.

Asthma Treatment, care and supplies related to asthma, as provided or prescribed by a participating physician or other qualified participating provider.

Autism Spectrum Disorder The Plan will cover medically necessary services that are generally recognized services when prescribed by the

participants PCP. Services are limited as outlined on the Schedule of Benefits. Generally recognized services may include:

1. screening between ages 18 and 24 months
2. evaluation and assessment services
3. applied behavior analysis; *
4. behavior training and behavior management
5. speech therapy
6. occupational therapy
7. physical therapy; or
8. medications or nutritional supplements used to address symptoms of autism spectrum disorder

An individual providing treatment prescribed must be a health care practitioner who is licensed, certified, or registered by an appropriate agency of this state; whose professional credential is recognized and accepted by an appropriate agency of the United States; or who is certified as a provider under the military health system. See Exclusions and Schedule of Benefits for limitations on speech, occupational and physical therapies.

****Applied Behavioral Analysis**
Covered diagnoses include Autism, developmental brain disorders known as Pervasive Developmental Disorders (PDD).
Other covered Pervasive Developmental Disorders not otherwise specified (PDD-NOS) are Asperger Syndrome, Rett Syndrome and Childhood Disintegrative Disorder.

- Autistic Disorder
- Atypical Autism
- Childhood Disintegrative Disorder
- Asperger's Disorder
- Rett's Disorder

The member may obtain services through a participating provider via outpatient services or through their Home Health benefit. Both benefits will have an applicable copay and no visit limitation with an ABA diagnosis. **Home Health visits cannot be combined with outpatient therapies benefit.

Behavioral Health Services The Services The following behavioral health services will be covered as any other illness.

(1) *Inpatient Behavioral Health/Alternative Treatment*. The Plan will cover the following inpatient/alternative behavioral health treatment.

(a) Treatment of behavioral or emotional illness or disorder for a person when confined in a hospital.

(b) Treatment under the direction and continued medical supervision of a Doctor of Medicine or doctor of osteopathy in a psychiatric day treatment facility that provides organizational structure and individualized treatment plans separate from an inpatient program.

(c) Treatment at a residential treatment center for children and adolescents or a crisis stabilization unit for behavioral or emotional illness which would otherwise necessitate confinement in a hospital.

Conditions for coverage include the following.

(i) Treatment in a psychiatric day treatment facility must be obtained under the direction and supervision of a participating physician.

(ii) Providers of services in a residential treatment center for children and adolescents and a crisis stabilization unit must be licensed or operated by the appropriate state agency or board.

(iii) Treatment rendered in a psychiatric day treatment facility must be delivered not more than eight hours in any 24-hour period, the attending physician must certify that the treatment is in lieu of hospitalization, and the facility must be accredited by the program of psychiatric facilities, or its successor, of the Joint Commission on Accreditation of Healthcare Organizations.

(iv) Treatment in a psychiatric day treatment facility, residential treatment center for children and adolescents, or crisis stabilization unit must be based on an individual treatment plan.

(v) Acute inpatient and outpatient covered services and supplies for the treatment of behavioral illness.

(2) *Outpatient Behavioral Health* Outpatient visits for crisis intervention and evaluation as may be necessary and appropriate for short-term evaluative behavioral health services, or short-term treatment.

Coverage under this subsection does not include coverage of addiction to a controlled substance or illicit drugs that is used in violation of the law, or behavioral illness resulting from the use of a controlled substance or

marijuana in violation of the law.

Biofeedback Therapy Biofeedback therapy is covered when it is reasonable and medically necessary for the individual for muscle reeducation of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, conventional treatments (heat, cold, massage, exercise, and support) have not been successful.

Blood and Blood Derivatives Including administration, when prescribed by a participating provider and determined to be medically necessary.

Breast Cancer Treatment Diagnosis and treatment including coverage for inpatient care for a participant for a minimum of:

(1) 48 hours following a mastectomy; and
(2) 24 hours following a lymph node dissection for the treatment of breast cancer.

unless the participant and the attending physician determine that a shorter period of inpatient care is appropriate.

Breast Pump A manual or non-hospital grade electric breast pump may be considered for purchase only. The purchase of a breast pump is limited to one per year per birth through the member's DME benefit. A member may obtain a breast pump during their pregnancy or after delivery. A hospital grade pump may be considered for purchase with the appropriate documentation supporting medical necessity as an authorization will be required. Supplies necessary for the use of a breast pump, such as tubing, an adapter, and breast shields are covered as needed.

Bone-Anchored Hearing Aids Considered a Prosthetic. Unilateral or bilateral fully or partially implantable bone-conduction (bone-anchored) hearing aid(s) may be considered medically necessary as an alternative to an air-conduction hearing aid in **patients 5 years of age and older** with a conductive or mixed hearing loss who also meet at least one of the following medical criteria:

- Congenital or surgically induced malformations of the external ear canal or middle ear (such as aural atresia)
- Hearing loss secondary to otosclerosis in persons who cannot undergo stapedectomy
- Severe chronic external otitis or otitis media
- Tumors of the external ear canal and/or tympanic cavity, and
- Meet the following audiologic criteria:

- A pure tone average bone-conduction threshold measured at 0.5, 1, 2, and 3 kHz of better than or equal to 45 dB (OBC and BP100 devices), 55 dB (Intenso device) or 65 dB (Cordele II device).

The BAHA Soft Band is medically indicated for **children less than 5 years of age with the same medical conditions.**

Cancer Care, Chemotherapy, and Radiation Therapy Treatment Therapy Treatment by x-ray, radium, or any other radioactive substance, or by chemotherapy. Prescribed orally administered anticancer medication that is used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications.

Chiropractic Care Services and supplies furnished in connection with correction by manual or mechanical means, of subluxation of the spine.

Dental Treatment & Dental Services that Must Be Performed in a Hospital Setting The Plan will cover certain services provided to a participant who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, behavioral, or medical reason as determined by the participant's PCP and the dentist. These services include the hospital or facility, and/or anesthesia charges only. Authorization will be required if services are provided outside of University Health, which includes The MARC OP Surgery Center only.

Injury to Sound Natural Teeth Restoration and correction of damage caused by external violent accidental injury to healthy, natural teeth occurring while covered under this Plan *and* provided within 24 months of the date of the accident.

Developmental Delays Services must be provided by an early intervention agency. Evaluations and therapies require a referral by a PCP. Children Pre-K and up are expected to receive their primary speech services in the school system.

Rehabilitative and habilitative therapies include:

- Occupational therapy evaluations and services
- Physical therapy evaluations and services
- Speech therapy evaluations and services; and
- Dietary or nutritional evaluations

Diabetes Care Covered services and supplies include diabetes treatment, equipment, supplies, medications, and self-management training, prescribed or provided by a participating physician or other participating provider. Member may be eligible for a continuous glucose monitoring system based on diagnosis and current drug formulary. Equipment may

include insulin pumps, transmitter, glucometers, CGMs etc. See Schedule of Benefits and Copayments.

Diagnostic Laboratory and Radiological Services Including professional fees. Diagnostic and lab fees are covered only if testing is performed at UH facilities.

Durable Medical Equipment Rental or purchase that is medically necessary and approved by Community First and will require prior authorization to establish medical necessity. Coverage is provided for the initial, standard equipment only. Any customizations, customized fits or upgrades to standard equipment will require prior authorization to establish medical necessity. If medical necessity is not established, any costs associated with customizations or customized fits and upgrades to standard equipment will be the member's responsibility.

Benefits for rental are limited to, and will not exceed, the purchase price of the equipment. For equipment purchased at the Plan's option, this item includes repair if not due to neglect or abuse, and necessary maintenance of purchased equipment not provided under a manufacturer's warranty or a purchase agreement. See Schedule of Benefits and Copayments for the maximum contract year limitation.

Eye Exam and Vision Care Your health plan coverage provides an annual medical eye exam through a network physician with a referral for certain medical conditions and may allow more than one eye exam based on medical necessity. This includes an annual diabetic eye exam for members diagnosed with diabetes and diabetic retinopathy.
Glaucoma testing every 12 months if you meet one of the following criteria:

- Diabetes diagnosis
- A family history of glaucoma
- African American and over 50 years of age
- Hispanic and over 65 years of age

Certain tests and treatments of eye diseases and conditions may be covered with a diagnosis of age-related macular degeneration

Routine eye exams or eye refractions for eyeglasses or contact lenses are not part of your medical benefit. This benefit is covered by your vision provider. All Community First Health Plans' members are automatically enrolled in Envolve vision which provides an annual vision benefit. Members may also enroll in additional routine vision coverage through EyeMed during Open Enrollment. Please see Envolve Vision and/or EyeMed for routine vision copayments and out of pocket costs.

Family Planning and Infertility Services related to the diagnosis of infertility shall be provided as medically necessary and as prescribed and authorized by a participating provider. Please see exclusions under Infertility Diagnosis and Treatment. The following services are covered:

(1) Counseling
(2) sex education instruction in accordance with medically acceptable standards
(3) contraceptive devices
(4) placement of contraceptive devices
(5) vasectomies
(6) tubal ligations
(7) diagnostic infertility services to determine the cause of infertility (see Exclusions
(8) surgical procedures to repair medical causes of infertility, to include intrauterine insemination. (See Exclusions)

infertility medications to stimulate ovulation, and not part of a treatment plan of in-vitro fertilization or artificial insemination and similar procedures (see Exclusions).

(9)

Foot Care Services and supplies for the care and treatment of diseases of, or injuries to the feet, when prescribed by the PCP and determined to be medically necessary by Community First.

Routine foot care may include:

- Cutting or removal of corns and calluses
- Clipping, trimming, or debridement of nails
- Shaving, paring, cutting or removal of keratoma, tyloma, and heloma
- Non-definitive simple, palliative treatments like shaving or paring of plantar warts which do not require thermal or chemical cautery and curettage

The following conditions represent systemic conditions that may result in the need for routine foot care:

- Amyotrophic Lateral Sclerosis (ALS)
- Arteritis of the feet
- Chronic indurated cellulitis
- Chronic venous insufficiency
- Intractable edema-secondary to a specific disease (e.g., congestive heart failure, kidney disease, hypothyroidism)
- Lymphedema-secondary to a specific disease (e.g., Milroy's disease, malignancy)
- Peripheral vascular disease
- Raynaud's disease

Shoe orthotics, insoles, shoe inserts or other supportive devices of the feet are covered only when prescribed as part of a treatment plan for someone with a primary diagnosis of diabetes. Orthopedic shoes are covered only when the shoe is an integral part of a medically necessary leg brace. Covered foot orthotics are limited to two per plan year and shoes are limited to two pair per plan year. See Exclusions.

Formulas Dietary formulas, if medically necessary for the treatment of Phenylketonuria and other Heritable Diseases. See exclusions.

Genetic Testing and Counseling As medically appropriate with prior authorization.

Health Education Services including, but not limited to, the following:

(1) Information about covered services, including recommendations on generally accepted medical standards for the use and frequency of such services.

(2) Diabetes self-management training provided by a participating provider who is licensed in Texas to provide such services. Self-management training includes, but is not limited to:

(a) training provided to a participant after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies.
(b) additional training required as a result of a significant change in the participant's symptoms or condition.
(c) periodic continuing education training when prescribed by a participating physician as warranted by the development of new techniques and treatments for diabetes.
(d) All diabetes self-management training is subject to Medical Director Review.

(3) Other disease specific health education programs provided by or approved by Community First.

(4) Prenatal education classes provided by Community First.

(5) Nutritional counseling and education provided by or approved by Community First.

Hearing Aids (including batteries) See Schedule of Copayments and Benefits for limitations.

Hearing Aid Exam Hearing aid examination and selection; binaural and monaural.

Home Health Care/ Skilled Nursing Services Skilled nursing provided by or supervised by a registered nurse (R.N.). The services must be provided by a participating home health agency; your PCP refers you or arranges the services and is preauthorized by Community First clinical team. Services may include physical, occupational, speech or respiratory therapy. Services are only provided for members who are homebound.

Homebound members are those who have a physical condition such that there is a normal inability to leave the home. Certain diagnoses or medical conditions may require initial home health care and transition to outpatient therapy based on medical necessity. Home Health visits cannot be combined with outpatient therapy benefit. In these instances, a preauthorization along with the physician treatment plan will be required. The skilled nursing services are of a temporary nature and will lead to rehabilitation and increased ability to function.

Hospice Care Services and Supplies Covered if authorized by a participating physician as part of a Hospice Care Program for a participant who is terminally ill.

(1) Hospice care services including pain relief, symptom management and supportive services to terminally ill participants and their immediate families on both an outpatient and inpatient basis.
(2) Counseling Services provided by a Hospice Provider.

Hospital Inpatient Services and Supplies Semi-private room and board. This includes normal daily services and supplies furnished by the hospital.

For any day on which a PCP authorizes the participant's stay in a private room in a hospital that has no semi-private rooms, hospital private room and board, including normal daily services and supplies, will be included as eligible services and supplies.

Hospital private room and board, including normal daily services and supplies, may also be included as eligible services and supplies for any day on which:

(1) the person is being isolated in a private room because of the person's communicable disease; or
(2) use of a private room is medically necessary for treatment of the person's illness or injury.

Hospital Outpatient Services and Supplies Covered services and supplies in connection with surgical treatment, including operating room and treatment, medical supplies such as splints and casts, and non- experimental drugs and medications furnished by and administered at the hospital or facility.

Implantables An object or device that is surgically implanted, embedded, inserted, or otherwise applied and related equipment necessary to operate, program and recharge the implantable. See Schedule of Benefits and Copayments for limitations.

Immunotherapy
Covered benefit in connection to treatment of cancer with applicable benefit level based on network option.

Injectables Medically necessary injectable drugs administered by a participating physician and subject to pre-authorization. Certain medications are subject to age restrictions. See Schedule of Benefits and Copayments.

Lymphedema Compression Treatment. Items mean standard and custom fitted gradient compression garments and other items determined by the Secretary that are;
1). Furnished on or after January 1, 2023, to an individual with a diagnosis of lymphedema for the treatment of such condition;
2). Primarily and customarily used to serve a medical purpose and for the treatment of lymphedema, as determined by the Secretary; and
3). Prescribed by a physician (or a physician assistant, nurse practitioner, or clinical nurse specialist).
Two garments at one time (or two sets of garments, if your treatment requires more than one piece) replaced every 6 months.

Maternity Inpatient Care The maternity benefit offered herein includes coverage for inpatient care for a mother and her newborn child in a health care facility for a minimum of:

(1) 48 hours following an uncomplicated vaginal delivery; and

(2) 96 hours following an uncomplicated delivery by caesarean section unless the participant and her attending physician determine that a shorter period of inpatient care is appropriate.

This benefit also covers maternity inpatient care for pregnant dependents. See I.B.2. Dependents Eligible for Coverage and III A.4.c. Special Dependent Coverage Rules for Newborn and Adopted Children.

Note: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in

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

If services are not rendered at UH facility, member may have additional out of pocket expenses i.e., supplies etc.

Obesity Drugs and Treatment Please see Limitations on page 33. Requires Preauthorization.

Ophthalmological Services Covered services and supplies needed for the diagnosis and treatment of diseases of the eye, or injury to the eye.

Orthotics Prescribed by a participating provider and determined to be medically necessary. Repair and replacement is covered unless due to misuse or loss. See Schedule of Benefits.

Outpatient Therapy Short term outpatient services which meet or exceed the Participants treatment goals and must be performed by a licensed therapy provider under the direction of a Physician. Therapies include physical, occupational, speech and hearing, pulmonary rehabilitation, and cardiac rehabilitation. See Schedule of Benefits for limitations. For a physically disabled person, treatment goals must include improvement or maintenance of functioning, or prevention of or slowing of further deterioration. Outpatient Therapy visits cannot be combined with Home Health Therapy benefits. See Schedule of Benefits for limitation.

Oxygen Oxygen and rental of equipment for use of oxygen, when medically necessary and prescribed by a participating physician.

Pain Management Services Medically necessary pain management treatment and related services that are ordered by a participating provider and preauthorized by Community First. Services can be expected to meet or exceed treatment goals and are scientifically proven and evidence-based to improve your medical condition.

Physicians' Services For surgical procedures and for other medical care.

Preventive Health Services The following preventive health services are covered:

(1) Well-baby and well childcare including childhood screening tests for hearing loss, as required by law, from birth through the date the child is 30 days old and any necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old;

(2) Annual eye and ear examination for children through age 17, to determine the need for vision and hearing correction.

(3) Periodic adult health evaluations.

(4) Pediatric and adult immunizations in accordance with Community First's clinical guidelines and/or as required by law.

(5) Medically appropriate COVID-19 tests must be FDA-authorized or approved and be ordered or reviewed by a health care professional to either 1) diagnose if the virus is present in a person due to symptoms or potential exposure, or 2) help in the treatment of the virus for a person. PCR testing for traveling purposes is limited to 2 per year per member.

(6) Annual well-woman exam including, but not limited to, periodic screening for breast and cervical cancer. A conventional pap smear screening or a screening using liquid-based cytology methods alone or in combination with a test for the detection of the human papillomavirus. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period.

Annual diagnostic testing for the detection of prostate cancer. Coverage is provided for:

(a)) a physical examination for the detection of prostate cancer; and

(b) a prostate-specific antigen test used for the detection of prostate cancer for each male who is:

(1) at least 50 years of age and asymptomatic; or

(2) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

(7) For qualified individuals, medically accepted bone mass measurement for the detection of low bone mass and to determine the risk of osteoporosis and fractures associated with osteoporosis. Qualified individual means:

(a) postmenopausal woman who is not receiving estrogen

replacement therapy.

(b) an individual with:

(1) vertebral abnormalities.
(2) primary hyperparathyroidism; or
(3) a history of bone fractures; or

(c) an individual who is:
(1) receiving long-term glucocorticoid therapy; or
(2) being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

(8) Medically necessary screenings for colorectal cancer. Multi-target Stool DNA Testing for colorectal Cancer Screening such as Cologuard. Cologuard is intended for the qualitative detection of colorectal neoplasia associated DNA markers and for the presence of occult hemoglobin in human stool.

Note: Under the Affordable Care Act, certain preventive health services are paid at 100% (i.e., Well Woman exam, Tests for detection of colorectal cancer, coverage for cervical cancer, benefits or detection and prevention of osteoporosis at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services. Specifically (1) if a recommended preventive service is billed separately from an office visit, then a plan may impose cost-sharing requirements with respect to the office visit, (2) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is the delivery of a preventive service, then a plan may not impose cost-sharing requirements with respect to the office visit, and (3) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of a preventive service, then a plan may impose cost-sharing requirements with respect to the office visit.

Prosthesis An external or removable artificial device that replaces a body part or function and is determined by Community First to be medically necessary. This benefit includes repair and replacement when due to growth and within the scope of normal wear and tear. Medically necessary criteria must be met. See Schedule of Benefits and Copayments.

Reconstructive Surgery After Mastectomy Surgery to provide coverage for (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and (3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

Reconstructive Surgery for Craniofacial Abnormalities in a Child younger than 18 years of age Surgery determined by Community First to be Medically Necessary to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease. See Exclusions.

Renal Dialysis Services and supplies furnished in connection with dialysis for renal disease.

Respiratory Therapy The performance of preventive, maintenance and rehabilitative airway-related techniques and procedures.

Sexually-Transmitted Infections (STI) Education, diagnosis and treatment for STIs, including HIV, AIDS, and AIDS-related illnesses.

Skilled Nursing Facility Services Covered Services and Supplies are subject to the conditions set forth below.

- Your PCP or attending specialist refers you and
- Certifies that the participant needs 24-hour-a-day nursing care. See Schedule of Benefits for limitations.

Smoking Cessation service or supply furnished to assist with smoking cessation program. This benefit applies to prescribed smoking cessation products.. See Schedule of Benefits, the UH Drug Rider and the University Family Care Plan Preferred Drug List (PDL). Some products are covered with a prescription from your Healthcare Provider.

Supplies Prescribed by a participating provider and determined to be medically necessary and appropriate by Community First. Medical supplies are non-reusable, disposable, and are not useful in the absence of illness or injury. To be considered "medically necessary or appropriate", a medical supply must be determined by Community First to meet all of these conditions and must not be listed under Exclusions. The supply(ies):

(1) Must be part of a participating provider's treatment plan.
(2) Must be based on current treatment protocols.
(3) Must be obtained from a participating provider.
(4) Must be required such that its omission would adversely affect the participant's health;
(5) Must be recognized as safe and effective for its intended use.
(6) Must be used in a manner that is consistent with generally accepted United States medical standards or guidelines.

Examples of medical supplies may include, but not be limited to, diabetic

supplies, ostomy supplies, job stockings, sterile dressings, and urinary catheters. See non-covered supplies under Exclusions.

Telemedicine Services provided through telehealth services and telemedicine medical services, to the extent that coverage is required by Section 1455.004 of the Texas Insurance Code. Providers or specialists that are under contract with the University Family Care Plan (UFCP) to provide telemedicine or telehealth services will be available to members of the UFCP. The amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for the covered health care service or procedure provided through an in-person consultation.

Temporomandibular Joint (TMJ) Medically necessary services for the diagnosis and surgical treatment of conditions affecting the temporomandibular joint which includes the jaw and the craniomandibular joint resulting from an accident, trauma, congenital defect, developmental defect, or pathology.

Transplant services Covered medical services including evaluation and supplies for medically necessary and appropriate transplant services including:

(1) Heart transplant
(2) Lung transplant
(3) Heart/Lung transplant
(4) Kidney transplant
(5) Kidney/pancreas transplant
(6) Liver transplant
(7) Liver/small bowel transplant
(8) Pancreas transplant
(9) Small bowel transplant
(9) Corneal transplant
(10) Bone marrow transplant for aplastic anemia, leukemia, severe combined immuno-deficiency disease, and Wiskott Aldrich syndrome.

Donor or prospective donor expenses are covered. The cost of artificial organs are excluded from coverage. Services or procedures considered experimental and/or investigational under current medical policy guidelines also are excluded. See Exclusions.

The Plan will not require that a participant travel out-of-state to receive transplant services unless the informed consent of the participant has been obtained, which explains the benefits and detriments of in-state and out-of-state options.

If the participant satisfies medical criteria developed by the Plan for receiving

transplant services, Community First will provide a written authorization for care to a transplant facility selected by Community First from a list of facilities it has approved. If, after referral, either the Plan or the medical staff of the referral facility determines that the participant does not satisfy its respective criteria for the services involved, the Plan's obligation is limited to paying for covered services provided prior to such determination according to the Schedule of Copayments.

C. LIMITATIONS

This section describes limits for the covered services under section B above. It also describes any modifications of those covered services for certain illnesses.

1. **Major Disaster or Epidemic** Community First will consistently make a good faith effort to provide or arrange for covered services, taking into account existing conditions and events. If there is a major disaster or an epidemic, Community First will provide or arrange for covered services to the extent possible or practical Community First nor any participating provider will have any liability or obligation on account of delay or failure to provide or arrange for covered services.

2. **Circumstances Beyond the Control of Community First or Participating Providers** Due to circumstances not within the control of Community First or participating providers, there may be a delay in providing or arranging for Covered Services, or it may not be practical or possible to do so. Community First nor any participating provider will have any liability or obligation on account of delay or failure to provide or arrange for covered services if a good faith effort has been made to do so. Some examples of such circumstances are complete or partial destruction of facilities because of war, riot, or civil insurrection; the disability of a significant number of participating providers; and other similar causes.

3. **Continuity of Treatment in the Event of the Termination of a PCP** Community First will notify you no less than thirty (30) days in advance if a participating physician or other provider treating you is going to be leaving the Community First network. If the physician or other provider is treating you under a "special circumstance" and the treating physician or provider makes the request, then Community First will continue to compensate the physician or other provider, on your behalf, for up to ninety (90) days, for up to nine (9) months in the case of a terminally ill person, or, in the case of a participant who is past the 24th week of pregnancy, for delivery of the child, immediate postpartum care, and the follow-up checkup within the first six (6) weeks of delivery. "Special circumstance" means a condition such that your physician or provider

reasonably believes discontinuation of care could cause harm to you.

Examples include:

a. A person who has a disability.
b. A person with an acute condition.
c. A person with a Life-Threatening illness.
d. A person who is past the 24th week of pregnancy.

4. **Non-Participating Provider and Out-of-Area Services and Benefits**
Only emergency care services are covered outside the network and/or service area, unless medically necessary covered services are not available through the Plan participating providers. If medically necessary covered services are not available through the Plan's participating providers, the Plan will allow, upon the request of a participating provider and within the time appropriate to the circumstances (but in no event to exceed five working days after receipt of reasonably requested documentation), a referral to a non-participating provider. Before Community First denies such referral, you may request a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested.

5. **Obesity Treatment**
Benefits for the surgical treatment of morbid obesity, performed on an inpatient or outpatient basis, are subject to the **pre-surgical requirements listed below**. The member must meet all the requirements.
   a. Diagnosis of morbid obesity (severe obesity is defined as a Body Mass Index $\geq$40 kg/m^2, or $\geq$35 kg/m^2 in the presence of comorbidities) for a period of 2 years prior to surgery;
   b. Participation in a medically supervised weight loss program, including nutritional counseling, for at least 3 months prior to the date of the surgery. (Note: Benefits are not available for commercial weight loss programs; see page 24 for our coverage of nutritional counseling services under Health Education);
   c. Pre-operative nutritional assessment and nutritional counseling about pre-and post-operative nutrition, eating and exercise – Evidence that attempt at weight loss in the 1 year prior to surgery have been ineffective.
   d. Psychological clearance of the member's ability to understand and adhere to the pre-and post-operative program, based on a psychological assessment performed by a licensed psychologist or psychiatrist (see page 19 for behavioral health benefits).
   e. Preoperative thyroid functions that are within normal range. Normalization of thyroid functions may take as long as 8 to 10 weeks if hypothyroidism is diagnosed.

f. A preoperative screening examination by a PCP or cardiologist who evaluate preoperative risk for surgery.
g. Member has not smoked in the 6 months prior to surgery.
h. Member has not been treated for substance abuse for 1 year.
i. See Schedule of Benefits/Copayments for applicable benefit maximums that apply to morbid obesity treatment. **Authorization is required and may be performed at University Hospital ONLY.**

6. **Telemedicine/Telehealth**
   a. These services can only be rendered by providers and specialists that are contracted with the University Family Care Plan (UFCP) to provide telemedicine and/or telehealth consultation services.

7. **Smoking Cessation**
   a. Benefit has a yearly maximum of $300
   b. Only for prescriptions/medications.

8. **Bone Anchored Hearing Aids**
   a. Benefit will be considered a prosthesis. The implantable device benefit will not apply here.

D. EXCLUSIONS

All services and benefits for care and conditions within each of the following classifications shall be excluded from coverage:

Abortion Services Unless determined to be medically necessary by a Participating Provider to preserve the life of the mother, or in the case of congenital anomalies incompatible with life.

Acupuncture

Ambulance Services Transport services for non-emergency services are excluded unless pre-authorization is obtained prior to service being rendered to establish medical necessity. If you are not transported, you will be responsible for billed charges.

Artificial Internal Organs and Animal Organs

Allowable cost of Covered Services Coverage normally provided for a Covered Service may not be applied toward the cost of a non-covered Service or Supply.

Alternative Treatments That includes but not limited to acupressure, acupuncture, aquatic therapy, aromatherapy, hypnotism, massage therapy, rolfing, art therapy, music therapy, dance therapy and horseback therapy.

Assisted Living Facility Room and Board for Acquired Brain Injury when the participant is capable of living at home and only needs a structured day program and when 24-hour care is not medically necessary.

Autism Spectrum Disorder Services considered to be investigational or experimental will not be covered if they fall outside the scope of generally recognized services.

Biofeedback Therapy Excluded for the treatment of ordinary muscle tension states or psychosomatic conditions.

Charges for Broken Appointments

Charges for completion of any forms

Charges made by the Employer or a close relative Services or supplies furnished by:

(1) the Employer; or
(2) You, Your spouse, or a child, brother, sister, or parent of You or Your spouse.

Chelation therapy Excluded except when used in the treatment of heavy metal poisoning.

Chemical Dependency aftercare services Services including, but not limited to, AA/NA, support or education groups, and/or other services that primarily focus on relapse prevention to the participant who completed treatment and/or their family members.

Clothing, shoes, and diapers unless specifically covered by this Certificate (e.g., correctional shoes or inserts associated with diabetes are covered).

Compounded Drugs that are experimental and/or not FDA approved are not covered

Corrective appliances and artificial aids Including, but not limited to, communication devices, wigs and eyeglasses or contact lenses of any type, except initial replacements for loss of the natural lens. Exceptions: One pair of eyeglasses or contact lenses after each cataract surgery with insertion of an intraocular lens. Eye care services are available for members enrolled in separate vision benefit.

Cosmetic surgery Services and supplies including cosmetic, furnished mainly to

change a person's appearance are excluded. This includes surgery performed to treat a behavioral, psychoneurotic or personality disorder through change in appearance. Certain procedures may be considered as a covered benefit based on medical necessity and preauthorization will be required.

Once a member has been discharged from a hospital stay in which the member received noncovered services, medical and hospital services required to treat a condition or complication that arises as a result of the prior non-covered services may be covered when they are reasonable and necessary in all other respects.

Custodial Care Services or supplies furnished in connection with custodial care.

Dental care, oral surgery or treatment of teeth or periodontium Services and supplies not covered unless the services (i) are for medically necessary diagnostic and/or surgical treatment of the temporomandibular (jaw or craniomandibular) joint (TMJ); or (ii) are received in connection with an Injury to sound natural teeth except for an Injury resulting from biting or chewing. See *c*overed services and supplies.

Dental braces, dental implants or any treatment related to the preparation or fitting of dentures are not covered. Oral appliances and devices to treat bruxism, or as part of an orthodontia care plan are not covered.

The Plan will not exclude a participant from coverage who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, behavioral, or medical reason as determined by the participant's PCP and the dentist.

Diagnostic tests to establish paternity of a child and tests to determine sex of an unborn child.

Educational Testing and Therapy motor or language skills or services that are educational in nature or are for vocational testing or training

Environmental consultations and modifications Consultations of an environmental engineer, air conditioners, humidifiers, dehumidifiers, purifiers, elevators, and chair lifts.

Experimental or Investigational Services and Supplies Services and supplies, including new and emerging health care technologies that are determined by the Plan to be Experimental or Investigational.

The Plan may, however, deem an experimental or investigational service or supply covered for treating a life-threatening illness or condition if it is determined by the Plan, through an Ombudsman Program, that the experimental or investigational service or supply at the time of the determination:

(1) is proved to be safe with promising efficacy; and
(2) is provided in a clinically controlled research setting; and
(3) uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Eye Surgery Services and supplies furnished in connection with eye surgery such as radial keratotomy and lasik, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Foot care Routine foot care, treatment of flat feet and treatment of subluxations of the feet are excluded. Orthopedic shoes are not covered, except as an integral part of a medically necessary leg brace. This does not include treatment of fractures or other acute injuries.

Gene Therapies Gene Therapy and Other Rare Diseases Includes, but not limited to, all treatment, services, surgical or invasive procedures, supplies or complications arising from or connected in any way to the administration of the procedure or treatment. Regardless of medical necessity.

Home and automobile modifications or improvements Excluded even when necessary to accommodate installation of covered services or to facilitate entrance or exit.

Hospital private room Excluded unless determined to be medically necessary.

Infertility drugs Drug therapy for infertility which involves:

(1) non-FDA approved indications.
(2) non-standard dosages, length of treatment, or cycles of therapy; or
(3) in-vitro fertilization procedures.

Infertility Diagnosis and Treatment Services or supplies furnished in connection with any procedures which involve harvesting, storage and/or manipulation of eggs and sperm for in-vitro fertilization. Other procedures excluded, but are not limited to:

(1) In-vitro fertilization
(2) Gamete or zygote intrafallopian transfer and similar procedures
(3) Reversal of voluntary induced sterility
(4) Surrogate parent services and fertilizations
(5) Donor egg or sperm
(6) Embryo transfer
(7) Embryo freezing

Infertility benefits excluded from coverage include transsexual surgery, gender

reassignment, and any services or supplies used in any procedures performed in preparation for or immediately after any of the above-referenced procedures.

Injectable Medications which have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration and the National Institute of Health.

Medical record charges Charges associated with copying or transferring medical records.

Military Service Connected Disabilities Services and supplies furnished in connection with military service-connected disabilities for which the participant is legally entitled to services and for which facilities are reasonably available to the participant.

Obesity Treatment Any treatment after the $30,000 lifetime maximum is met. Includes, but not limited to, all treatment, services, surgical or invasive procedures or complications arising from or connected in any way, for treatment of obesity, services and supplies furnished in connection with any weight loss program or food supplements used to achieve weight loss, liposuction, gastric bypass, jejunal bypass and balloon procedures.

Over-the-counter medications and supplies Any care, treatment, service, supply or item that is available without a physician's recommendation or written prescription, including a dietary formula, is excluded unless expressly covered under this Plan (e.g., over-the-counter diabetic supplies are covered, as are dietary formulas necessary for the treatment of Phenylketonuria and other heritable diseases). Examples of over-the-counter items not covered: band- aids, tape, gauze bandages, ACE bandages, elastic joint supports, TED hose, paper towels, etc.

Personal comfort items Including but not limited to, personal care kits provided on admission to a hospital or comparable facility, telephone, newborn infant photographs, meals for guests of the patient, and other articles which are not determined to be medically necessary or appropriate for the specific treatment of the illness or injury.

Physical examinations provided solely for the purpose of travel out of the country, other employment, or school abroad and sports physicals.

Prescription Medications Unless (i) furnished by a hospital during a hospital inpatient stay, (ii) specifically listed in the "Covered Services" section above. This is specifically related to Behavioral Health Services for Inpatient and Residential Treatment and should be written by a licensed physician.

Private Duty Nursing

Public Facility Services and supplies furnished in connection with conditions

that state or local law requires be treated in a public facility.

Reconstructive Surgery for Craniofacial Abnormalities for anyone 18 years of age or older. See Covered Services.

Recreational, educational and sleep therapy including any related diagnostic services.

Reduction Mammoplasty for cosmetic purposes, except for post-mastectomy reduction of the unaffected breast to achieve a symmetrical appearance.

School-based therapy services

Services and supplies Services and supplies that meet the following conditions.

a. Unnecessary services and supplies. Services and supplies that are not medically necessary or appropriate for the diagnosis and/or treatment of an illness or injury. Examples are rubber sheets, incontinent pads, diapers, non-sterile rubber gloves, emesis basins, powder, batteries (except for hearing aid batteries) etc.

b. Required by a court decree regarding a divorce action, a motor vehicle violation or other judgment not directly related to this Plan, if they would not be covered in the absence of such a decree.

c. Related to preservation and/or storage of body parts, fluids or tissues, except for autologous blood and related collection and storage costs in connection with covered non-experimental services and supplies.

d. Not furnished or authorized by a PCP.

e. Furnished for cosmetic surgery except what is listed under covered services.

f. Over-the-counter supplies.

g. Received from a nurse who does not require the skill and training of a nurse.

Sex changes All services, medications and/or supplies furnished in conjunction with the sex change process. This includes hormonal medications required before and after surgery.

Sex therapy, sex counseling and sexual dysfunction or inadequacies that do not have a physiological or organic basis.

Therapies including speech, occupational and physical on an outpatient basis in conjunction with Home Health Care/Therapies. Certain diagnoses or medical conditions may require initial home health care and transition to outpatient therapy based on medical necessity. See Home Health Care/Skilled Nursing Services under Covered Services.

Thermograms and thermography measuring the temperature variations at the body surface.

Vaccines provided for the purpose of travel out of the country obtaining other employment or school abroad.

Vocational rehabilitation

Voluntary sterilization reversal of a previous surgical procedure intended to induce permanent infertility.

Work Related Injury or Illness Services and supplies for any work-related injury if any other source of coverage or reimbursement which is in force and in effect for the services. Sources of coverage or reimbursement available to you may include your employer, a work-related benefit plan maintained by your employer, and any Workers' Compensation, occupational disease, or similar program under local, state, or federal law.

V. RIGHT OF SUBROGATION AND REIMBURSEMENT UNDER THE PLAN

If the Plan pays or provides medical benefits for an illness or injury that was caused by an act or omission of any person or entity, the Plan will be **subrogated** to all rights of recovery of a plan participant, to the extent of such benefits provided or the reasonable value of services or benefits provided by the Plan. The Plan, once it has provided any benefits, is granted a **lien** on the proceeds of any payment, settlement, judgment, or other remuneration received by the plan participant from any sources, including but not limited to:

- a third party or any insurance company on behalf of a third party, including but not limited to premises, homeowners, professional, DRAM shop, or any other applicable liability or excess insurance policy.
- underinsured/uninsured automobile insurance coverage regardless of the source.
- no fault insurance coverage, such as personal injury or medical payments protection regardless of the source.
- any award, settlement or benefit paid under any worker's compensation of law claim or award.
- any indemnity agreement or contract.
- any other payment designated, delineated, earmarked or intended to be paid to a plan participant as compensation, restitution, remuneration for injuries sustained or illness suffered as a result of the negligence or liability, including contractual, of any individual or entity.
- any source that reimburses, arranges, or pays for the cost of care.

Assignment

Upon being provided any benefits from the Plan, a plan participant is considered to have assigned his or her rights of recovery from any source including those listed herein to the Plan to the extent of the reasonable value of services as determined by the Plan or benefits provided by the Plan

No plan participant may assign, waive, compromise, or settle any rights or causes of action that he/she or any dependent may have against any person or entity who causes an injury or illness without the express prior written consent of the Plan and/or the Plan administrator.

Reimbursement

The Plan, by providing benefits, acquires the right to be reimbursed for the reasonable value of services or benefits provided to a plan participant, and this right is independent and separate and apart from the subrogation, lien and/or assignment rights acquired by the Plan and set forth herein.

The Plan is also entitled to recover from plan participant the value of benefits and services provided, arranged, or paid for, by anyone including those listed herein.

If a plan participant does not reimburse the Plan from any settlement, judgment, insurance proceeds or other source of payment, including those identified herein, the Plan is entitled to reduce current or future benefits payable to or on behalf of a plan participant until the Plan has been fully reimbursed.

Plan's Actions

The Plan in furtherance of the rights obtained herein may take any action it deems necessary to protect its interest, which will include, but not be limited to:

- place a lien against a responsible party or insurance company to the extent benefits have been paid.
- bring an action on its own behalf, or on the plan participant's behalf, against the person, entity or insurance company.
- cease paying the plan participant's benefits until the plan participant provides the Plan Sponsor with the documents necessary for the Plan to exercise its rights and privileges; and
- the Plan may take any further action it deems necessary to protect its interest.

Obligations of the Plan Participant to the Plan

- If a plan participant receives services or benefits under the Plan, the plan participant must immediately notify the Plan Sponsor of the name of any individual or entity against whom the plan participant might have a claim as a result of illness or injury (including any insurance company that provides coverage for any party to the claim) regardless of whether or not the plan participant intends to make a claim. For example, if a plan participant is injured in an automobile accident and the person who hit the plan participant was at fault, the person who hit the plan participant is a person whose act or omission has caused the plan

participant's illness or injury.

- A plan participant must also notify any third-party and any other individual or entity acting on behalf of the third-party and the plan participant's own insurance carriers of the Plan's rights of subrogation, lien, reimbursement, and assignment.

- A plan participant must cooperate with the Plan to provide information about the plan participant's illness or injury including, but not limited to providing information about all anticipated future treatment related to the subject injury or illness.

- The plan participant authorizes the Plan and The Bratton Firm, to pursue, sue, compromise and/or settle any claims described herein, including but not limited to, subrogation, lien, assignment, and reimbursement claims in the name of the plan participant and/or Plan. The plan participant agrees to fully cooperate with the Plan in the prosecution of such a claim. The plan participant agrees and fully authorizes the Plan and the Bratton Firm to obtain and share medical information on the plan participant necessary to investigate, pursue, sue, compromise and/or settle the above-described claims. The Plan and The Bratton Firm specifically are granted by the plan participant the authorization to share this information with those individuals or entities responsible for reimbursing the Plan through claims of subrogation, lien, assignment, or reimbursement in an effort to recoup those funds owed to the Plan. This authorization includes, but is not limited to, granting to the Plan and The Bratton Firm the right to discuss the plan participant's medical care and treatment and the cost of same with third and first-party insurance carriers responsible for the incident in question. Should a written medical authorization be required for the Plan to investigate, pursue, sue, compromise, prosecute and/or settle the above-described claims, the plan participant agrees to sign such medical authorization, or any other necessary documents needed to protect the Plan's interests.

- Additionally, should litigation ensue, the plan participant agrees to and is obligated to cooperate with the Plan and/or any and all representatives of the Plan, including subrogation counsel, in completing discovery, obtaining depositions and/or attending and/or cooperating in trial in order to affect the Plan's subrogation, lien, assignment or reimbursement rights.

- The plan participant agrees to obtain consent of the Plan before settling any claim or suit or releasing any party from liability for the payment of medical expenses resulting from an injury or illness. The plan participant also agrees to refrain from taking any action to prejudice the Plan's recovery rights.

- Furthermore, it is prohibited for plan participant to settle a claim against a third party for non-medical elements of damages, by eliminating damages relating to medical expenses incurred. It is prohibited for a plan participant to waive a claim for medical expenses incurred by plan participants who are minors.

- To the extent that a plan participant makes a claim individually or by or through an attorney for an injury or illness for which services or benefits were provided by the Plan, the plan participant agrees to keep the plan updated with the investigation and prosecution of said

claim, including, but not limited to providing all correspondence transmitted by and between any potential defendant or source of payment; all demands for payment or settlement; all offers of compromise; accident/incident reports or investigation by any source; name, address, and telephone number of any insurance adjuster involved in investigating the claim; and copies of all documents exchanged in litigation should a suit be filed.

- Nothing in these provisions requires the Plan to pursue the plan participant's claim against any party for damages or claims or causes of action that the plan participant might have against such party as a result of injury or illness.

- The Plan may designate a person, agency, or organization to act for it in matters related to the Plan's rights described herein, and the plan participant agrees to cooperate with such designated person, agency, or organization the same as if dealing with the Plan itself.

Made Whole Doctrine

The Plan's right of subrogation, lien, assignment, or reimbursement as set forth herein will not be affected, reduced, or eliminated by the "made whole doctrine" and/or any other equitable doctrine or law which requires that the plan participant be "made whole" before the Plan is reimbursed. The Plan has the right to be repaid 100% first from any settlement, judgment, remuneration, insurance proceeds or other source of funds a plan participant receives. The Plan has the right to be reimbursed first whether or not a portion of the settlement, judgment, remuneration, insurance proceeds or other source of funds are identified as a reimbursement for medical expenses. The plan has the right to be reimbursed first whether or not a plan participant makes a claim for medical expenses.

Attorneys' Fees

The Plan will not be responsible for any expenses, fees, costs, or other monies incurred by the attorney for the plan participant and/or his or her beneficiaries, commonly known as the common fund doctrine. The Plan participant is specifically prohibited from incurring any expenses, costs, or fees on behalf of the Plan in pursuit of his rights of recovery against a third-party or Plan's subrogation, lien, assignment, or reimbursement rights as set forth herein. No court cost, filing fees, experts' fees, attorneys' fees, or other cost of a litigation nature may be deducted from the Plan's recovery without prior, express written consent of the Plan.

A plan participant must not reimburse their attorney for fees or expenses before the Plan has been paid in full. The Plan has the right to be repaid first from any settlement, judgment, or insurance proceeds a plan participant receives. The Plan has a right to reimbursement whether or not a portion of the settlement, judgment, insurance proceeds or any other source or payment was identified as a reimbursement of medical expenses.

Wrongful Death/Survivorship Claims

In the event that the plan participant dies as a result of his/her injuries and a wrongful death or survivorship claim is asserted the plan participant's obligations become the obligations of the plan participant's wrongful death beneficiaries, heirs and/or estate.

Death of Plan Participant

Should a plan participant die, all obligations set forth herein shall become the obligations of his heirs, survivors and/or estate.

Control of Settlement Proceeds

A plan participant may not use an annuity or any form of trust to hold/own settlement proceeds in an effort to bypass obligations set forth herein. A plan participant agrees that they have actual control over the settlement proceeds from the underlying tort claim from which they are to reimburse the plan whether or not they are the individual or entity to which the settlement proceeds are paid.

Payment

The plan participant agrees to include the Plan's name as a co-payee on any and all settlement drafts or payments from any source. The fact that the Plan does not initially assert or invoke its rights until a time after a plan participant, acting without prior written approval of the authorized Plan representative, has made any settlement or other disposition of, or has received any proceeds as full or partial satisfaction of, plan participant's loss recovery rights, shall not relieve the plan participant of his/her obligation to reimburse the Plan in the full amount of the Plan's rights.

Severability

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

Incurred Benefits

The Plan reserves the right to reverse any decision associated with the reduction or waiver of charges related to services or benefits provided if and when the Plan discovers that the plan participant has been involved in an injury or accident and may be compensated by one of the sources set forth herein. Should this occur, the plan participant is deemed to have incurred the full billed charges or the full cost of the benefits or services rendered.

Non-exclusive Rights

The rights expressed in this document in favor of the Plan are cumulative and do not exclude any other rights or remedies available at law or in equity to the Plan or anyone in privity with the Plan.

The Provisions herein bind the plan participant, as well as the plan participant's spouse, dependents, or any members of the plan participant's family, who receives services or benefits from the Plan individually or through the plan participant.

VI. GENERAL RULES FOR COORDINATION OF BENEFITS

If a participant is eligible to receive benefits under other health care plan(s). The Plan Administrator will coordinate our benefits with those of any other plan(s) that provides benefits to you.

A. DEFINITIONS

1. **Health Care Program**: Any of the following which provide benefits or services for, or by reason of, medical, dental, vision care or treatment:

   a. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid or any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

   b. Group insurance or other coverage for persons in a group, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. But this does not include school accident-type coverage for grammar school, high school, and college students.

2. **Separate Programs**: Each contract or other arrangement for coverage listed above is a Separate Program. If an arrangement has two parts and the Coordination of Benefits rules apply to one of the two, each of the parts is a separate program.

3. **Primary or Secondary Plan:** The rules establishing the order of benefit determination whether this plan is Primary or Secondary.

   a. Primary Plan benefits are determined before those of the other plan.

   b. If a health care plan does not contain a Coordination of Benefits provision, that health care plan is primary. The primary health care plan pays benefits before the secondary health care plan pays. If the

Plan is determined to be the secondary payor, then the Plan will be liable only for the amount due under the secondary plan rules, regardless of whether or not a payment is made by the primary plan.

4. **Allowable Expense**: The usual and prevailing charge or negotiated rate, whichever is less, for a needed service or supply, when the charge, service or supply is covered at least in part by one or more Programs of the same type (Dental, Vision Care, or Medical Program) covering the person for who claim is made.

   When a Program provides benefits in the form of services, the Reasonable Cash Value for each service rendered will be considered both an Allowable Expense and a benefit paid. When payment under a Program is based on a contracted fee, that fee or the physician's usual charge, whichever is less, will be considered the Allowable Expense.

   If a participant has expenses for a stay in a hospital private room, the term Allowable Expense does not include the difference between the charge for the Hospital private room and the eligible charge for a hospital room under this Program, unless:

   a. the Hospital private room charges are a covered expense under one of the Programs; or

   b. the participant's stay in a hospital private room is Medically Necessary in terms of generally accepted medical practice.

   The term Allowable Expense does not include any amount that is not payable by the Plan because a participant does not adhere to the Managed Care Provisions (as defined below).

5. **Managed Care Provisions**: Those provisions that are intended to reduce unnecessary medical care or to make medical services and supplies available at a reduced cost. Examples of Managed Care Provisions include, but are not limited to, second surgical opinion programs and Preauthorization programs.

6. **Claim Determination Period**: A Contract Year does not include any part of the Contract Year while the person has no coverage under this Plan or any part of the Contract Year before the date these or similar rules take effect.

B. EFFECT ON BENEFITS

1. **This Plan's Rules for the Order in which Benefits are Determined:** When a participant's health care is the basis for a claim, this Plan determines its order of benefits using the first of the following rules that applies:

   a. Non-Dependent/Dependent: The benefits of a Plan that covers the person as a subscriber are determined before those of the Plan which covers the participant as a dependent, except if the participant is also a Medicare beneficiary and as a result of the rule established by Title XVII of the Social Security Act and implementing regulations, Medicare is:

      (1) Secondary to the Plan covering the participant as a dependent; and

      (2) Primary to the Plan covering the participant as other than a dependent (e.g., a retired employee), then the benefits of the Plan covering the participant as a dependent are determined before those of the Plan covering that participant as other than a dependent.

   b. Dependent Child/Parents Not Separated or Divorced: Except as stated below when this Plan and another Plan cover the same child as a dependent of different persons, called "parents":

      (1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

      (2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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

   c. Dependent Child/Separated or Divorced Parents: If two or more Plans cover a person who is a dependent child of divorced or separated parents, benefits for the child are determined in this order:

      (1) first, the Plan of the parent with custody of the child.
      (2) then, the Plan of the spouse of the parent with custody of

the child; and

(3) finally, the Plan of the parent not having custody of the child.

However, the following exceptions apply:

(1) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply when any benefits are actually paid or provided before the entity has that actual knowledge.

(2) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, benefits for the child are determined as outlined above. ("Dependent Child/Parents Not Separated or Divorced").

d. Active/Inactive Eligible Employee: The benefits of a Plan which covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

e. Continuation Coverage: If a participant whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, benefits for the participant are determined in this order:

(1) first, the benefits of the Plan covering the person as an employee, or as that person's dependent.

(2) second, the benefits under the continuation coverage.

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

f. Longer/Shorter Length of Coverage: If none of the above rules determine the order of benefits, the benefits of the Plan which covered a participant longer are determined before those of the Plan which covered that person for the shorter term.

2. **Effect of Reduction in Benefits:** When these rules reduce this Plan's benefits, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

C. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply this coordination of benefits rules. The Plan has the right to decide which facts it needs. It may get needed facts for, or give them to, any other organization or person as allowable by law. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Community First any facts it needs to pay the claim.

D. FACILITY OF PAYMENT

A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit provided under this Plan. The Plan will have no further liability with respect to that amount. The term "payment made" includes providing benefits in the form of services, in which case the payment made shall be deemed to be the actual costs of any benefits provided in the form of services.

E. RIGHT OF RECOVERY

If payments have been made by the Plan that are more than what should have been paid under the coordination of benefits provisions, the Plan shall have the right to recover only the excess amount that we paid from one or more of the persons or organizations that may be responsible for the services and benefits provided.

F. Local/In-Network vs Out of Network/Out of State

1. If an employee and/or dependent is utilizing other insurance (i.e., Humana, Blue Cross Blue Shield, etc.) then, CF will coordinate benefits as the secondary payer. Please keep in mind that the services obtained outside of the UFCP Network must be within the Primary Insurance's network in order for CF to coordinate benefits as secondary payer.

2. Please keep in mind any services, including emergency services outside of UH Network, will not be covered by the University Family Care Plan as a secondary payer.

VII. COORDINATING BENEFITS WITH MEDICARE

A. WHEN MEDICARE IS THE PRIMARY PAYER

Eligible Retirees If you are an eligible retiree, and elected Medicare Part A&B or Part C your health care coverage will be determined under Medicare *before the Plan* determines benefits.

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If you elect to accept Part A only

Part A: Community First will pay all of the Medicare Part A deductible, less any applicable Copayment/Percentage Copayment for an in-network provider through the UFCP Network.

For PPO providers, Community First will pay the PPO deductible and co-insurance. If the provider is not in network with UFCP Network or First Health, there will be no secondary coverage.

Part B: If the member has not elected Part B coverage, Community First will pay as the primary payor and will pay per the Schedule of Benefits.

Local/In-Network vs Out of Network/Out of State

1. When Medicare is primary: CF **will** coordinate benefits as secondary payer when utilization of benefits occurs outside of the UFCP Network but **within Bexar County**.
2. When Medicare is primary: CF **will not** coordinate benefits as secondary payer when utilization of benefits occurs outside of the UFCP Network and **outside Bexar County**.

B. WHEN THE PLAN IS THE PRIMARY PAYER

If Community First is Primary, then the UFCP Network must be utilized.

1. **Active employees aged 65 or older** If you are an active employee aged 65 or older and are eligible for Medicare, you may continue to be covered under this Plan on the same basis as an employee under age 65.

2. **Spouses aged 65 and older of active employees If** you are an active employee and your spouse is age 65 or older, and you have enrolled your spouse for dependent coverage, the Plan will be the primary payer for your spouse's health care coverage and will determine your spouse's benefits under this Plan *before* Medicare pays benefits.

3. **Active employees and dependents under age 65 and eligible for Medicare because of a disability If** you are an employee or dependent, are eligible for Medicare because of a disability, the Plan will be the primary payer for your health care coverage and will determine your benefits under this Plan *before* Medicare pays benefits.

4. **Active employees or dependents who are eligible for Medicare only because of End Stage Renal Disease (ESRD)** If you are an employee or dependent and are diagnosed with ESRD, Community First will be primary for the first 30 months after you become eligible to join Medicare. Medicare will become the primary once the 30-month period has passed.

C. RETIREES UNDER AGE 65 RECEIVING SOCIAL SECURITY DISABILITY

Community First shall provide only secondary benefits as if Part B coverage is in force, even if Part B is not purchased by the eligible participant. Community First will not require members to purchase Medicare Part B Coverage.

VIII. CLAIM RULES

These rules apply if a charge is made to a participant for any covered service or supply under the Plan.

A. REIMBURSEMENT PROVISIONS FOR NON-PARTICIPATING PROVIDERS OR OUT-OF-AREA CLAIMS

Only emergency care is covered outside of the Plan's network and/or service area, unless medically necessary covered services are not available through participating providers. The Plan will reimburse the non-participating provider at the negotiated or usual and customary rate for medically necessary covered services, requested by participating providers and approved by Community First within forty-five (45) days of Community First's receipt of a claim with the documentation reasonably necessary to process the claim, unless a different time frame is provided for by written agreement between the parties.

Non-participating providers may require immediate payment for their services and supplies. If you pay a bill for covered services, then submit a copy of the paid bill along with a completed claim form to Community First's Member Services Department requesting reimbursement (Claim forms may be obtained from the Member Services Department). Include all of the following information on your request:

1. The patient's name, address and the identification number and Group number and your relationship to the Subscriber from Your identification card.

2. Name and address of the provider of your service (if not on the bill).

3. If you receive a bill for authorized covered services from a non-participating provider, you may ask Community First to pay the provider directly. Send the bill to Community First according to the procedures listed above.

B. PROOF OF LOSS

Community First must be given written proof of the loss for which claim is made

under the Plan. This proof must cover the occurrence, character, and extent of that loss. It must be furnished within sixty (60) days after the date of the loss. However, it may not be reasonably possible to do so. In that case, the claim will still be considered valid if the proof is furnished as soon as reasonably possible.

C. PHYSICAL EXAM

The Plan, at its own expense, has the right to examine the person whose loss is the basis of claim. The Plan may do this when and as often as is reasonable while the claim is pending.

D. LEGAL ACTION

No action at law or in equity will be brought to recover on the Plan until 60 days after the written proof described above is furnished. No such action will be brought more than one year after the end of the time within which proof of loss is required.

IX. GENERAL INFORMATION

A. COMPLAINT/APPEAL PROCESS

1. **Where to File a Complaints/Complaint Appeals** should be directed to Community First's Member Services Department at 1-800-434-2347 or 210-358-6090 or in writing to: 12238 Silicon Drive, Suite 100, San Antonio, Texas 78249.

2. **General.** Participants are required to submit all Complaints through Community First's internal Complaints and Appeals process, which we have outlined for you below.

The Plan encourages the informal resolution of complaints. The Plan will not retaliate against you, including cancellation of coverage or refusal to renew coverage, simply because you, or a person acting on your behalf, have filed a complaint against the Plan or Community First or appealed a decision of Community First.

If you would like assistance in filing a complaint or wish to designate someone to represent you in resolving your complaint, please contact Community First's Member Services Department at the number above.

3. **Process for Complaint Resolution**

Complaints will be handled in the following manner:

Step	Action
a.	You, or someone acting on your behalf, notifies Community First orally, or in writing, of a complaint.
b.	Upon receipt of a written complaint, we will send you a letter acknowledging receipt of your complaint within five working days. The letter will include the date Community First received the complaint, as well as a description of the complaint and Appeal process and timeframes. If we have received an oral complaint, you will receive a one-page complaint form, which should be completed and returned immediately for prompt resolution of the complaint.
c.	Community First will investigate the written complaint and send you a letter explaining the resolution of your complaint. Community First will acknowledge, investigate and resolve your written Complaint within 30 calendar days after the date of receipt of your written complaint, or a completed complaint form. Community First will investigate complaints received within one year from the date of service, otherwise the complaint will be deemed ineligible for the complaint and appeals process.

4. **Appeal Process**

Appeals will be handled in the following manner:

Step	Action
a.	If you are not satisfied with Community First's resolution of your complaint, you or a person acting on your behalf may notify Community First, in writing, of your wish to appeal a Complaint decision, within 90 calendar days after the date of the decision, as indicated on your complaint resolution letter.
b.	Community First will send you a letter acknowledging receipt of your request for a complaint appeal within five working days after the date of receipt of your written request for a complaint appeal. If we have received an oral appeal, we will include an appeal form, which should be completed and returned immediately for prompt resolution of the appeal.
c.	Community First will schedule a Complaint Appeal Committee to review your appeal, which will consist of Community First

representatives from the following departments and a Medical Director: Network Management, Population HealthManagement, Member Services, and Claims.

No individual serving on the panel may have previously been involved in the disputed decision that is the subject of the Appeal. You, or a person acting on your behalf, may present written alternative expert testimony, valid Summary of Benefits language to support your request for appeal, and submit any additional pertinent information which was not previously considered by Community First. Relevant documents will be reviewed by the Complaint Appeals Committee and considered along with additional information gathered during the investigation of the complaint appeal.

d. The Complaint Appeal Committee will render a decision and Community First will notify you or the person acting on your behalf, in writing, within 30 calendar days after the date of receipt of your written request for a complaint appeal.

e. The decision rendered by the Complaint Appeal Committee will be deemed final and binding on you and the Plan.

5. **Maintenance of Records.** The Plan or Community First will maintain a record of each complaint and/or appeal as well as any proceedings and any actions taken on a complaint and/or appeal for three years from the date of receipt of a complaint, or as required by law. You may obtain a copy of the record on your complaint, appeal and any proceedings.

6. **Appeal of an adverse determination**

a. **Appeals of adverse determination should be directed to:**

Population Health Management Resolution Department
Community First Health Plans
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249
210-358-6050

b. **General.** Participants are required to submit all appeals through Community First's internal Complaint and Appeal process, which we have outlined for you below

c. **Appeals of Adverse Determinations will be handled in the following manner:**

Step	Action
(1)	You, or someone acting on your behalf, notifies Community First orally, or in writing, of an appeal.
(2)	An appeal acknowledgment letter will be sent to the appealing party within 5 working days of receipt. The letter will include:
	(a) the date Community First received the appeal, (b) a reasonable list of documents to be submitted by the appealing party to CF for the Appeal. (c) a medical record request form may be sent by CF to the provider of service. (d) an appeal form to the appellant if the appeal was oral.
(3)	The Community First PHM Resolution Department will refer the appeal to an appropriate clinical consultant who was not involved in the initial adverse determination. A clinical consultant who has expertise in the field of physical or behavioral medicine that is appropriate for the service at issue makes the appeal decision.
(4)	Community First will provide written notification to the participant, provider of record, and PCP of record, when applicable, of the determination of the appeal as soon as practical, but in no case later than 30 days after it receives the oral or written Appeal.
(5)	An appropriate health care provider will make all Appeal decisions for adverse determination. If the Appeal is denied, and within ten (10) Working Days the health care provider sets forth, in writing, good cause for having a particular type of a specialty Provider review the case, the denial will be reviewed by a health care provider in the same or similar specialty as typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review. Such specialty review will be completed within fifteen (15) Working Days of receipt of the request.

7. **Process for Requesting Independent Review of an Adverse Determination:**

Step	Action

a. You, or someone acting on your behalf whose appeal of an adverse determination is denied by Community First on behalf of UH may seek review of that determination by an Independent Peer Review Organization.

b. The request for the IPRO must be in writing.

c. An IPRO appeal acknowledgment letter will be sent to the appealing party within 5 working days of receipt. The acknowledgment letter will include:

(1) the date CF received the IPRO appeal.
(2) a reasonable list of documents to be submitted by the appealing party to CF for the IPRO appeal;
(3) a medical record request form may be sent by CF to the provider of service.
(4) a one-page Appeal Form to the Appellant if the IPRO appeal is oral.

d. The resolution staff will notify the participant/participant representative, and UH of the final determination: within 30 calendar days of receipt of the original request for IPRO for standard Appeals,

e. There is no right of appeal of the IPRO determination by either the participant/ participant representative, however, the participant may complain to UH.at any time.

8. Expedited IPRO Appeals of Adverse Determinations

Expedited IPRO Appeals may be requested for denials of care for life-threatening conditions, which would seriously jeopardize the participant's life or health, and denials of continued stays for hospitalized patients.

- a health care practitioner with knowledge of the participants' medical condition (e.g., a treating practitioner) may act as the authorized representative of the participant.
- the request must be written.

The PHM Resolution Unit will determine whether the request will be treated as an expedited appeal based on UR Agent requirements.

a. If the IPRO Appeal will not be expedited, CF will:

(1) transfer the IPRO Appeal to the standard IPRO Appeal

process.

(2) provide oral notice to the participant/participant representative of the decision not to expedite within one (1) working day from the date of receipt of the IPRO Appeal.

(3) provide written notice within one (1) Working day from receipt of the appeal.

(4) The notice, which will serve as the IPRO Appeal acknowledgment letter, will contain the following information:

- the decision not to expedite the IPRO Appeal request.
- the request will be processed using the standard timeframe; iii inform the participant of the right to file a complaint if he or she disagrees with the decision not to expedite.
- inform the participant of the right to resubmit a request for an Expedited IPRO Appeal with any physician's support; and
- provide instructions about the complaint process and its timeframes.

b. If the decision is to expedite the IPRO Appeal, CF will assign the IPRO appeal to a Clinical Consultant that has not previously reviewed the case and who is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

c. The IPRO will submit its determination to CF; the CF resolution staff will notify the participant/participant Representative, and UH of the final determination:

(1) within 30 calendar days of receipt of the original request for standard IPRO Appeals, or

(2) in the event a Life-threatening Condition, the determination must be made not later than the earlier of:

(3) the 5th day after the date the IPRO receives the information necessary to make the determination; or

(4) the 8th day after the date the IPRO receives the request that the determination be made.

d. Initial notice of the decision may be delivered orally followed by a written Notification of the determination within one (1) working day from the expedited IPRO Appeal request to the participant or participant representative.

e. There is no right of appeal of the IPRO determination by either the participant or participant representative, however, the participant

may complain to UH at any time.

B. IDENTIFICATION CARDS

Any identification cards (called ID Cards) issued by the Plan, are for identification only and remain the property of the Plan. Possession of an ID Card does not convey any rights to benefits under the Plan. Any person who receives services, supplies, or other benefits to which the person is not entitled by the terms of the Plan will be charged for the actual costs incurred by the Plan for any such services or supplies or for the amount of any such benefits. If any participant permits another person to use the participant's ID Card, the Plan may:

1. invalidate that participant's ID Card; and
2. terminate that participant's coverage as provided in the "WHEN YOUR COVERAGE ENDS" section.

C. CONFIDENTIAL NATURE OF MEDICAL RECORDS

Any information from a participant's medical records or received from providers or hospitals incident to the physician-patient or hospital-patient relationships will be kept confidential as permitted by applicable law. Such information may not be disclosed without the consent of the participant, except as is reasonably necessary in connection with the administration of the Plan, as permitted by law. Each participant agrees that participating providers or consulting physicians may release medical records to Community First, and any of its subsidiaries or affiliates, as is reasonably necessary for claim determination, litigation, or other normal business activities.

D. ASSIGNMENTS

Benefits provided to a participant under the Plan are personal to the participant and are not assignable or otherwise transferable.

E. NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Plan may be sent by United States Mail, postage prepaid, addressed as follows:

If to Community First: At its address shown on the first page of this Summary of Benefits.

If to a participant: To the last address provided by the participant on an

enrollment or change of address form actually delivered to Community First.

F. WHEN YOUR COVERAGE ENDS

1. **Employee and Dependent Coverage**.

a. Your Employee Coverage or Your Dependent Coverage will end when the first of these occurs:

(1) Your membership in the covered classes for the coverage ends because your employment ends (see "End of Employment" section below).

(2) You fail to pay, when due, any contribution required for your Employee Coverage. Failure to contribute for Dependent Coverage will not cause your Employee Coverage to end.

(3) You no longer reside, live or work within the Service Area.

(4) You become eligible under Part A of Medicare by reason of reaching age 65, you elect Medicare as your primary benefit program (for active Eligible Employees and their Qualified Dependents) and choose not to continue the Plans Health Care Coverage.

(5) You fail to enroll in Part A of Medicare, if required by UH (for retired Eligible Employees and their Qualified Dependents).

(6) The coverage is dependent coverage, and your employee coverage ends.

b. Your Dependent Coverage for a Qualified Dependent will end when that person:

(1) moves his or her permanent residence outside the service area. Court ordered dependents that reside outside of the service area may continue to be covered under the UFCP plan but must obtain care through the UFCP or UFCP Expanded Network (applicable out of pocket costs will apply such as deductible and coinsurance. Services obtained outside of the UFCP or UFCP Expanded Network without a prior authorization will be the member's responsibility.

(2) ceases to be a qualified dependent. (See the section entitled "Continued Coverage for an Incapacitated Child" below.)

(3) reaches maximum age limit, as stated in section "Who is Eligible to Become Covered." Coverage will terminate at the end of the dependent's birthday month.

c. End of Employment: For purposes of coverage under the Plan, your employment ends when you are no longer considered to be employed by UH. But, for Coverage purposes, UH may consider you as still employed and in the covered classes during certain types of absences from work. UH decides whether you are to be considered as still employed during those types of absences and for how long. In making such a determination, UH does not discriminate among persons in like situations.

You may be considered as still employed up to any time limit on your type of absence. When so considered, your eligible employee coverage and dependent coverage will be continued only while you are paying contributions for such coverage at the time and in the amounts, if any, required by UH (whether or not those coverages would otherwise be non-contributory coverages). But the coverages will not be continued after they would end for a reason other than end of employment. The types of absences and time limits include disability and leave of absence. Contact the UH Human Resources Department for further details.

d. Cancellation and Non-Renewal of Coverage: If any of the following conditions exist, UHS will give written notice to the participant that the person is no longer a participant for the Plan:

(1) *Nonpayment of Amounts Due Under the Contract. UH* may cancel your coverage, after providing you with at least a 30-day written notice, if you fail to pay the amounts due, such as failure to pay any copayment or to make any reimbursement to UH required under the Plan. The Plan is not required to provide written notice of cancellation for failure to pay premium, and you may be held responsible for the cost of services received after the premium due date.

(2) *Fraud or Intentional Material Misrepresentation.* If you furnish incorrect or incomplete information in a statement made for the purpose of effecting coverage under the Plan, your coverage may be cancelled after not less than 15 days written notice. This condition is subject to the provisions

of the section entitled "INCONTESTABILITY OF COVERAGE."

(3) *Fraud in the Use of Your Identification Card, Facilities or Services.* If you permit any other person who is not a member of the Family Unit to use any identification card issued by the Plan to you, or if you fraudulently access any Participating Facilities or services provided by the Plan, your coverage may be cancelled after not less than 15 days' written notice.

(4) *Untenable Relationship*. If you are unable to establish and maintain a satisfactory relationship with a Participating Provider, or you fail to abide by the rules and regulations of the Plan, Community First will send you a 30-day written notice outlining the unsatisfactory nature of the relationship and specify the changes necessary to avoid termination. If you fail to make the necessary changes, coverage may be cancelled at the end of the thirty (30) days.

(5) *Misconduct Detrimental to Safe Plan Operations.* Coverage may be cancelled immediately if a Participant engages in any misconduct that is detrimental to safe plan operations and the delivery of services.

(6) *Failure to Meet Eligibility Requirements.* If a participant fails to meet eligibility requirements other than the requirement that he or she reside, live, or work in the Service Area, coverage may be cancelled immediately, subject to continuation of coverage provisions.

(7) *Failure to Reside, Live or Work in the Service Area.* If a participant neither resides, lives or works in the service area, coverage may be cancelled after a 30-day written notice, but only if coverage is terminated uniformly without regard to any health status related factor of the participant. Coverage for a court-ordered dependent cannot be cancelled solely because the child does not reside, live or work in the service area.

If the Plan gives the participant such written notice of termination of coverage:

(a) that person will cease to be a participant for the benefits of the coverage on the date immediately following thirty (30) days after such written notice is given by the Plan; and

(b) no benefits will be provided to the person under the coverage after such date.

Any action by the Plan under these provisions is subject to review in accordance with the Complaint and Appeals Process.

G. CONTINUATION PRIVILEGE

1. **Continued Coverage for an Incapacitated Child**: Your dependent coverage for a child will not end just because the child has reached a certain age and both a. and b. below are true:

   a. The child is then behaviorally or physically incapable of earning a living. UH must receive proof of this within the next 30 days: and
   b. The child otherwise meets the definition of qualified dependent.

   If these two conditions are met, the age limit will not cause the child to stop being a qualified dependent under the Plan. This will apply as long as the child remains incapacitated as described in a. above.

2. **Continued Coverage at You or Your Dependent's Option**: You or your dependent may be eligible for continued coverage upon the occurrence of certain events as described in below.

   a. Continued Coverage under COBRA. A participant may be eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) with the same benefits as provided under the Plan upon the occurrence of a qualifying event. Qualifying events are listed below, along with the length of time that COBRA coverage is available.

YOUR BENEFITS

DEPENDENTS BENEFITS

Qualifying Event	Length of Time COBRA Coverage is Available

Termination of Your Employment (unless due to gross misconduct)	18 months (29 months for a person who qualifies for Social Security disability benefits)
Reduction in Your work hours	18 months (29 months for a person who qualifies for Social Security disability benefits)
You become entitled to Medicare	36 months
Your death	36 months
Your divorce or legal separation	36 months
Dependent child loses eligibility	36 months

The continuation of coverage periods shown above include any periods that the participant was covered under any other continuation of coverage. The continuation of coverage may be terminated sooner than the indicated length of time when:

- the plan ends.
- the participant fails to timely pay the premium.
- the participant first becomes eligible for Medicare.
- in the case of a participant who is disabled when the continuation coverage begins, the participant becomes ineligible for disability benefits under the Social Security Act; provided, however, this will apply only if the participant becomes ineligible after such continuation coverage has been in effect for at least 18 months; or
- the participant becomes covered under another health plan that does not contain any exclusion or limitation with respect to any such pre-existing condition of the participant.

Election for continuation of coverage under COBRA must be made within (60) days of the later of: (i) the occurrence of a qualifying event, or (ii) the date you or your Dependent receives the appropriate COBRA election forms that must be provided by the Plan.

X. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

A. UH is required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) to:

1. Make sure that your health information and the health information of your family members, which UH and/or its business associates, receive and maintain on behalf of the Plan, is kept private. This health information is referred to in this section as "your protected health information."
2. Give to you a Notice of Privacy Practices concerning how UH will comply with HIPAA with respect to your protected health information. UH has provided a copy of this notice to all covered employees. A copy is posted on the UH infoNET UH reserves the right to change the notice at any time.

B. Who May Use Your Protected Health Information.

Under HIPAA, your protected health information, which is held by or for the Plan, may only be used by or disclosed to the parties that administer the Plan claims, such as Community First Health Plans, Inc., other business associates who assist UH with operating the Plan, and certain UH employees in connection with their Plan responsibilities.

C. How Your Protected Health Information May Be Used

Your protected health information may only be used for Plan payment and operations and certain other limited purposes, as permitted, or required by HIPAA, or to the extent you (or in certain circumstances, a family member) have authorized the use or disclosure of that information. The UH employees and the Plan's business associates are bound by these restrictions and conditions concerning your protected health information.

D. Your Rights Under HIPAA

In addition to protecting the Plan's use and disclosure of your and your family's health information, HIPAA also gives you and your family (collectively, you) various rights with respect to that information. For example, you have the right to inspect and copy your protected health information that is held in the Plan's official files, with certain exceptions. You also have the right to request that incomplete or incorrect information be amended. In addition, you have the right to request a list of certain extraordinary disclosures of your protected health information that may have been made after April 14, 2003.

If you would like, you may request restrictions or limitation on how, when, and to whom the Plan sends your protected health information. For example, you may ask the Plan to send information about your claims and payments to you at a different address.

E. Questions and Complaints

Additional information on the permissible uses and disclosures of your protected health information, and your rights under HIPAA, can be found in the Notice of Privacy Practices. If you have certain questions about your HIPAA privacy rights

of if you believe your rights have been violated, you may contact or file a complaint with Community First Member Services, or the Secretary of the Department of Health and Human Services...

XI. DEFINITIONS

Acquired Brain Injury: A neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior. Covered services include the following:

1. Cognitive Communication Therapy: Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
2. Cognitive Rehabilitation Therapy: Services designed to address therapeutic cognitive activities, based on an assessment, and understanding of the individual's brain-behavioral deficits.
3. Community Reintegration Services: Services that facilitate the continuum of care as an affected individual transitions into the community.
4. Neurobehavioral Testing: An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current behavior status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.
5. Neurobehavioral Treatment: Interventions that focus on behavior and the variables that control behavior.
6. Neurocognitive Rehabilitation: Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
7. Neurocognitive Therapy: Services designed to address neurological deficits in informational processing and to facilitate the development of higher-level cognitive abilities.
8. Neurofeedback Therapy: Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved behavior performance and behavior, and stabilized mood.
9. Neurophysiological testing: An evaluation of the functions of the nervous system.
10. Neurophysiological Treatment: Interventions that focus on the functions of the nervous system.
11. Neuropsychological Testing: The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
12. Neuropsychological Treatment: Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
13. Post-acute Transition Services: Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

14. Psychophysiological Testing: An evaluation of interrelationships between the nervous system and other bodily organs and behavior.
15. Psychophysiological Treatment: Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
16 Remediation: The process (es) of restoring or improving a specific function.
17. Outpatient Day Treatment Services: Structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.
18. Post-Acute Care Treatment Services: Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Adopted Child: A child for whom an adoption is final or a child who has become subject of a suit for adoption by an eligible employee. For the purposes of eligibility, an adopted child must be enrolled, at the option of the eligible employee, within either:

1. (31) days after the eligible employee is a party in a suit for adoption; or
2. (31) days after the date the adoption is final.

Adverse Determination: The determination by Community First, that the health care services furnished or proposed to be provided or proposed to be provided to a participant are not medically necessary or are experimental or investigational.

After Hours Care: Health care services provided to a participant for an illness or an injury that occurs after normal provider office hours.

Alzheimer's Disease: **a neurologic disease characterized by loss of behavior ~~mental~~ ability severe enough to interfere with normal activities of daily living, lasting at least six months, and not present from birth. Appeal:** A request, orally or in writing, for reconsideration of a decision reached under the formal Complaint and Appeals process.

Appeals Panel or Panel: A panel, composed of equal numbers of Community First Staff, Physicians or other providers, and participant's, which advises Community First on the resolution of a dispute.

Associated Company: Employers that are the Plan Sponsors (UH) subsidiaries or affiliates and are included under the Plan.

Autism Spectrum Disorder: A neurobiological disorder that includes Autism, Syndrome, or Pervasive Developmental Disorder (Not otherwise specified).

Balance Billing: The practice of charging a participant the balance of a non-network health

care provider's fee for services received by the participant that is not fully reimbursed by the Plan.

Body Mass Index: A particular marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Bone-Anchored Hearing Aid (BAHA): Considered a prosthetic, BAHA is a surgically implantable medical device for treatment of hearing loss that works through direct bone conduction. For hearing loss caused by damage or blockage to the outer or middle ear (conductive or mixed hearing loss), or those with single-sided deafness, are candidates for a BAHA device. These patients typically receive little or no benefit from traditional hearing aids.

Chemical Dependency: The abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance.

Chemical Dependency Treatment Center: A facility that provides a program for the treatment of chemical dependency pursuant to a written treatment plan approved and monitored by a physician and meets one of these tests:

- Is affiliated with a hospital under a contractual agreement with an established system of patient referral.
- Is licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse.
- Is licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Children: Includes your natural-born children, an adopted child or children who have become subject of a suit for adoption by the eligible employee, your stepchildren, foster children who depend on you for support and maintenance, and any children for whom you must provide medical support under an order issued under Section 14.061, Family Code, or enforceable by a Court in this State. Also included is a grandchild of yours and you have a court order or legal guardianship for.

Community First: Community First Health Plans, Inc.

Complainant: A physician, provider, participant, or other person designated to act on behalf of a participant, who files a complaint.

Complaint: Any dissatisfaction expressed by a complainant to Community First, orally or in writing, with any aspect of the organization or operation, including but not limited to, dissatisfaction with plan administration; procedures related to review or appeal of an adverse determination; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions. A complaint does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to

the satisfaction of the participant and does not include a provider's or participant's oral or written dissatisfaction or disagreement with an adverse determination.

Contract Year: The twelve (12) month period, commencing with the effective date of the Plan, during which coverage is in effect.

Contributory Coverage, Non-contributory Coverage: Contributory coverage is coverage for which the Plan requires Employee contributions. Non-contributory coverage is coverage for which the Plan does not require employee contributions.

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

Copayment: An amount required to be paid by a participant, in addition to premium, in connection with certain covered services and supplies. A copayment may be a set dollar amount or a percentage of the cost of the service.

Counseling Services: Supportive services provided under a hospice care program by members of the hospice team in counseling sessions with the family unit. These services are to assist the family unit in dealing with the death of a terminally ill person.

Court-Ordered Dependent: Dependent children whose eligibility for coverage is determined by a court-ordered child support or medical support document.

Covered Services and Supplies: The services and supplies covered under the Plan.

Covered Classes: All eligible employees who live, work, or reside in the service area but are not covered under the Plan.

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

Custodial Care: Services which are not intended primarily to treat a specific injury or illness (including behavioral illness or substance abuse/chemical dependency). These services may include:

1. services related to watching or protecting a participant.
2. services related to performing or assisting a participant in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can usually be self- administered; and services not required to be performed by trained or skilled medical or paramedical personnel.

Dependent: Your dependent is someone who:

- Is your spouse or your child and who meets the eligibility requirements of this Plan,

or another person who is a dependent under eligibility rules that are set by the UH

- is listed by you on the enrollment form, and
- for whom the required premium has been paid
- is a court ordered dependent
- a child of any age who is medically certified as disabled and dependent on the parent. The Plan requires proof of dependent eligibility status for any dependent over the limiting age for dependents.

Dependent Coverage: Coverage that applies to a dependent.

Eligible Employee: An employee who works on a full-time basis forty (40 hours) per week or at least part time twenty (20) hours per week. The term does not include:

1. an employee who works on a, temporary, seasonal, or substitute basis; or

2. an employee who is covered under:

    a. another health benefit plan
    b. a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et. Seq.
    c. the Medicaid program if the employee elects not to be covered.
    d. another federal program, including the CHAMPUS program or Medicare program, if the employee elects not to be covered; or
    e. a benefit plan established in another country if the employee elects not to be covered

Eligible Retiree: A former employee who meets eligibility criteria that have been set by UH.

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

1. placing his or her health in serious jeopardy.
2. serious impairment to bodily functions.
3. serious dysfunction of any body organ or part.
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Employee Coverage: Coverage that applies to an eligible employee or eligible retiree.

Employer: University Health Collectively, all Associated Companies.

Experimental or Investigational: Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time Community First makes a determination regarding coverage in a particular case, meet one of the following criteria:

1. Full and final approval has not been granted by the US Food and Drug Administration for the treatment of the patient's medical condition.

2. Specific evidence shows that the service, technology, supply, treatment, procedure, drug therapy or device is being provided subject to a) phase I or phase II clinical trial or the experimental arm of a phase III clinical trial, b) a protocol to determine the safety, toxicity, maximum tolerated dose, efficacy, or efficacy in comparison to the standard means of treatment or diagnosis, or c) protocol approved by and under the supervision of an institutional review board.

3. The published authoritative medical and scientific literature a) has not defined, or supports further research to define, the safety, toxicity, maximum tolerated dose, efficacy or efficacy in comparison to the standard means of treatment or diagnosis, and b) does not demonstrate statistically significant improvement in the efficacy or outcomes for the service, technology, supply, treatment, procedure, drug therapy or device compared to standard services, technologies, supplies, treatments, procedures, drug therapies or devices.

Eye Exam: Examinations to determine the need for corrective lenses of any type.

Facility Based Physician: A radiologist, anesthesiologist, pathologist, emergency department physician or neonatologist to whom a facility has granted clinical privileges and provides services to patients of the facility.

Family Unit: Collectively, you and your dependents who are participants.

Freestanding Emergency Medical Care Facility: means a facility, structurally separate and distinct from a hospital that receives an individual and provides emergency care.

Gene Therapy: a medical treatment used to correct defective genes in order to cure a disease or help the body better fight disease.

Open Enrollment Period: A period of at least thirty (30) days each year, set by UH during which an Eligible Employee, may:

1. Elect coverage under the Plan.
2. Elect to change benefits under the Plan; or
3. Elect to change from other coverage to the Plan.

Health Care Coverage: The services that are included in this Summary of Benefits.

Health Care Facility: A hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility providing health care services.

Health Status Related Factor: Any of the following in relation to a participant: health status; medical condition (including both physical and behavioral illnesses); claims experience; receipt of health care; medical history; genetic information; evidence of insurability (including conditions arising out of acts of domestic violence, including family violence; or disability.

Heritable Disease: An inherited disease that may result in intellectual or developmental disability or death.

Home Health Care: A program, prescribed in writing by a participating physician and administered by a home health care agency, that provides for the care and treatment of a person's illness or injury in the person's home.

Home Health Care Agency: An organization that has been licensed or certified as a home health agency in the state of Texas or is a home health agency as defined in Medicare.

Hospice: An organization that provides short periods of stay for a terminally ill person in the home or in a home-like setting for either direct care or respite. This organization may be either freestanding or affiliated with a hospital. It must operate as an integral part of a hospice care program. If such an organization is required by a state to be licensed, certified, or registered, it must also meet that requirement to be considered a hospice.

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

Hospital Inpatient Stay: A hospital stay for which a room and board charge is made by the hospital.

Illness: Any disorder of the body or mind of a participant, but not an injury.

Immunotherapy: a medical treatment that uses the body's own immune system to help fight cancer.

Implant: An object or device that is surgically implanted, embedded, inserted, or otherwise applied and related equipment necessary to operate, program and recharge the implantable

(e.g., hip joints, heart pacemakers, penile implants, cochlear implants and implanted electrical stimulators).

Independent Review Organization: An organization selected as provided under Chapter 4202 of the Texas Insurance Code.

Initial Enrollment Period: The initial period of enrollment after a potential participant first becomes an eligible employee, or first becomes a qualified dependent.

Injury: Trauma or damage to some part of the body of a participant.

Individual Treatment Plan: A plan with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program.

Life-Threatening Condition: A disease or other medical condition with respect to which death is probable unless the course of the disease is interrupted. A participant or the participant's provider of record shall determine the existence of a life-threatening condition on the basis that a prudent lay person possessing an average knowledge of medicine and health would believe that his or her disease or condition is life-threatening.

Medicaid: Title XIX (Grants to States for Medical Assistance Programs) of the United States Social Security Act, as amended from time to time.

Medical Director: A physician who is retained by Community First to coordinate and supervise the delivery of health care services for participants through participating physicians and participating providers.

Medical Emergency: A recent onset of a medical and/or behavioral health condition requiring emergency care.

Medical Necessity or Medically Necessary: Health care services which are determined to be medically appropriate, and prevent illness or deterioration of medical conditions, or provide early screening, interventions and/or treatments for conditions that cause suffering or pain, physical deformity, limitations in function, or endanger life. Such services are consistent with the diagnosis; provided at appropriate facilities and at the appropriate levels of care; consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies; and are no more intrusive or restrictive than necessary.

Medicare: Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as amended from time to time.

Morbid Obesity: This means the Body Mass Index that is greater than 40 kilograms per meter squared or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

Participant: An employee who is covered for employee coverage under the Plan or a dependent with respect to whom an employee is covered for dependent coverage.

Non-Participating Provider: A physician, hospital, or other provider of medical services or supplies that is not a participating provider, and, therefore, not contracted with Community First.

Observation Period: A short-term hospital stay lasting less than 24 hours.

Ombudsman Program: Independent medical review program that provides case review for new and emerging technologies/therapies including, but not limited to, issues pertaining to the experimental/investigational status of an intervention, clinical trials and research studies, and other clinical information, for the purpose of assisting Community First in determining Medical Necessity and appropriateness.

Out-of-Area: Outside the approved service area.

Out-of-Pocket: The copayment amounts that are the participant's responsibility each contract year. The specific out-of-pocket maximum copayment that applies under this Plan is listed in the attached Schedule of Copayments. Community First will assist the participant in determining when he or she has satisfied the out-of-pocket maximum copayment, so it is important to keep all receipts for copayments actually paid. Copayments that are paid toward certain covered services are not applicable to a participant's out-of-pocket as set forth in the attached Schedule of Copayments.

Orthotics: A custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improves function, or relieve symptoms of a disease.

Participating Physician: A physician who is either a (PCP) or a specialty care physician and who has contracted with Community First to provide services to participants.

Participating Provider: A physician, hospital, or other provider of medical services or supplies that is licensed or certified in the state in which it is located, and which has contracted with Community First to arrange for or provide services and supplies for medical care and treatment of participants.

Phenylketonuria An inherited condition that may cause severe severe intellectual disability if not treated.

Physician: Any individual licensed to practice medicine by the Texas State Board of Medical Examiners

Plan: The Summary of Benefits and any addendum, which collectively provides and defines coverage for particular employees and dependents.

Plan Administrator: University Health

Plan Sponsor: University Health

Plan Summary: The information provided to employee's concerning coverage and benefits to assist in understanding and using available benefits.

Preauthorization: The verbal or written approval by the Plan Administrator, another payor, or other permitted person or entity, including a corresponding approval prior to admitting a participant to a facility, or to providing certain other covered services to a participant, when approval is required for such services.

Prescription Medication and/or Supplies: This means only:

1. a medicinal substance that, by law, can be dispensed only by prescription.

2. other items that require a prescription order to be dispensed.

Primary Care Physician (PCP): A participating physician (generally an internal medicine, general medicine, pediatrics or family practice physician) who is chosen by or for a participant to:

1. providing primary medical care to the participant.
2. maintain the continuity of the participant's medical care; and initiate referrals to participating or non-participating physicians and/or other providers.

Prosthesis: An external or removable artificial device that replaces a limb, body part or function and is determined by Community First as medically necessary.

Psychiatric Day Treatment Facility: A behavior health facility that provides treatment for individuals suffering from acute, behavior, and nervous disorders in a structured psychiatric program using Individual treatment plans and that is clinically supervised by a physician of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Reasonable Cash Value: The cash value assigned to a service or supply provided, ordered or authorized by a participating provider. Community First will base its determination on the range of charges generally made by providers in the area for a like service or supply and take into account any unusual circumstances and any medical complications that require additional time or special skill, experience, and/or facilities in connection with a particular service.

Referral: A recommendation by a participant's PCP or other treating provider for a patient to be evaluated or treated by another physician or provider.

Related Hospital Inpatient Stays: Separate hospital inpatient stays of a person that occur as a result of the same illness or injury. Hospital inpatient stays will be considered unrelated

if:

1. the admission is for a period of thirty (30) days or more between stays.

2. the stays result from wholly unrelated causes.

Residential Treatment Center for Children and Adolescents: A child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is licensed or operated by the appropriate state agency or board.

Serious Behavior Illness: The following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM): (A) bipolar disorders (hypomanic, manic, depressive, and mixed; (B) depression in childhood and adolescence; (C) major depressive disorders (single episode or recurrent); (D) obsessive-compulsive disorders; (E) paranoid and other psychotic disorders; (F) schizo-affective disorders (bipolar or depressive; and
(G) schizophrenia.

Service Area: The geographic area within which covered services and supplies for medical care and treatment are available and provided, by participating providers, under the Plan, to participants who live, reside, or work within that geographic area.

Skilled Nursing Facility: An institution that meets all of these tests:

1. Meets all Texas licensing requirements and is legally operated.
2. It mainly provides short-term nursing and rehabilitation services for persons recovering from Illness or Injury. The services are provided for a fee from its patients and include both room and board and 24-hour-a-day skilled nursing service.
3. It provides the services under the full-time supervision of a physician or registered nurse (R.N.); or, if full-time supervision by a physician is not provided, it has the services of a Physician available under a contractual agreement.
4. Does not include an institution or part of one that is used mainly as a place for custodial care, rest or for the aged.

Special Enrollment Period: A period outside of the initial enrollment period and the open enrollment period during which an employee or dependent can enroll in the Plan. The special enrollment period for both employees and dependents can be activated by:

1. Loss of other coverage (other than for cause or non-payment of premium).
2. A new dependent acquired by an employee through marriage, birth, adoption or placement for adoption.
3. A court order requiring the employee to cover a spouse or child.

Specialty Care Physician: A participating physician who provides certain specialty medical care to participants upon referral by a PCP as approved by the Medical Director. Specialty medical care does not include the following specialties: internal medicine,

general medicine, pediatrics, and family practice. But specialty medical care may include these specialties if approved by the Medical Director.

Surgical Procedure: Typically considered an invasive procedure including, but not limited to: cutting, suturing, treatment of burns, correction of fracture, reduction of dislocation, manipulation of joint under general anesthesia, electrocauterization, tapping (paracentesis), application of plaster casts, endoscopy, or injection of sclerosing solution.

Supplies: Medical supplies are non-reusable, disposable, and are not useful in the absence of illness or injury. Common household items are not considered medical supplies.

Telehealth Service: A health service, other than a telemedicine medical service, delivered by a provider acting within the scope of his or her license, who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

- telephone visits
- compressed digital interactive video, audio, or data transmission.
- clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine medical service: A health care service initiated by a physician, or another provider authorized by law to act under physician delegation and supervision, for purposes of patient assessment by a provider, diagnosis or consultation by a physician, treatment, or the transfer of medical data, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

- compressed digital interactive video, audio, or data transmission.
- clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- other technology that facilitates access to health care services or medical specialty expertise.

Terminally Ill Person: A person whose life expectancy is six (6) months or less, as certified by a participating physician.

Toxic Inhalant: A volatile chemical under Chapter 484, Health and Safety Code, or abusable glue or aerosol paint under Section 485.001, Health and Safety Code.

Urgent Care: Health care services provided in a situation other than an emergency which are typically provided in settings such as a physician or provider's office or urgent care center, as a result of an acute injury or illness, including an urgent behavioral health situation, that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result

in serious deterioration of the condition of his or her health.

Utilization Review: A system for prospective, concurrent, or retrospective review of the Medical Necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services being provided or proposed to be provided to a member. Utilization Review does not include elective requests for clarification of coverage.

Utilization Review Agent: Community First, or an entity licensed by the Texas Department of Insurance as a utilization review agent, that conducts utilization review for Community First.

You and Your: An employee or a participant.