SUMMARY OF BENEFITS

University Family Care Plan

Expanded Network Option
Utilizing First Health Provider Network

2024

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 358-2275. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

IMPORTANT: This is a summary presented by the University Health to provide you with information about your University Family Care Plan's Expanded Network Option. Please call Community First Health Plan's Member Services Department at the number below if you have questions.

A. Who is Community First?

Community First Health Plans is the administrator of the health care coverage plans that is offered to University Health employees and family members.

B. How can you reach us?

You can reach us from any place in Texas or any other state by calling:

1-800-434-2347
Local: 210-358-6090

Our address is:

Community First Health Plans, Inc.
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249

C. Provider Network. The Expanded Network is offered by First Health. Please call 1-888-226-5116 or access the Provider Directory located at www.myfirsthealth.com

D. University Family Care Plan Expanded Network Service Area includes in network First Health Providers Nationwide.

E. How do I access benefits through the Expanded Network?

1. **Accessing Benefits inside the Expanded Network.**

University Family Care Plan participants, who wish to seek services outside the family of UH providers, can utilize the Expanded Network of doctors and hospitals by presenting their ID card at the time of service. These services will then be subjected to the co-pays, co-insurance and deductibles required under the Expanded Network option detailed later in this benefit summary document. If a participant seeks initial eligible treatment from a contracted provider in the Expanded Network, all eligible related services will be covered under the Expanded Network unless performed at the University Health.

It is very important to note that any service received by providers outside of the Expanded Network will be the sole responsibility of the participant. There are no 'out-of-network' benefits provided through the Expanded Network option other than some specific services that may include emergency services. If you have any questions about how to use this expanded coverage, we encourage you to call Community First to speak with a member services representative.

2. Other Situations.

a. **Emergency Care**. Please reference Emergency Care Services, Section I below.

b. **Continuity of Care if Participating Provider Leaves the Expanded Network.** If your participating provider leaves the Expanded Network, you may continue to see that provider and receive benefits under "special circumstances," however, you must notify Community First to continue to do so. "Special circumstance" means a condition such that your participating provider reasonably believes discontinuation of care could cause harm to you, such as a disability, an acute condition, a life-threatening illness, or a pregnancy that is past the 24th week. If your participating provider makes such a request and special circumstances exist, Expanded Network benefits will continue:

(1) In the case of a terminally ill person, for up to nine (9) months.
(2) In the case of a participant who is past the 24th week of pregnancy, through the delivery of the child, immediate postpartum care, and the follow-up checkup within the first six (6) weeks of delivery. An authorization is required to approve accessing this provision of coverage.
(3) In the case of other special circumstances, for 90 days.

F. What are the Plan's Covered Services and Benefits?

Basic Expanded Network Plan Coverage: Schedule of Benefits.

ALL COVERED CHARGES ARE SUBJECT TO THE CALENDAR YEAR DEDUCTIBLE UNLESS NOTED.

Note: Expanded Network specialists can be accessed directly without referral from a PCP.

G. Prescription Coverage

- **Filling Prescriptions at Participating Pharmacies.** Prescriptions written by a non-UH/UMA/UT provider can be filled at the UH Pharmacy. Expanded Network acquired prescriptions cannot be filled through mail order to access cost-savings.
- **Filling Prescriptions at Non-Participating Pharmacies in the event of an emergency.** Participants may have prescriptions filled at pharmacies that are non-participating providers in the event of an emergency or out of area travel but will have to pay full cost for such prescriptions and file a claim for reimbursement with Community First.
- **Co-insurance for Covered Supplies** is 15% of the standard pharmacy contract rate or other rate negotiated with a participating provider.
- **Out-of-Pocket Limitation.** Co-payments or co-insurance paid toward prescription

Medications are not applicable to any <u>annual</u> out-of-pocket maximum.

H. Transplant Coverage

Only transplants unavailable through the UH network will be covered under the Expanded Network option.

I. *What emergency care services and after-hours care services are available to participants through the Expanded Network?*

Emergency Care Services

Emergency care is defined as health care services provided in a hospital emergency facility or comparable 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.

If a medical emergency occurs, participants should go to the nearest participating or non-participating emergency facility.

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.

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% co-insurance after annual deductible is met. Hospitals outside of the First Health Network (Expanded Network) and outside of Texas, 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. Ultimately, the member may be responsible for the balance of billed charges, if any.

If it is determined that a medical emergency does exist, Community First will approve, or deny coverage of post-stabilization care, as requested by a treating provider, within the timeframe appropriate to the circumstances.

During a true emergency and as the member’s condition is stabilized, the Plan pays for services to a non-participating provider at the Expanded Network plan rate. Once the patient is stabilized, the patient must be moved to a facility that is under the Expanded

Network or the member will be responsible for charges associated with the emergency after the stabilization. If the provider who treated the member indicates that follow-up care to complete the treatment is needed, 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. In cases where those follow-up services could be delivered from a UH network provider by transferring the stabilized patient to receive services at a UH network provider, those services will be covered under the Expanded Network plan deductibles and co-insurance.

After-Hours Care

After-hours care is defined as 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.

Services received at an Expanded Network urgent care provider will be covered under the Expanded Network option only.

J. What are the Expanded Network's out-of-area benefits?

Only emergency services are available outside the service area. If non-emergency services are accessed out of the service area, the employee and/or dependent will be responsible for the entire cost of those services.

K. Your Share of Expenses

1. **Deductibles.**

   a. **Calendar Year Deductible.** Benefits for each participant are subject to a deductible amount that you must pay each calendar year before receiving many benefits under the Plan. It is equal to the amount shown in the Schedule of Benefits as the calendar year deductible. See the *Schedule of Benefits* attached to this Summary of Benefits. Deductibles and co-pays are not combined to reach the Expanded Network option deductibles.

   b. **Family Calendar Year Deductible.** The calendar year deductible for you and each of your dependents is subject to a family calendar year deductible. Once the family calendar year deductible is met, you and your dependents will not be responsible for any more deductible payments during that calendar year. For example, if the calendar year individual deductible is $575 and the family calendar year deductible is $1,155 you and your dependents will not have to pay a total of more than $1,155 in

calendar year deductibles, regardless of the number of dependents you have. One participant cannot pay more than his/her individual calendar year deductible to reach the family calendar year deductible more quickly.

2. **Co-payments/Co-insurance and the Annual Out-of-Pocket Maximums.**

Co-payments/Co-insurance means the portion of cost of medical services that a participant must pay under their health care coverage. For example, under the Expanded Network option, the Plan pays for 70% of a covered benefit after the calendar year deductible is met. Your co-pay or co-insurance would be 30% of the covered benefit. Co-pay/Co-insurance does not include:

(1) Deductibles.
(2) Services, supplies, or charges that are not covered under the Plan.
(3) The amount of a reduction in benefits because precertification requirements were not met. See the Schedule of Benefits.

Annual Out-of-Pocket Maximums. The Expanded Network option coverage limits the amount of co-payment/co-insurance that you or any one of your dependents must pay to the "Annual Out-of-Pocket Maximum" stated in the *Schedule of Benefits.* The Plan also limits the amount of co-payment/co-insurance that you and your dependents collectively must pay to the **"Family Annual Out-of-Pocket Maximum"** stated in the *Schedule of Benefits.* One participant cannot pay more than his or her share of co-payment/co-insurance specified in the Schedule of Benefits to reach the family annual out-of-pocket maximum more quickly.

3. **Maximum Benefit Levels**

a. **Calendar Year Maximum Benefit.** Some benefits are limited to a specific number of days or visits allowed during a calendar year benefit period. See the *Schedule of Benefits.* The calendar year is from January 1 through December 31 of the same year. The initial calendar year benefit period is from a participant's effective date of coverage through December 31 of the same year.

4. **Non-Expanded Network provider (Out-of-Network) Benefits.** Any service provided by a non-contracted provider will be the sole responsibility of the participant, unless it was of an emergency nature.

5. **Non-Participating Facility Based Physicians.** When you receive services at a participating hospital, you should ask about the contract status of the facility-based physicians that will be treating you as these physicians may not participate in Community First's Expanded Network and may balance bill you for amounts not paid by Community First. 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, 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 receive a bill from any participating provider asking you to pay for something other than a deductible or co-insurance, please notify Community First's Member Services Department immediately.

6. When accessing the Expanded Network, please check if the provider is currently participating in the Expanded Network. If a provider is not currently contracted with the Expanded Network, you will be responsible for all billed charges.

L. Pre-existing conditions, Limitations and Exclusions.

1. **Pre-existing Conditions**

    - **What is a Pre-existing Condition?** The Expanded Network option does not have any pre-existing condition requirements for enrolled participants.

2. **The Limitations and Exclusions listed in the University Family Care Plan Document apply to the Expanded Network option.**

    - **Obesity Treatment covered under UH Network only**. All procedures and services will only be performed at University Hospital, no other UT medicine locations.

M. What are requirements relating to Preauthorization of Benefits?

1. **What is Precertification?** Precertification by Community First establishes in advance the medical necessity of certain covered benefits. It ensures that services will not be denied based on medical necessity. **However, Precertification does not guarantee payment of benefits.** Payment of benefits is also subject to other requirements such as, medical exclusions and limitations, payment of premium and eligibility at the time the services are provided.

2. **Who is Responsible for *Preauthorization* of Benefits?** If you receive services from an Expanded Network provider, those providers will seek precertification for you from Community First. However, you should validate that precertification was obtained at least forty-eight (48) hours prior to scheduled services, except in emergency situations. If you receive services from an Expanded Network provider, you are responsible for obtaining precertification, although the provider may obtain it for you.

3. **How to Obtain *Preauthorization*?** Your participant ID card contains the telephone number for you or a provider to call when seeking preauthorization. The call should be made between 8:30 a.m. and 5:00 p.m., Monday through

Friday. Calls made after hours or on weekends or holidays will be routed to Nurse Link.

4. Community First must be contacted as soon as hospital confinement or inpatient or outpatient surgical procedures are recommended. Community First will discuss the diagnosis, the need for hospitalization or surgery, and the expected length of confinement as well as coordinate discharge needs.

5. Medical services that currently must be preauthorized by Community First are listed online for your review or by calling Member Services at 210-358-6090. Precertification requirements can be found on our website at https://communityfirsthealthcoverage.com /.

The member will be responsible for the applicable co-insurance, deductible, and any outstanding balance(s). The reduction does not apply to the out-of-pocket maximum.

6. **Concurrent Review.** In addition to preauthorizing inpatient admissions, Community First will conduct “concurrent review” of the medical necessity of continued inpatient confinement. “Concurrent review” means that Community First will continue to evaluate the need for ongoing Hospitalization.

7. If a hospital confinement continues beyond the number of days preauthorized by Community First, no benefits will be payable for any unauthorized days of confinement.

N. What Happens If My Provider Leaves the Expanded Network?

You may continue to see your provider if he leaves the Expanded Network under certain circumstances. Please refer to the section Continuity of Care if participating provider leaves the Expanded Network.

O. Where can I file a Complaint?

Please reference the complaint and appeal process outlined in the University Family Care Plan under Complaint/Appeals Process.