

**YAVAPAI COMBINED TRUST
(YCT)**

**Plan Document
for
Medical, Dental, Vision and Short Term Disability Benefits**

Amended, restated, and effective July 1, 2016

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ARTICLE 1: INTRODUCTION

WHAT THIS DOCUMENT TELLS YOU

This document describes the medical and dental benefits for participants in the **Yavapai Combined Trust (YCT)**, hereafter referred to as the “Trust.” There is also a chapter on Short Term Disability Benefits Coverage and a chapter on Vision Plan benefits that pertains to certain employees of some of the participating employers of this Trust.

- **The Plan described in this document is effective as of July 1, 2016 and replaces any other plan document previously provided to you.**
- This Plan is self-insured with claims paid by independent claims administrators.
- The Plan is not subject to the provisions of the Employment Retirement Income Security Act of 1974 (ERISA).

This document is designed to provide participants with easy access to information about the medical and dental benefits and, when applicable, short term disability benefits and vision plan benefits under Yavapai Combined Trust. Please review the materials and, if you feel it is appropriate, show it to those members of your family who are or will be covered by the Plan. The information covered in this document includes explanations of:

- the coverages provided;
- the procedures to follow in submitting claims; and
- your responsibilities to provide necessary information to the Plan.

Please be advised that the Plan is based upon certain definitions and limitations that are listed in the Definitions and Exclusions chapters of this booklet. Also, from time to time, there may be a need to add or change the Plan in some way. When this occurs, the Trust will communicate information explaining the changes to participants. Once the Plan changes have occurred, the information communicating the changes will supersede any previous information about the particular benefit or procedure that is different from what is described here.

Current information regarding the Plan can be found on the YCT Website: www.yctrust.net.

It is hoped that this document, as well as any notices of Plan changes, will be a convenient and useful tool for participants and family members in assisting with general benefits questions. Your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment. No individual shall have accrued or vested rights to benefits under this Plan. A vested right refers to a benefit that an individual has earned a right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed.

While recognizing the many benefits associated with this Plan, it is also important to note that not every expense you incur for health care is covered by the Plan.

Yavapai Combined Trust intends this Plan to be permanent, but since future conditions possibly affecting the Plan cannot be anticipated or foreseen, the Trust reserves the right to amend, modify or terminate this Plan at any time, which may result in the termination or modification of your coverage. Expenses incurred prior to the Plan termination will be paid as provided under the terms of this Plan prior to its termination.

SPANISH LANGUAGE ASSISTANCE

Este documento contiene una breve descripción sobre sus derechos de beneficios del plan, en Inglés. Si usted tiene dificultad en comprender cualquier parte de este documento, por favor de ponerse en contacto con su Departamento de Personal/Recursos Humanos a la dirección y teléfono en el (Quick Reference Chart) de este documento.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Plan Administrator information regarding change of name, address, marriage, divorce or legal separation, birth, death of any covered family member, change in status of a Dependent Child, Medicare enrollment or disenrollment, or the existence of other coverage.

Notify the Plan preferably within 31 days, but no later than 60 days, after any of the above noted events.

Failure to give this Plan a timely notice (as noted above) may cause you, your Spouse and/or Dependent Child(ren):

- a. to lose the right to obtain COBRA Continuation Coverage, or
- b. may cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability, or
- c. may cause claims to not be able to be considered for payment until eligibility issues have been resolved, or
- d. may result in your liability to repay the Plan if any benefits are paid to an ineligible person.

QUESTIONS YOU MAY HAVE

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Claims Administrator (or your Human Resource representative) at their phone number and address located on the Quick Reference Chart in this document. As a courtesy to you, the claims staff may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. Your most reliable method is to put your questions into writing and fax or mail those questions to the Claims Administrator and obtain a written response from the Claims Administrator.

IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR COVERAGE

Choices that you make, or that are made on account of a referral by your physician, that result in out-of-network charges or medically unnecessary care that is not payable by the Plan, are YOUR responsibility.

A referral from an in-network physician to an out-of-network physician does NOT make the claim from the out-of-network physician payable at the in-network rate.

Your Human Resources office and the Plan's Claims Administrator are available to help answer questions and to explore options for coverage, but ultimately it is your responsibility to understand this Plan.

ARTICLE 2: QUICK REFERENCE CHART

Whom to Call for Help or Information: When you need information, please check this document first. If you need further help, call the people listed in the following chart:

QUICK REFERENCE CHART	
Information Needed	Contact the following
<p>Claims Administrator</p> <ul style="list-style-type: none"> • Medical, Behavioral Health, Dental and Vision Claims and Claim appeals • Eligibility • COBRA Administration • Short Term Disability claims administration (for employees of certain participating employers of the Trust) • Medicare Part D Notice • Summary of Benefits and Coverage (SBC) 	<p>Summit Administration Services, Inc. P.O. Box 25160 Scottsdale AZ 85255-0102 Phone: (888) 690-2020 or (480) 505-0400 Fax: (480) 505-0407 http://www.summit-inc.net/ Trust website: www.yctrust.net</p>
<p>Medical Preferred Provider Network</p> <ul style="list-style-type: none"> • PPO Preferred In-Network Providers • Network Behavioral Health Providers • CAUTION: Use of a non-PPO network hospital, facility or Health Care Provider could result in you having to pay a substantial balance of the provider’s billing (see definition of “balance billing” in the Definition chapter of this document). Your lowest out of pocket costs will occur when you use In-Network PPO providers. 	<p>Blue Cross and Blue Shield of Arizona (BCBSAZ) Please contact the network at their website below: www.azblue.com/chsnetwork (the Blue Preferred PPO Network) or available through www.yctrust.net or call the Medical Plan Claims Administrator above for assistance.</p> <p><i>Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross and Blue Shield Association, provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross and Blue Shield Plans outside of Arizona.</i></p>
<p>Medical Providers under Direct Contract to this Plan</p> <ul style="list-style-type: none"> • In addition to the Blue Cross network, the Plan has contracted directly with some local Yavapai County-based health care providers who have extended to the Plan, and you, a discount off the price of their usual fees. These providers ARE considered in-network. 	<p>To determine which providers are contracted, visit the Plan’s website at www.yctrust.net.</p>
<p>Utilization Management (UM) Program</p> <ul style="list-style-type: none"> • Precertification • Case Management • Claim appeals for UM decisions 	<p>American Health Group, Inc. (AHG) 2152 S. Vineyard Ave., Suite 103 Mesa, AZ 85210 (602) 265-3800 or (800) 847-7605</p>

QUICK REFERENCE CHART	
Information Needed	Contact the following
<p>Employee Assistance Program (EAP)</p> <ul style="list-style-type: none"> Employee Assistance Program (EAP) counseling and referral for up to 3 free behavioral health (mental health and substance abuse) counseling sessions per problem. 	<p>Holman Frazier LLC 1-800-321-2843 www.holmangroup.com</p> <p>User name: holmanfrazier Password: YCT3950 (case sensitive)</p>
<p>Childhood Immunizations (other than from your primary doctor)</p>	<p>Yavapai County Health Dept. Childhood Immunizations (928) 583-1000</p>
<p>Mammogram Screening Program</p> <ul style="list-style-type: none"> Women age 30 and older are eligible for annual screenings. 	<p>Mobile On-site Mammography (MOM)</p> <ul style="list-style-type: none"> Patients under 30 years of age need a Physician's referral. No referral needed for ages 30 and older. Bring your medical ID card, Dr's name and address along with the location of your prior mammogram films. The mobile mammogram cannot screen women who have breast implants. To make an appointment during the annual sponsored program, call 1-800-285-0272. <p>See also the Radiology and Wellness rows of the Schedule of Medical Benefits for more information on annual mammograms.</p>
<p>Prescription Drug Program</p> <ul style="list-style-type: none"> ID Cards Retail Network Pharmacies Mail Order (Home Delivery) Pharmacy Prescription Drug Information & Formulary Preauthorization (prior auth) of Certain Drugs Specialty Managed Drugs Direct Member Reimbursement for use of an out-of-network retail pharmacy 	<p>OptumRx</p> <p>Customer service (available 24/7): 866-328-2005 or 1-800-797-9791 Precertification (Rx Prior Auth line): 800-711-4555, Option 1 Fax line: 800-527-0531 Mail Order: 888-290-9990 or 1-800-797-9791 Mail Order address: OptumRx P. O. Box 2975 Mission, KS 66201 Specialty Pharmacy: 1-866-218-5445 Website: www.OptumRx.com</p>
<p>COBRA Administrator</p>	<p>Summit Administration Services, Inc. P.O. Box 25160 Scottsdale AZ 85255-0102 Phone: (888) 690-2020 or (480) 505-0400 Fax: (480) 505-0405</p>
<p>Medicare Part D Notice of Creditable Coverage</p>	<p>Sent annually in October to home address. Contact your Human Resource Department.</p>
<p>Plan Administrator for the Yavapai Combined Trust</p> <ul style="list-style-type: none"> To contact the Board of Trustees 	<p>c/o Human Resources Director, Yavapai County 1015 Fair Street Room 338 Prescott, AZ 86305 Phone: (928) 771-3252 Fax: (928) 771-3419 Email: wendy.ross@yavapai.us</p> <ul style="list-style-type: none"> YCT Website: www.yctrust.net

QUICK REFERENCE CHART

Information Needed	Contact the following
<p>Yavapai College</p> <ul style="list-style-type: none"> • HIPAA Privacy Notice • HIPAA Privacy/Security Officer 	<p>Human Resources Director, Yavapai College 1100 E. Sheldon Prescott, AZ 86301 Phone: (928) 776-2211 Fax: (928) 776-2202</p> <ul style="list-style-type: none"> • Privacy/Security Officer Yavapai College: (928) 776-2289 • See also www.yc.edu
<p>City of Prescott</p> <ul style="list-style-type: none"> • HIPAA Privacy Notice • HIPAA Privacy/Security Officer 	<p>Benefits Specialist, City of Prescott 201 S. Cortez St Prescott, AZ 86303 Phone: (928) 777-1347 Fax: (928) 777-1213</p> <ul style="list-style-type: none"> • Privacy/Security Officer, City of Prescott: (928) 777-1216
<p>Yavapai County</p> <ul style="list-style-type: none"> • HIPAA Privacy Notice • HIPAA Privacy/Security Officer 	<p>Human Resources Manager, Yavapai County 1015 Fair Street Room 338 Prescott, AZ 86305 Phone: (928) 771-3252 Fax: (928) 771-3419</p> <ul style="list-style-type: none"> • Privacy/Security Officer, Yavapai County: (928) 771-3252 • See also www.yavapai.us
<p>Town of Chino Valley</p> <ul style="list-style-type: none"> • HIPAA Privacy Notice • HIPAA Privacy/Security Officer 	<p>Human Resources Department, Town of Chino Valley 202 N. State Route 89 Chino Valley, AZ 86323 Phone: (928) 636-2646 Fax: (928) 636-1977</p> <ul style="list-style-type: none"> • Privacy/Security Officer, Town of Chino Valley: (928) 636-2646 • See also www.chinoaz.net

BRIEF OVERVIEW OF MEDICAL BENEFITS FOR THE YAVAPAI COMBINED TRUST (YCT)

IMPORTANT NOTE: For a more complete explanation of benefits you **MUST** refer to the Schedule of Medical Benefits, Exclusions, and Definitions chapters.
 Precertification is required on medical services over \$1,000 and elective admissions. Deductible applies to all services except where noted.
REMINDER: Except in an emergency, Out-of-Network claims are paid in accordance with the Plan's definition of Allowed Charge.

Medical Services	Premier Plan		Basic Plus Plan
	In-Network Benefits Preferred PPO Providers	Out-of-Network Non-Preferred Providers	Preferred PPO Providers ONLY No coverage out of network!
Out-of-Pocket Limit: Applies only to coinsurance under these plan options. Does not accumulate copays, deductibles, precertification penalties, charges over the Allowed Charge, non-covered benefits, out-of-network charges, outpatient Rx drugs or wellness services over \$300/yr.	\$3,000 per person/plan yr. \$6,000 per family/plan yr.	Unlimited (No out-of-pocket limit)	\$6,000 per person/plan yr. \$12,000 per family/plan yr.
Deductible per person per plan year.	\$300/person \$600/family	\$300/person \$600/family	\$600/person \$1,200/family
Inpatient Hospital or Outpatient Surgical Facility	80%	60%	60%
Emergency Room, Emergency Inpatient Admission, Urgent Care or Ambulance (ER copay waived if admitted into hospital. Deductible applies to all benefits listed in this row.)	ER Facility: \$100 copay/visit then plan pays 80%. Urgent Care Facility: 80% Ambulance: 80%. ER/Urgent Care physician services: 80%.	ER Facility: \$100 copay/visit then plan pays 80%. Urgent Care Facility: 60%. Ambulance: 80%. ER/Urgent Care physician services: 80%	ER Facility: \$100 copay/visit then plan pays 60%. Urgent Care Facility: 60%. Ambulance: 60%. ER/Urgent Care physician services: 60%.
Primary Care Physician (PCP) Office Visits	\$20 copay/visit, no deductible	60%	60%
Other Physician Office Visits	80%	60%	60%
Wellness/Routine Physical for Employees & Dependents 19 months and older: The first \$300 per person per plan year is paid as noted to the right, then, after deductible met, Plan pays 10% of eligible expenses and these eligible expenses do not accumulate to the out-of-pocket limit.	100%, no deductible (See the Wellness row of the Schedule of Medical Benefits for more information)	100%, no deductible (See the Wellness row of the Schedule of Medical Benefits for more information)	100%, no deductible (See the Wellness row of the Schedule of Medical Benefits for more information)
Well Baby Exam: (birth through 18 months)	100%, no deductible after \$20 copay/visit	100%, no deductible, after \$20 copay/visit	100%, no deductible after \$20 copay/visit
Immunizations for Children and Adults	100%, no deductible	100%, no deductible	100%, no deductible
Outpatient X-rays, Surgeon fees, Anesthesia Fees, Allergy Injections	80%	60%	60%
Outpatient Laboratory services	Hospital based lab: 80%, after deductible met Non-hospital based lab: 100%, no deductible	60%, after deductible met	Hospital based lab: 60%, after deductible met Non-hospital based lab: 100%, no deductible
Alternative Health Care Services (Acupuncture, Naturopathic and/or Chiropractic Services) payable to a max. of 8 visits/plan yr.	80%	60%	60%
Physical & Occupational Therapy max 50 visits per injury or illness. Speech Therapy max 8 visits per plan yr.	80%	60%	60%
Certified Nurse Midwife.	80%	60%	60%
Durable Medical Equipment max. \$5,000 per person per plan yr. then plan pays 10%. Oxygen equipment/supplies max. \$3,000 per person per plan yr. then plan pays 10%	80%	60%	60%
Hearing Exams and Hearing Aides max \$1,500/person once every 3 years	80%	60%	60%
Home Health Services max. 60 days per plan year	80%	60%	60%
Behavioral Health: EAP: up to 3 free visits/problem/person.	Outpatient: 100% after \$20 copay per visit, no deductible. Inpatient: 80%	Outpatient or Inpatient: 60%	Outpatient or Inpatient: 60%

Outpatient Prescription Drug Benefits	Premier Plan or the Basic Plus Plan
No deductible. If the actual cost of the drug is less than the copay or coinsurance, you pay the actual drug cost.	<p>In-Network Retail Pharmacy (up to a 30-day supply, no deductible): <i>Generic:</i> \$10 copay, <i>Preferred Brand:</i> 20% of the cost of the drug to a maximum of \$100 copay per fill, <i>Non-Preferred Brand:</i> 50% of the cost of the drug with a \$20 minimum and \$150 copay maximum per fill.</p> <p>In-Network Retail Pharmacy (up to a 90-day supply, no deductible): <i>Generic:</i> \$30 copay, <i>Preferred Brand:</i> 20% of the cost of the drug to a maximum of \$300 copay per fill, <i>Non-Preferred Brand:</i> 50% of the cost of the drug with a \$60 minimum and \$450 copay maximum per fill.</p> <p>Mail Order (up to 90-day supply, no deductible): <i>Generic:</i> \$15 copay, <i>Preferred Brand:</i> \$40 copay, <i>Non-Preferred Brand:</i> \$100 copay</p>

BRIEF OVERVIEW OF MEDICAL BENEFITS FOR THE YAVAPAI COMBINED TRUST (YCT)

IMPORTANT NOTE: For a more complete explanation of benefits you **MUST** refer to the *Schedule of Medical Benefits, Exclusions, and Definitions* chapters. Precertification is required on medical services over \$1,000 and elective admissions. **Deductible applies to all services** except where noted. **REMINDER:** Except in an emergency, *Out-of-Network claims are paid in accordance with the Plan's definition of Allowed Charge.*

Medical Services	HDHP with Health Savings Account (HSA)	
	In-Network Benefits Preferred PPO Providers	Out-of-Network Non-Preferred Providers
Out-of-Pocket Limit: This HDHP Plan has an Out-of-Pocket Limit which limits your annual cost-sharing for covered essential health benefits received related to Medical Plan deductibles, coinsurance, and copayments. The Out-of-Pocket Limit is the most you pay during a one year period (the plan year) before your health plan starts to pay 100% for covered essential health benefits.	\$2,500 per year for an individual with self-only coverage \$5,000 per year for an individual in the family or for the entire family This out-of-pocket limit also accumulates eligible expenses for emergency services performed in an out-of-network emergency room.	\$10,000 per year for an individual with self-only coverage \$20,000 per year for an individual in the family or for the entire family
Deductible per person per plan year.	\$2,500 per year for an individual with self-only coverage; \$5,000 for an individual in the family or for the entire family. SPECIAL NOTE: For families enrolled in the HDHP with HSA option, this Plan requires that the family (including any individual in the family) must meet the family deductible (e.g. \$5,000) before any reimbursement is made for eligible medical expenses (other than for preventive care).	
Inpatient Hospital or Outpatient Surgical Facility	100% after deductible met	50% of Allowed Charges after deductible met
Emergency Room, Urgent Care Facility or Ambulance	ER Facility and Physician fees: 100% after deductible met. Urgent Care Facility or Ambulance: 100% after deductible met.	ER Facility and Physician fees: 100% after deductible met. Urgent Care Facility or Ambulance: 50% of Allowed Charges after deductible met.
Physician Office Visits, Anesthesia services, Surgeon fees, Allergy Injections, Certified Nurse Midwife	100% after deductible met	50% of Allowed Charges after deductible met
Wellness/Preventive Care Services: Plan covers preventive services, immunizations and certain supplies required by the Health Reform law for children and adults. Details at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/ . Age and frequency guidelines apply to covered preventive care.	100%, no deductible (See the Wellness row of the Schedule of Medical Benefits for more information)	50% of Allowed Charges after deductible met. (See the Wellness row of the Schedule of Medical Benefits for more information)
Outpatient X-rays. Certain services are payable as wellness.	100% after deductible met	50% of Allowed Charges after deductible met
Outpatient Laboratory services. Certain services are payable as wellness.	100% after deductible met	50% of Allowed Charges after deductible met
Alternative Health Care Services (Acupuncture, Naturopathic and/or Chiropractic Services) payable to a max. of 8 visits/plan yr.	100% after deductible met	50% of Allowed Charges after deductible met
Physical & Occupational Therapy max 50 visits per injury or illness. Speech Therapy max 8 visits per plan yr.	100% after deductible met	50% of Allowed Charges after deductible met
Durable Medical Equipment max. \$5,000 per person per plan yr. then plan pays 10%. Oxygen equipment/supplies max. \$3,000 per person per plan yr. then plan pays 10%	Breast pump and supplies: No charge. All other DME: 100% after deductible met	50% of Allowed Charges after deductible met
Hearing Exams and Hearing Aides max \$1,500/person once every 3 years	100% after deductible met	100% after deductible met
Home Health Services max. 60 days per plan year	100% after deductible met	100% after deductible met
Behavioral Health: EAP: up to 3 free visits/problem/person.	Outpatient visits and Inpatient Admission: 100% after deductible met	Outpatient visits and Inpatient Admission: 50% of Allowed Charges after deductible met

Outpatient Prescription Drug Benefits	HDHP with Health Savings Account (HSA)
In-Network Retail Pharmacy or Mail Order for Generic Drug, Preferred Brand Drug or Non-Preferred Brand Drug.	After you meet your annual medical plan deductible, the Outpatient Prescription Drug benefits are payable at no charge. As a reminder, your <u>least expensive drugs</u> are <u>Generic drugs</u> obtained at an In-network Retail pharmacy or through the plan's Mail Order service.

ARTICLE 3: SCHEDULE OF MEDICAL BENEFITS

A chart outlining a description of two of the Plan’s medical benefits and explanations of them appears below and on the following pages. Following this, there is a separate chart explaining the High Deductible Health Plan (HDHP) associated with the Health Savings Account (HSA).

Each of the Plan’s medical benefits is described in the first column, with Hospital Services (Inpatient) and Physician and Other Health Care Practitioner Services appearing first and all other benefits following in **alphabetical order**. Explanations and limitations of those benefits are shown in the second column. The columns also outline the specific differences in the benefit allowance when you use Preferred PPO Providers, or Out-of-Network Providers (considered to be Non-Preferred Providers). **Note that the Basic Plus Plan uses only Preferred PPO Providers, except in an emergency.**

SCHEDULE OF MEDICAL BENEFITS				
All benefits are subject to the deductible except where noted. All admissions, plus procedures/treatment over \$1,000 must be precertified. See the Utilization Management chapter for details. This chart lists what this Plan pays. See the definition of Allowed Charge. See also the Medical Exclusions and Definition chapters of this document. <i>*REMINDER: Except in an emergency, Out-of-Network claims are paid in accordance with the Plan’s definition of Allowed Charge.</i>				
Benefit Description	Explanations and Limitations of Benefits	Premier Plan		Basic Plus Plan (ONLY BCBSAZ Preferred PPO Providers are covered)
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
Deductible <ul style="list-style-type: none"> The deductible is the amount you must pay each plan year before the Plan pays benefits. 	<ul style="list-style-type: none"> Under the Premier Plan, the deductible for in-network providers <u>does not</u> accumulate to meet the deductible for out-of-network providers and vice versa. 	\$300 per person \$600 per family	\$300 per person \$600 per family	\$600 per person \$1,200 per family (No Out-of Network coverage except emergency care)
Out-of-Pocket Limit on Coinsurance <ul style="list-style-type: none"> The out-of-pocket limit under the Premier Plan and Basic Plus Plan is the maximum amount of coinsurance you are responsible for paying each plan year, in addition to the Deductible, before the Plan pays 100% of your covered Eligible Medical Expenses. Under these plan options the out-of-pocket limit accumulates only coinsurance. It does not accumulate copays, deductibles, precertification penalties, charges over the Allowed Charge, non-covered benefits, out-of-network charges, outpatient Rx drugs or wellness services over \$300/yr. Note that a new out-of-pocket limit must be met each plan year. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. 	<ul style="list-style-type: none"> Under the Premier Plan, there is an out-of-pocket limit for in-network services only and none for out-of-network services. Under the Basic Plus Plan there is no out-of-pocket limit on out-of-network expenses because the Basic Plus Plan does not cover any services from an out-of-network provider except in an emergency. In this case the out-of-network claims for an emergency do accumulate to the in-network OOP limit. Some out-of-pocket expenses do not apply to this out-of-pocket limit, including: <ol style="list-style-type: none"> Your individual or family deductible and any copayments. All expenses for medical services or supplies that are not covered by the Plan, such as Out-of-Network expenses under the Basic Plus Plan. All charges in excess of the Plan’s allowed charge amount. All charges in excess of a maximum Plan benefit. Any additional expenses applicable because you failed to comply with the Utilization Management Program set forth in the Utilization Management Program chapter of this document. All expenses for medical services or supplies incurred with respect to outpatient prescription drugs. Wellness expenses in excess of \$300 per person per year. Expenses from out-of-network providers if you are enrolled in the Premier Plan. 	\$3,000 per person \$6,000 per family	Unlimited (No out-of-pocket limit) Under the Premier Plan, expenses for out-of-network providers <u>do not</u> accumulate to meet the out-of-pocket limit for in-network providers.	\$6,000 per person \$12,000 per family (No Out-of Network coverage except emergency care)

SCHEDULE OF MEDICAL BENEFITS

All benefits are subject to the deductible except where noted. All admissions, plus procedures/treatment over \$1,000 must be precertified.

See the Utilization Management chapter for details. This chart lists what this Plan pays.

See the definition of Allowed Charge. See also the Medical Exclusions and Definition chapters of this document.

**REMINDER: Except in an emergency, Out-of-Network claims are paid in accordance with the Plan's definition of Allowed Charge.*

Benefit Description	Explanations and Limitations of Benefits	Premier Plan		Basic Plus Plan (ONLY BCBSAZ Preferred PPO Providers are covered)
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
<p>Hospital Services (Inpatient)</p> <ul style="list-style-type: none"> Room & board in semiprivate room with general nursing services. Specialty care units (e.g., intensive care unit, cardiac care unit). Lab/x-ray/diagnostic services. Related medically necessary ancillary services (e.g., prescriptions, supplies). Newborn care (see also the Physician and Other Health Care Practitioner Services section of this chart). Emergency: see the Emergency row in this Schedule. 	<ul style="list-style-type: none"> Elective hospitalization is subject to precertification. There is a penalty for failure to precertify and all hospitalization is subject to concurrent review as described in the Utilization Management chapter for details. Note that if you are admitted to an Out-of-Network hospital for emergency services, and are not yet ready for discharge, the UM Company will work with your physician to have you transported into an In-Network hospital or other appropriate In-Network health care setting as soon as is possible. Private room is covered only if medically necessary. If a private room is the only accommodation available, (such as with a private room birthing suite) the plan will pay an Allowed Charge amount. Hospitalization for dental services is covered only if the Plan Administrator or its designee determines it to be medically necessary to safeguard the health of the patient. 	<p>80% after deductible met</p>	<p>60% of the Allowed Charge (after deductible met) and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p> <p>80% after deductible met if it is an emergency inpatient admit.</p>	<p>60% after deductible met</p>

SCHEDULE OF MEDICAL BENEFITS

All benefits are subject to the deductible except where noted. All admissions, plus procedures/treatment over \$1,000 must be precertified.

See the Utilization Management chapter for details. This chart lists what this Plan pays.

See the definition of Allowed Charge. See also the Medical Exclusions and Definition chapters of this document.

**REMINDER: Except in an emergency, Out-of-Network claims are paid in accordance with the Plan's definition of Allowed Charge.*

Benefit Description	Explanations and Limitations of Benefits	Premier Plan		Basic Plus Plan (ONLY BCBSAZ Preferred PPO Providers are covered)
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
<p>Physician and Other Health Care Practitioner Services</p> <ul style="list-style-type: none"> Office, hospital and other health care facility of Physicians and other covered health care practitioners. Surgeon fees. Assistant surgeon (only if medically necessary). Anesthesia fees for Physicians (or Certified Registered Nurse Anesthetists (CRNA) only in conjunction with a surgical procedure). Pathologist fees. Radiologist fees. Nurse midwife. Physician assistant. Nurse practitioner. Circumcision for newborn males ages birth to 10 weeks of age. 	<ul style="list-style-type: none"> Some Physician services are subject to precertification, see the Utilization Management Program chapter for details. The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure. Assistant surgeon fees will be reimbursed for services to a maximum of 20% of the eligible allowed charge expenses payable to the primary surgeon. Medically necessary supplies, including medicines and injectables used to treat the covered condition in the Physician's office, are considered part of the visit fee. Nurse midwife fees are payable. Newborn male circumcision is subject to a \$50.00 copayment. For Premier Plan only: Emergency hospital admission is covered at 80% coinsurance in-network or out-of-network, from the time of admission to discharge. This includes Physician and ancillary services while hospitalized. Preferred PPO Provider: Lab and x-ray services are covered under the copay only when such services are obtained, processed and interpreted within the Physician's office. A copay does not apply to in-office surgical and invasive procedures. 	<p>No deductible and 100% after a</p> <p>\$20 copay per visit for services performed in the office of a Primary Care Physician (PCP) that includes only a family practitioner, general practitioner, internist, OB/GYN or pediatrician.</p> <p>All other services subject to the deductible and paid at 80% after deductible met</p> <p>Nurse midwife 80% after deductible met</p>	<p>60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p> <p>Physician fees associated with an emergency inpatient hospital admit paid at 80% after deductible met.</p> <p>Nurse midwife 60% after deductible met</p>	<p>60% after deductible met</p> <p>Physician fees associated with an emergency inpatient hospital admit: 60% after deductible met</p> <p>Nurse midwife 60% after deductible met</p>
<p>Allergy Services</p> <ul style="list-style-type: none"> Allergy sensitivity testing, including skin patch or Rast/Mast blood tests. Desensitization and hyposensitization (allergy shots given at periodic intervals), including allergy antigen. 	<ul style="list-style-type: none"> Desensitization injections are covered only when provided by a licensed Health Care Practitioner. If desensitization shots are administered in the Primary Care Physician's office, only the copay/co-insurance applies. The allowance for antigen is based on a 3-month supply and a per vial cost. 	<p>80% after deductible met</p>	<p>60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>	<p>60% after deductible met</p>

SCHEDULE OF MEDICAL BENEFITS

All benefits are subject to the deductible except where noted. All admissions, plus procedures/treatment over \$1,000 must be precertified.

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See the definition of Allowed Charge. See also the Medical Exclusions and Definition chapters of this document.

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Benefit Description	Explanations and Limitations of Benefits	Premier Plan		Basic Plus Plan (ONLY BCBSAZ Preferred PPO Providers are covered)
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
Alternative Health Care Services <ul style="list-style-type: none"> Acupuncture. Chiropractic Services: Services performed by or under the direction of a chiropractor, acting within the scope of his or her license. Naturopathic services or supplies. 	<ul style="list-style-type: none"> Plan year maximum benefit for alternative health care services is 8 visits per person per plan year after the deductible is met. Alternative health care services may not be applied to other benefits noted in this Schedule. Services and supplies are covered only if the Plan Administrator or its designee determines that the practitioner is licensed or duly authorized to practice in the jurisdiction in which the services are provided. 	Acupuncture, Naturopath and Chiropractic benefits: 80% after deductible met if a preferred provider is available, otherwise see the non-preferred column.	Acupuncture, Naturopath and Chiropractic benefits: 60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	Acupuncture, Naturopath and Chiropractic benefits: 60% of the Allowed Charge after deductible met.
Ambulance Services <ul style="list-style-type: none"> Ground transportation (e.g., ambulance) to the nearest appropriate facility as medically necessary for treatment of medical emergency, acute illness or inter health care facility transfer. Air transportation only as medically necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the health status of the patient. 	<ul style="list-style-type: none"> No coverage is provided for non-emergency use of ambulance transportation services. See also the row titled Emergency Services in this Schedule of Medical Benefits. 	80% after deductible met	80% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	60% after deductible met
Ambulatory Surgicenter	<ul style="list-style-type: none"> See the row titled Specialized Health Care Facilities in this Schedule of Medical Benefits. 			

SCHEDULE OF MEDICAL BENEFITS

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		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
<p>Behavioral Health Services (EAP and Mental Health and Substance Abuse Services in any Plan Option)</p> <p>EAP Program:</p> <ul style="list-style-type: none"> The EAP Program offers up to 3 free visits per problem, per person with an EAP Counselor regardless of which Plan Option an eligible individual is enrolled, if any. See the Quick Reference Chart in the front of this document for the phone number to the EAP. <p>Behavioral Health Services:</p> <ul style="list-style-type: none"> Outpatient visits, including Intensive Outpatient Program (IOP) visits Inpatient admission including partial hospitalization Residential treatment program Psychological (Psychiatric) Testing. 	<ul style="list-style-type: none"> <u>Inpatient behavioral health admission, partial hospitalization and residential treatment program must be pre-approved</u> by the Utilization Management Program whose phone number is listed on the Quick Reference Chart in the front of this document. Behavioral Health residential treatment program for individuals needing treatment in a highly structured 24-hour therapeutic environment that cannot be safely, efficiently or effectively treated in a less intensive setting. A residential treatment facility must be properly licensed in the state in which the facility operates. <u>See the precertification requirements noted above.</u> See the specific exclusions related to behavioral health services in the Medical Exclusions chapter. 	<p>EAP Visits: 100%, no deductible</p> <p>Outpatient: No deductible. Plan pays 100% after a \$20 copay per visit</p> <p>Inpatient admission, Residential treatment facility and Psych Testing: 80% after deductible met</p>	<p>EAP Visits: 100%, no deductible</p> <p>Outpatient and Psych Testing: 60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p> <p>Inpatient admission, Residential treatment facility: 60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p> <p>80% after deductible met if it is an emergency inpatient admit.</p> <p>Facility fees and Physician fees associated with an emergency inpatient hospital admit paid at 80% after deductible met.</p>	<p>EAP Visits: 100%, no deductible</p> <p>Inpatient admission, Residential treatment facility or Outpatient: 60% after deductible met</p>
Birthing Center/Facility	<ul style="list-style-type: none"> See the row titled Specialized Health Care Facilities in this Schedule of Medical Benefits. 			
<p>Blood Transfusions</p> <ul style="list-style-type: none"> Blood transfusions and blood products and equipment for its administration. 	<ul style="list-style-type: none"> Covered only when ordered by a Physician. Expenses related to autologous blood donation (patient's own blood) when provided for a covered person for covered services arising from an illness or injury. 	80% after deductible met	60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	60% after deductible met

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations of Benefits	Premier Plan		Basic Plus Plan (ONLY BCBSAZ Preferred PPO Providers are covered)
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
Chemotherapy <ul style="list-style-type: none"> Chemotherapy services and supplies are payable when ordered by a Physician. 	<ul style="list-style-type: none"> Payment for chemotherapy varies according to the Plan's allowable fees in the location where the service is rendered (e.g., hospital, ambulatory surgicenter, doctor's office, home, etc.). See other sections of this Schedule of Medical Benefits for payment guidelines. 	80% after deductible met	60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	60% after deductible met
Chiropractic Services	<ul style="list-style-type: none"> See the row titled "Alternative Health Care Services" in this Schedule of Medical Benefits. 			
Corrective Appliances (Prosthetic and Orthotic Devices, other than Dental) <ul style="list-style-type: none"> Coverage is provided for rental (payable only up to the allowed purchase price of the corrective appliance) or purchase of standard models, at the option of the Plan, and for medically necessary repair, adjustment, servicing and replacement of these devices. Replacement payable if due to a change in the covered person's physical condition or if the device cannot be satisfactorily repaired. Occupational therapy (orthotic) supplies needed to assist the person in performing activities of daily living, payable at the usual cost-sharing to a maximum of \$500 per person per plan year, thereafter the plan pays 10%. Colostomy or ostomy (orthotic) supplies. See also the Hearing Services section of this Schedule. 	<ul style="list-style-type: none"> See the specific exclusions related to corrective appliances in the Medical Exclusions chapter. To help determine what prosthetic or orthotic appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Definitions chapter. Corrective appliances are covered only when ordered by a Physician. For prosthetic devices the plan pays the usual cost-sharing up to \$30,000 per person per lifetime per limb or device for the appliance, including necessary supplies, repair, and servicing; thereafter the plan pays 10%. Foot orthotics (orthopedic or corrective shoes and other supportive appliances for the feet) are payable to a maximum of one pair per person per plan year. One pair of prescription contact lenses or eyeglasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular surgery. Anti-embolism (e.g. Jobst) garments limited to three pairs per person per plan year. Mastectomy bras and external silicone breast prostheses. 	80% after deductible met	60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	60% after deductible met

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations of Benefits	Premier Plan		Basic Plus Plan (ONLY BCBSAZ Preferred PPO Providers are covered)
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
Diabetes Education <ul style="list-style-type: none"> Diabetes counseling sessions for the management of diabetes. Diabetes Education Benefit is payable to a maximum of 5 visits per person per lifetime. 	<ul style="list-style-type: none"> Diabetes education not subject to the deductible. Diabetes education services are in addition to the Plan's wellness benefits described later in this Schedule of Medical Benefits. Primary Care Physician referral required. 	No deductible, 100% up to the diabetes education lifetime maximum.	No deductible, 100% up to the diabetes education lifetime maximum.	No deductible, 100% up to the diabetes education lifetime maximum.
Dialysis <ul style="list-style-type: none"> Renal (kidney) dialysis services are covered in the inpatient, outpatient or home setting. 	<ul style="list-style-type: none"> Covered when ordered by a Physician. 	80% after deductible met	60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	60% after deductible met

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		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
<p>Drugs and Medicines</p> <ul style="list-style-type: none"> Coverage is provided only for FDA approved pharmaceuticals requiring a prescription and FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or other health care practitioner authorized by law to prescribe them. Coverage includes: prenatal vitamins and other prescription vitamins needed to treat a medical condition, prescription contraceptives, Ritalin, diabetic supplies, insulin, and insulin syringes. Outpatient prescription drugs are administered by a Prescription Drug Program whose name, phone number and website are listed on the Quick Reference Chart. Contact the Prescription Drug Program for: <ol style="list-style-type: none"> drugs needing pre-approval by the clinical staff of the Prescription Drug Program, drugs on the list of preferred drugs (also called formulary) as selected by the Prescription Drug Program. A copy of the formulary is available from the Prescription Drug Program's website or your HR Office There is no payment for drugs not listed on the formulary. Physicians may appeal non-formulary drugs they believe are needed by a patient by calling the Prescription Drug Program. drugs with a quantity limit payable by the Plan or drugs under step therapy. Specialty drugs are products derived from living organisms used by individuals with unique health concerns and include items such as injectables for multiple sclerosis, rheumatoid arthritis or hepatitis. These drugs require precertification, are managed because they often require special handling, are date sensitive and usually available in a 30-day quantity. For specialty drugs call the Specialty Drug Pharmacy Center of the Prescription Drug Program noted on the Quick Reference Chart. 	<ul style="list-style-type: none"> Retail Prescriptions (up to a 30 or 90-day supply, no deductible): For the location of in-network retail pharmacies contact the Prescription Drug Program whose name & phone number are listed on the Quick Reference Chart in this document. If the actual cost of the drug is less than the copay/coinsurance, you pay the actual drug cost. Mail Order Home Delivery: (up to a 90-day supply, no deductible): To use mail order contact the Prescription Drug Program on the Quick Reference Chart in the front of this document or your Human Resource Dept. for a mail order packet of information. Exclusions: some of the drugs excluded from coverage under this plan include over-the-counter (OTC) products, hair growth, experimental, fertility/infertility, weight control and prescriptions that have an over-the-counter (OTC) alternative. See also the exclusions related to Drugs & Medicines in the Medical Exclusions chapter as well as the definition of "Experimental and/or Investigational" in the Definitions chapter. Direct Member Reimbursement for use of an Out-of-Network Retail Pharmacy: If you fill a prescription at an out-of-network pharmacy location, you will need to pay for the drug at the time of purchase and later send your drug receipt with a claim form to the Claims Administrator as listed on the Quick Reference Chart. Claim forms may be obtained from the YCT Website listed on the Quick Reference Chart or from your Human Resource Dept. For eligible prescriptions, you will be reimbursed the receipt cost minus the appropriate retail copay/coinsurance. Smoking/Tobacco cessation benefit: Coverage is extended for prescription smoking/tobacco cessation products (such as nicotine gum or patches) intended to assist an individual to stop smoking or using tobacco products. The drugs are payable through the Prescription Drug Program using the appropriate generic or non-preferred level of benefits. Present a written prescription from a physician for prescription smoking/tobacco cessation products to the retail pharmacist. This benefit is not available under the plan's mail order program. Drugs not yet FDA approved are not covered. New FDA-approved drugs will be covered unless an amendment states otherwise or the drug class is excluded. 	<p>Outpatient Prescription Drug Coinsurance and Copayments are not applied to meet the plan's out-of-pocket limit or medical plan deductible.</p> <p>No deductible applies to these Outpatient Prescription Drug benefits.</p> <ul style="list-style-type: none"> The Plan provides a mandatory generic program meaning that if a brand name drug is dispensed in place of a generic, regardless if you or the Physician request it, you will pay the brand copay plus the difference in cost between the generic and brand name drug. <p>Note that if the cost of the drug is less than the copay you pay just the cost of the drug.</p> <p style="text-align: center;"><u>IN-NETWORK RETAIL PHARMACY</u> (up to a 30-day supply, no deductible)</p> <ul style="list-style-type: none"> Generic: \$10 copay Preferred Brand: 20% of the cost of the drug to a maximum of \$100 copay per fill. Non-Preferred Brand: 50% of the cost of the drug with a \$20 minimum and \$150 copay maximum per fill. <p style="text-align: center;"><u>IN-NETWORK RETAIL PHARMACY</u> (up to a 90-day supply, no deductible)</p> <ul style="list-style-type: none"> Generic: \$30 copay Preferred Brand: 20% of the cost of the drug to a maximum of \$300 copay per fill. Non-Preferred Brand: 50% of the cost of the drug with a \$60 minimum and \$450 copay maximum per fill. <p style="text-align: center;"><u>MAIL ORDER</u> (up to 90-day supply, no deductible.)</p> <ul style="list-style-type: none"> Generic: \$15 copay Preferred Brand: \$40 copay Non-Preferred Brand: \$100 copay 		

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations of Benefits	Premier Plan		Basic Plus Plan (ONLY BCBSAZ Preferred PPO Providers are covered)
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
<p>Durable Medical Equipment (DME)</p> <ul style="list-style-type: none"> Coverage is provided for rental (payable only up to the allowed purchase price of the durable medical equipment) or purchase of standard models, at the option of the Plan, and for medically necessary repair, adjustment, servicing and replacement of this equipment. Replacement payable if due to a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired. Benefits are payable for medically necessary oxygen, along with the medically necessary equipment and supplies required for its administration. Coverage is provided for diabetic glucose meter and other medically necessary diabetes durable medical equipment. 	<ul style="list-style-type: none"> See the specific exclusions related to durable medical equipment in the Medical Exclusions chapter. To help determine what durable medical equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions chapter. For example, no benefits are payable for the following items: exercise equipment, air cleaners, air filters, or motorized wheelchairs and carts, (except as determined by the Plan Administrator or its designee, that a standard wheelchair is not appropriate and the motorized chair functions as the sole means of transportation for that individual). Durable medical equipment is covered only when its use is medically necessary and it is ordered by a Physician. A statement is required from the prescribing Physician describing how long the equipment is expected to be necessary. This statement will assist in determining whether the equipment will be rented or purchased. For durable medical equipment (except oxygen) the first \$5,000 per person per plan year is payable at the usual cost-sharing; thereafter, the plan pays 10%. Charges in excess of \$1,000 must be precertified through the Utilization Management Company whose telephone number is listed on the Quick Reference Chart in this document. Oxygen and the equipment and supplies for its administration is payable up to \$3,000 per person per plan year at the usual cost-sharing; thereafter, the plan pays 10%. 	<p>80%after deductible met</p>	<p>60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>	<p>60% after deductible met</p>

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		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
<p>Emergency Room (ER) Facility, and Urgent Care Facility</p> <ul style="list-style-type: none"> Hospital emergency room for a medical emergency. Urgent care facility Ambulance: see the Ambulance row in this Schedule. Refer to the Physician Services row for information on how the professional fees associated with the ER, urgent care or ambulance are payable associated with these facility fees. 	<ul style="list-style-type: none"> Emergency room services covered only when services are for a medical emergency. See definition of "Emergency (Medical)" in the Definitions chapter. No coverage is provided for non-emergency use of emergency room services. Copay waived if you are admitted to the hospital within 24 hours of the ER or urgent care visit. Copay is not applied to meet the deductible. Note that if you are admitted to an Out-of-Network hospital for emergency services, and are not yet ready for discharge, the UM Company will work with your physician to have you transported into an In-Network hospital or other appropriate In-Network health care setting as soon as is possible. For Premier Plan only: Emergency hospital admission is covered at 80% (in-network or out-of-network) from the time of admission to discharge. This includes Physician and ancillary services while hospitalized. 	<p>Emergency Room: After you pay a \$100 copay per visit, the plan pays 80% after deductible met.</p> <p>Physician fees associated with an emergency room visit or urgent care facility visit paid at 80% after deductible met.</p> <p>Urgent Care Facility: 80% after deductible met</p>	<p>Emergency Room: After you pay a \$100 copay per visit, the plan pays 80% of the Allowed Charge after deductible met.</p> <p>Physician fees associated with an emergency room visit or urgent care facility visit paid at 80% after deductible met.</p> <p>Urgent Care Facility: 60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>	<p>Emergency Room: After you pay a \$100 copay per visit, the plan pays 60% after deductible met.</p> <p>Non-PPO provider services are considered payable only if the services are for a medical emergency as the term "Emergency" is defined in the Definitions chapter.</p> <p>Urgent Care Facility: 60% after deductible met</p>
<p>Family Planning Services</p> <ul style="list-style-type: none"> Sterilization services (e.g., vasectomy, tubal ligation, implants such as Essure). Fertility and infertility diagnostic services for the employee and spouse only. Fertility treatment and drugs are not covered. Prescription contraceptives are payable including: oral birth control pills/patch, intrauterine devices (IUD), implantable birth control devices (e.g. Nexplanon), injectables (e.g. Depo-Provera, Lunelle) and diaphragms. Certain prescription contraceptives are payable under the Prescription Drug Program. 	<ul style="list-style-type: none"> See the specific exclusions related to Family Planning in the Medical Exclusions chapter. No coverage for fertility and infertility treatment or treatment of sexual dysfunction. 	<p>80% after deductible met</p>	<p>60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>	<p>60% after deductible met</p>

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<p><u>Genetic Testing and Counseling</u></p> <ul style="list-style-type: none"> The genetic testing payable under this Plan is for: <ul style="list-style-type: none"> state-mandated newborn screening tests for genetic disorders (referred to as surrogate biochemical markers); fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Plan Administrator or its designee; tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity; genetic testing recommended by the American College of Obstetrics and Gynecology for pregnant women such as genetic carrier testing for cystic fibrosis; genetic testing (e.g. BRCA) and genetic counseling required as a Preventive service, in accordance with Health Reform regulations (see the Wellness row in this Schedule). the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants if <u>all</u> the following conditions are met: <ul style="list-style-type: none"> the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; <u>and</u> the covered individual displays clinical features/symptoms, or is at direct risk of developing the genetically linked heritable disease/condition in question (pre-symptomatic); <u>and</u> the results of the test will directly impact the clinical decision-making, clinical outcome or treatment being delivered to the covered individual. Genetic Counseling is payable when ordered by a Physician, performed by a qualified Genetic Counselor and provided in conjunction with a genetic test that is payable by this Plan. 	<ul style="list-style-type: none"> See the definitions of Genetic Counseling and Genetic Testing in the Definitions chapter. See the Exclusions chapter for exclusions relating to Genetic Testing and Counseling, in addition to those indicated here: <ul style="list-style-type: none"> No coverage for pre-parental genetic testing (also called carrier testing) intended to determine if a prospective parent or parents have chromosomal abnormalities that are determined by the Plan Administrator or its designee to be likely to be transmitted to a child of that parent or parents. No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of individuals who are not covered under this Plan. Genetic testing costs may be covered for a non-covered individual only if such testing would directly impact the treatment of a covered plan participant. Plan participants can contact the Medical Plan Claims Administrator or Utilization Management Program to assist in determining if a proposed genetic test will be covered or excluded. 	<p>80% after deductible met</p>	<p>60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>	<p>60%after deductible met</p>

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		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
Hearing Services <ul style="list-style-type: none"> Hearing exam and hearing aid. 	<ul style="list-style-type: none"> Hearing exam and corrective hearing aid payable to a maximum of \$1,500 per person every three years. Implantable hearing devices (e.g. cochlear implant for individuals with profound hearing loss) covered under Prosthetics in the Corrective Appliance row this Schedule. 	80% after deductible met	60% after deductible met	60% after deductible met
Home Health and Home Infusion Services <ul style="list-style-type: none"> Part-time, intermittent skilled nursing care services and medically necessary supplies to provide home health care or home infusion therapy services, subject to a plan year maximum Plan benefit shown in the Explanations and Limitations column. Home services other than skilled nursing care are not covered. 	<ul style="list-style-type: none"> See the specific exclusions related to home health care and custodial care (including personal care and child care) in the Exclusions chapter of this document. Covered only when ordered by a Physician. Maximum Plan benefit for skilled nursing Care services and supplies to provide home health care and home infusion therapy services is 60 visits per plan year. Home hospice coverage is described in this Schedule under Specialized Health Care Facilities benefits. Home physical therapy services coverage is described in this Schedule under Rehabilitation Services benefits. Prescription drug coverage is described in this Schedule under Drugs and Medicines benefits. 	80% after deductible met	60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	60% after deductible met
Hospice	<ul style="list-style-type: none"> See the row titled Specialized Health Care Facilities in this Schedule of Medical Benefits. 			
Laboratory Services (Outpatient) <ul style="list-style-type: none"> Technical and professional fees. 	<ul style="list-style-type: none"> Covered only when ordered by a Physician. Refer also to the Physician and Other Health Care Practitioner Services section of this Schedule for information about lab performed in the Physician's office by a Preferred PPO provider. 	Hospital based lab services: 80% after deductible met Non-hospital based lab services: 100%, no deductible	60%, of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	Hospital based lab services: 60% after deductible met Non-hospital based lab services: 100%, no deductible

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations of Benefits	Premier Plan		Basic Plus Plan (ONLY BCBSAZ Preferred PPO Providers are covered)
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
<p>Maternity Services</p> <ul style="list-style-type: none"> Hospital and birthing center charges and Physician fees for medically necessary maternity services. For information on payable genetic testing, see the Genetic Testing row in this Schedule. Termination of pregnancy. See the specific exclusions related to Family Planning in the Medical Exclusions chapter. See also, the special rule for coverage of newborn dependent children in the Eligibility chapter. 	<ul style="list-style-type: none"> Pregnancy-related care is covered for a female employee or spouse only. No coverage is provided for pregnancy-related expenses for dependent daughters. No coverage for adoption expenses. This Plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Termination of pregnancy is payable only when the attending Physician certifies that the female employee's or spouse's health would be endangered if the fetus were carried to term, or where medical complications arise from an abortion. No coverage for termination of pregnancy for dependent child. 	<p style="text-align: center;">For professional fees associated with maternity services: After you pay a \$100 copay toward the physician fees associated with maternity and delivery services, the Plan pays 80% after deductible met</p> <p style="text-align: center;">Hospital, Birthing Center and all other services: 80% after deductible met</p>	<p style="text-align: center;">For professional fees associated with maternity services: After you pay a \$100 copay toward the physician fees associated with maternity and delivery services, the Plan pays 60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p> <p style="text-align: center;">Hospital, Birthing Center and all other services: 60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>	<p style="text-align: center;">For professional fees associated with maternity services: After you pay a \$100 copay toward the physician fees associated with maternity and delivery services, the Plan pays 60% after deductible met</p> <p style="text-align: center;">Hospital, Birthing Center and all other services: 60% after deductible met</p>
<p>Nondurable Medical Supplies</p> <p>Coverage is provided for:</p> <ul style="list-style-type: none"> Sterile surgical supplies used immediately after surgery. Supplies needed to operate or use covered durable medical equipment or corrective appliances. Supplies needed for use by skilled home health or home infusion therapy personnel, but only during the course of their required services. 	<ul style="list-style-type: none"> Diabetic supplies (e.g. test-strips, lancets) and insulin syringes for diabetics are covered under the Drugs and Medicines benefits. To determine what nondurable medical supplies are covered, see the definition of "Nondurable Medical Supplies" in the Definitions chapter. 	80% after deductible met	60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	60% after deductible met

SCHEDULE OF MEDICAL BENEFITS

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		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
Oral and Craniofacial Services <ul style="list-style-type: none"> Accidental Injury to Teeth/Jaw. Oral and/or craniofacial surgery. Oral surgery is limited to cutting procedures for removal of tumors, cysts, abscess, acute injury and impacted teeth partially or totally covered by bone. These services will first be considered under the dental plan and any services not payable under the dental plan will then be considered under the medical plan. In no event will services be paid in full under both plans. 	<ul style="list-style-type: none"> See the specific exclusions related to dental services in the Dental Exclusions chapter. Treatment of Accidental Injuries to the Teeth/Jaw: This medical plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan Administrator or its designee, all of the following conditions are met: <ul style="list-style-type: none"> The accidental injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and The dental treatment will return the person's teeth to their pre-injury level of health and function. See also the definition of Injury to Teeth in the Definitions chapter of this document. These services will first be considered under the dental plan and any services not payable under the dental plan will then be considered under the medical plan. No coverage for surgical treatment of TMJ syndrome/dysfunction. Non-surgical treatment of TMJ syndrome/dysfunction, including appliances, is payable at the usual cost-sharing to a maximum of \$500 per person per plan year; thereafter the plan pays 10%. 	80% after deductible met	60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	60% after deductible met
Outpatient Surgery Facility/Center	<ul style="list-style-type: none"> See the row titled Specialized Health Care Facilities in this Schedule of Medical Benefits. 			
Radiology (X-Ray), Nuclear Medicine and Radiation Therapy Services (Outpatient) <ul style="list-style-type: none"> Technical and professional fees associated with diagnostic and curative services, including radiation therapy. 	<ul style="list-style-type: none"> Covered only when ordered by a Physician. Some radiology procedures are covered under the Wellness Program (e.g., screening mammogram). Refer also to the Physician and Other Health Care Practitioners Services section of this Schedule regarding x-rays performed in the Physician's office by a Preferred PPO provider. 	Annual Mammogram: 100% no deductible All other services: 80% after deductible met	60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	Annual Mammogram: 100% no deductible All other services: 60% after deductible met

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		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
<p>Reconstructive Services</p> <ul style="list-style-type: none"> Includes expenses for reconstructive surgery, procedures or treatment intended to improve bodily function and/or correct a deformity resulting from disease, trauma, congenital anomalies or prior covered therapeutic procedure. This Plan complies with the Women's Health and Cancer Rights Act of 1998 and provides medical and surgical benefits in connection with a mastectomy and for certain reconstructive surgery, in a manner determined in consultation with the attending physician and the patient, as follows: <ul style="list-style-type: none"> Reconstruction of the breast on which the mastectomy was performed. Surgery on the other breast to produce a symmetrical appearance. Prostheses and physical complications of all stages of mastectomy, including lymphedemas. 	<ul style="list-style-type: none"> See the specific exclusions related to Cosmetic Services (including reconstructive surgery) in the Medical Exclusions chapter. Most cosmetic and dental (including orthognathic) services are excluded from coverage. Contact the Claims Administrator to verify whether a proposed service is cosmetic or reconstructive. 	80% after deductible met	60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	60% after deductible met
<p>Rehabilitation Services (Cardiac and Pulmonary)</p> <ul style="list-style-type: none"> Cardiac rehabilitation is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.). Pulmonary rehabilitation is available to those individuals who are able to actively participate in a pulmonary rehabilitation program that is likely to improve their pulmonary condition, as determined by the Plan Administrator or its designee. 	<ul style="list-style-type: none"> Cardiac or pulmonary rehabilitation programs must be ordered by a Physician. For cardiac rehabilitation coverage is provided for a maximum of 12 weeks, not to exceed \$3,000 per person per cardiac incident at the usual cost-sharing, thereafter the plan pays 10%. For pulmonary rehabilitation coverage is provided for a maximum of 12 weeks not to exceed a total of \$1,500 per person per lifetime at the usual cost-sharing, thereafter the plan pays 10%. 	80% after deductible met	60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	60% after deductible met

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<p>Rehabilitation Services (Physical, Occupational, and Speech Therapy)</p> <ul style="list-style-type: none"> Short-term active, progressive Rehabilitation services (occupational, physical, or speech therapy) performed by licensed or duly qualified therapists as ordered by a Physician. Rehabilitation services covered only when ordered by a Physician. Inpatient rehabilitation services in an acute hospital, rehabilitation unit or facility or skilled nursing facility for short term, active, progressive, rehabilitation services that cannot be provided in an outpatient or home setting. Outpatient physical therapy performed in conjunction with services ordered by or under the direction of a chiropractor are subject to the Plan's limitations for Chiropractic Services (as described in the row of this Schedule of Medical Benefits titled Alternative Health Care Services). 	<ul style="list-style-type: none"> Maintenance rehabilitation, habilitation services and coma stimulation services are not covered. See specific exclusions relating to Rehabilitation Therapies in the Medical Exclusions chapter. Inpatient rehabilitation admission requires precertification (see Article 6). Benefits for inpatient rehabilitation services are payable up to the overall rehab maximum noted above, not to exceed 60 consecutive days per person per injury or illness. Outpatient rehabilitation services (physical and occupational therapy) is payable up to 50 visits per person per injury or illness. Speech therapy is payable up to 8 visits per person per plan year and is covered if the services are provided by a licensed or duly qualified speech therapist to restore speech or to correct dysphagic or swallowing defects and disorders lost due to illness, injury or surgical procedure. Speech therapy is not considered medically necessary and is not a covered benefit for self-correcting dysfunctions causing dysfluency or articulation disorders such as stuttering, stammering, lisping and tongue thrusting. 	80% after deductible met	60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	60% after deductible met
<p>Second and Third Physician Opinions</p> <ul style="list-style-type: none"> Includes only one office visit per opinion. 	<ul style="list-style-type: none"> See the Utilization Management Program chapter for details of the Second and Third Opinion Programs. Additional medically necessary tests are covered under other Plan provisions. Voluntary 2nd and 3rd physician opinions at the desire of the patient are paid per the Plan's normal physician payment as listed in the row of this Schedule called "Physician and Other Health Care Practitioner Services." 	<p>Plan required opinions paid at 100%, no deductible.</p> <p>Patient requested opinions paid at 80% after deductible met</p>	<p>Plan required opinions paid at 100%, no deductible.</p> <p>Patient requested opinions paid at 60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>	<p>Plan required opinions paid at 100%, no deductible.</p> <p>Patient requested opinions paid at 60% after deductible met</p>
<p>Skilled Nursing Facility (SNF)</p>	<ul style="list-style-type: none"> See the row titled Specialized Health Care Facilities in this Schedule of Medical Benefits. 			

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		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
Sleep Disorders <ul style="list-style-type: none"> Sleep studies are payable when performed for the purpose of detecting sleep apnea. This benefit pays for medically necessary diagnosis and treatment of sleep apnea. 	<ul style="list-style-type: none"> Covered only when ordered by a Physician. Medically necessary treatment of sleep apnea will be considered for payment under the covered plan benefit associated with the service that is ordered as a treatment for sleep apnea (e.g., medical equipment is covered under the Durable Medical Equipment benefit, Dr. office visit covered under Physician services, etc.). 	80% after deductible met	60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	60% after deductible met
Smoking/Tobacco Cessation Support	<ul style="list-style-type: none"> See the Drug row for more information. 			
Specialized Health Care Facilities <ul style="list-style-type: none"> Ambulatory Surgical Facility (Outpatient Surgery) Birthing Center Hospice Skilled Nursing Facility (SNF) Subacute Care Facility also called Long Term Acute Care (LTAC) Facility. 	<ul style="list-style-type: none"> Admissions to some specialized health care facilities are subject to precertification. See the Utilization Management chapter for details and a discussion of the penalty for failure to precertify. Specialized health care facility services must be ordered by a Physician. To determine if a facility is a "Specialized Health Care Facility," see the Definitions chapter of this document. Benefits for skilled nursing facility or subacute facility confinement limited to 60 days per person per injury or illness. 	80% after deductible met	60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	60% after deductible met
Spinal Manipulation Services	<ul style="list-style-type: none"> See the row titled "Alternative Health Care Services" in this Schedule of Medical Benefits. 			

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		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
<p>Transplantation (Organ and Tissue)</p> <ul style="list-style-type: none"> Coverage is provided only for eligible services directly related to medically necessary transplantation of human organs or tissue including: liver, heart, bone marrow, cornea, kidney, lung(s), pancreas, intestine including: <ul style="list-style-type: none"> Facility and professional services, FDA approved drugs, and medically necessary equipment and supplies. Organ or tissue procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor. Reasonable and necessary expenses incurred by a donor who is covered by the Plan, without any deductibles and coinsurance applicable to those expenses. Reasonable and necessary expenses incurred by a donor who is not covered by the Plan, without any deductibles and coinsurance applicable to those expenses, but only to the extent the donor is not covered by the donor's own insurance or health care plan. 	<ul style="list-style-type: none"> See the specific exclusions related to Experimental and/or Investigational Services and Transplantation in the Medical Exclusions chapter. Transplantation services are subject to precertification. See the Utilization Management Program chapter for details. Benefits are payable only if services are provided in a hospital or specialized health care facility approved by the Plan Administrator or its designee. Travel expenses payable only when the surgery is precertified and case managed by the Utilization Management Company. Travel expenses includes: <ul style="list-style-type: none"> Two round trip "coach" transportation charges for the patient and one family member or companion, to and from the transplant site. Lodging for two people (one room) as pre-approved by the Plan Administrator or its designee, and not to exceed \$150/day. Receipts are required when submitting lodging, and travel expenses for payment consideration. In accordance with IRS rules, meals are not reimbursed under this travel benefit. Travel expense benefit not to exceed \$10,000 per transplant. 	<p style="text-align: center;">80% after deductible met only when approved by the Plan.</p>	<p style="text-align: center;">60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>	<p style="text-align: center;">60% after deductible met</p>

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		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)	
<p>Weight Control Services</p> <ul style="list-style-type: none"> Surgical treatment of morbid obesity (as defined by the Plan) including gastric restrictive procedures, gastric or intestinal bypass or reversal of a previously performed weight management surgery. Surgical procedures to treat morbid obesity (including reversal) are payable to a maximum of \$20,000 per person per lifetime. 	<p>Morbidly Obese, Morbid Obesity is defined by the Plan Administrator or its designee, to mean the:</p> <ol style="list-style-type: none"> Presence of morbid obesity that has persisted for at least 5 years, defined as either: <ol style="list-style-type: none"> body mass index (BMI) (<i>term defined at the end of this definition</i>) exceeding 40; or BMI greater than 35 in conjunction with ANY of the following severe co-morbidities: <ol style="list-style-type: none"> coronary heart disease; or type 2 diabetes mellitus; or clinically significant obstructive sleep apnea; or high blood pressure/hypertension (BP > 140 mmHg systolic and/or 90 mmHg diastolic) Patient has completed growth (18 years of age or documentation of completion of bone growth); AND Patient has participated in a Physician-supervised nutrition and exercise program (including dietitian consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record. This Physician-supervised nutrition and exercise program must meet ALL of the following criteria: <ol style="list-style-type: none"> Participation in nutrition and exercise program must be supervised and monitored by a Physician working in cooperation with dietitians and/or nutritionists; AND Nutrition and exercise program must be 6 months or longer in duration; AND Nutrition and exercise program must occur within the two years prior to surgery; AND Participation in Physician-supervised nutrition and exercise program must be documented in the medical record by an attending Physician who does not perform bariatric surgery. Note: A Physician's summary letter is not sufficient documentation. <p>NOTE: BMI is calculated by dividing your weight (in kilograms) by height (in meters) squared: $BMI = \frac{\text{weight in kilograms}}{\text{height in meters}^2}$ or compute using the Obesity Education Initiative website: http://www.nhlbi.nih.gov/about/org/oei. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by 0.0254.</p> <p>No coverage for post-weight loss skin reduction procedures/surgery.</p>	80% after deductible met	60% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.	60% after deductible met

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<p>Wellness Programs: Periodic Well Baby Examinations and Immunizations (age birth through 18 months)</p> <ul style="list-style-type: none"> Outpatient well baby visits and routine childhood immunizations according to CDC recommendations (e.g., DPT, Polio, MMR, HIB, hepatitis, chickenpox, tetanus). The frequency of well child visits immunizations and other wellness services is payable according to the recommendations of the American Academy of Pediatrics. Other immunizations for children at high risk are covered under the regular medical plan benefits. For coverage of wellness services beyond age 18 months see the next row of this Schedule. 	<ul style="list-style-type: none"> See the Newborn Dependent Children coverage section in the Eligibility chapter, and the exclusion of expenses for physical examinations and testing required for school, camp, recreation, sports, etc., in the General Exclusions section of the Medical Exclusions chapter. Coverage is provided for well baby visits and immunizations from birth through 18 months. Deductibles do not apply to these wellness benefits. Expenses exceeding the maximum wellness allowance cannot be applied to deductibles. Childhood immunizations are also available through the Yavapai County Health Department whose phone number is listed on the Quick Reference Chart in the front of this document. If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than "wellness," claims will be processed under the Plan's usual deductible and/or copay/coinsurance. 	<p>Visits: 100% after a \$20 copay per visit, no deductible.</p> <p>Immunizations: 100%, no deductible.</p>	<p>Visits: 100% of the Allowed Charge amount after a \$20 copay per visit, no deductible, and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p> <p>Immunizations: 100% of the Allowed Charge amount, no deductible, and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>	<p>Visits: 100% after a \$20 copay per visit, no deductible.</p> <p>Immunizations: 100%, no deductible</p>

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<p>Wellness Programs: Periodic Health Maintenance Examinations (age 19 months and up)</p> <ul style="list-style-type: none"> Periodic physical exam to include routine wellness related blood/lab tests. Immunizations for Children and Adults: Routine childhood immunizations, age-appropriate, payable according to the recommendations of the American Academy of Pediatrics and the Center for Disease Control (CDC). Immunizations do not accumulate to the \$300 level and are paid at no charge. Proctoscopy after age 50, once per plan year. Proctoscopy under age 50 if warranted by family history, once per plan year. Prostatic specific antigen (PSA) screening lab test. Screening mammogram. A screening mammogram is payable annually starting at age 30 and older. Gyn exam with pap smear lab test for covered persons age 18 and over, limited to one per plan year. Electrocardiogram (EKG), annually. Chest x-ray (once per plan year). Ear irrigations. Bone density screening (non-diagnostic) for osteoporosis screening. 	<ul style="list-style-type: none"> Annual Maximum Benefit: Coverage is provided for physical exams including certain testing. The first \$300 per person per plan year is paid at 100%, no deductible, thereafter the Plan pays 10% of eligible charges after the deductible is met and these eligible charges do not accumulate to meet your out-of-pocket limit. Mammograms and Wellness –related lab tests such as blood, PSA test, & pap smear are payable at 100% no deductible and no annual limit is applied when using in-network providers. Deductibles do <u>not</u> apply to the first \$300 of these wellness benefits. See also the Quick Reference Chart for information about the mobile onsite mammogram (MOM) program. If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than “wellness,” claims will be processed under the Plan’s usual deductible and/or copay/coinsurance. No coverage of immunizations needed for foreign travel such as for yellow fever/typhoid. 	<p>Annual Mammogram and wellness related lab tests: 100% no deductible</p> <p>All other wellness services: The first \$300 per person per plan year is paid at 100%, no deductible, thereafter the Plan pays 10% of eligible charges after the deductible is met and these eligible charges do not accumulate to meet your out-of-pocket limit.</p> <p>Immunizations: 100%, no deductible.</p>	<p>The first \$300 per person per plan year is paid at 100% of the Allowed Charge, no deductible, thereafter the Plan pays 10% of eligible charges after the deductible is met and these eligible charges do not accumulate to meet your out-of-pocket limit.</p> <p>You may be responsible for the difference between the billed charges and the amount this Plan allows.</p> <p>Immunizations: 100% no deductible.</p>	<p>Annual Mammogram and wellness related lab tests: 100% no deductible</p> <p>All other wellness services: The first \$300 per person per plan year is paid at 100%, no deductible, thereafter the Plan pays 10% of eligible charges after the deductible is met and these eligible charges do not accumulate to meet your out-of-pocket limit.</p> <p>Immunizations: 100%, no deductible.</p>
<p>Wellness Program: Screening Colonoscopy</p>	<ul style="list-style-type: none"> Screening Colonoscopy is payable (at the frequency recommended by the American Cancer Society) beginning at age 50 and repeated every 10 years. The colonoscopy may be payable at a younger age or more frequently with proof of a first-degree relative with a history of colorectal cancer or a diagnosis of familial adenomatous polyposis or hereditary non-polyposis colorectal cancer. 	<p>Screening Colonoscopy: 80% after deductible met</p>	<p>Screening Colonoscopy: 60% of the Allowed Charge amount after deductible met</p>	<p>Screening Colonoscopy: 60% after deductible met</p>

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p>Deductible</p> <ul style="list-style-type: none"> The deductible is the amount you must pay each plan year before the Plan pays benefits. 	<ul style="list-style-type: none"> SPECIAL NOTE: For families enrolled in the HDHP with HSA option, this Plan requires that the family (including any individual in the family) must meet the family deductible (e.g. \$5,000) before any reimbursement is made for eligible medical expenses (other than for preventive care). 	<p>\$2,500 per year for an individual with self-only coverage \$5,000 per year for an individual in the family or for the entire family (see special note to the left)</p> <p>Under this HDHP, both in-network and out-of-network covered provider services accumulate to meet the annual deductible.</p>	
<p>Out-of-Pocket Limit</p> <ul style="list-style-type: none"> This HDHP Plan has an Out-of-Pocket Limit which limits your annual cost-sharing for covered essential health benefits received related to Medical Plan deductibles, coinsurance, and copayments. The Out-of-Pocket Limit is the most you pay during a one year period (the plan year) before your health plan starts to pay 100% for covered essential health benefits. The Out-of-Pocket Limit is accumulated on a plan year basis. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. The amount of the in-network Out-of-Pocket Limit may be adjusted annually, in an amount that is consistent with regulations published by the Department of Health and Human Services. 	<ul style="list-style-type: none"> The Out-of-Pocket Limit does not include or accumulate: <ol style="list-style-type: none"> Premiums for coverage, Expenses for medical services or supplies that are not covered by the Plan, Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for out-of-network providers, Penalties for non-compliance with Utilization Management programs, Charges in excess of the Medical Plan's maximum benefits. Out-of-Pocket Limits are NOT interchangeable, meaning you may not use a portion of an In-Network Out-of-Pocket Limit to meet an Out-of-Network Out-of-Pocket Limit and vice versa, except that emergency services performed in an Out-of-Network Emergency Room will apply to meet the in-network Out-of-Pocket Limit. In accordance with law, the family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than \$5,000 per year when using in-network providers. 	<p>\$2,500 per year for an individual with self-only coverage</p> <p>\$5,000 per year for an individual in the family or for the entire family</p> <p>This out-of-pocket limit also accumulates eligible expenses for emergency services performed in an out-of-network emergency room.</p>	<p>\$10,000 per year for an individual with self-only coverage</p> <p>\$20,000 per year for an individual in the family or for the entire family</p>

SCHEDULE OF MEDICAL BENEFITS

All benefits are subject to the deductible except where noted. All admissions, plus procedures/treatment over \$1,000 must be precertified. See the Utilization Management chapter for details. This chart lists what this Plan pays.

See the definition of Allowed Charge. See also the Medical Exclusions and Definition chapters of this document.

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p>Hospital Services (Inpatient)</p> <ul style="list-style-type: none"> Room & board in semiprivate room with general nursing services. Specialty care units (e.g., intensive care unit, cardiac care unit). Lab/x-ray/diagnostic services. Related medically necessary ancillary services (e.g., prescriptions, supplies). Newborn care (see also the Physician and Other Health Care Practitioner Services section of this chart). Emergency: see the Emergency row in this Schedule. 	<ul style="list-style-type: none"> Elective hospitalization is subject to precertification. There is a penalty for failure to precertify and all hospitalization is subject to concurrent review as described in the Utilization Management chapter for details. Note that if you are admitted to an Out-of-Network hospital for emergency services, and are not yet ready for discharge, the UM Company will work with your Physician to have you transported into an In-Network hospital or other appropriate In-Network health care setting as soon as is possible. Private room is covered only if medically necessary. If a private room is the only accommodation available, (such as with a private room birthing suite) the plan will pay an Allowed Charge amount. Hospitalization for dental services is covered only if the Plan Administrator or its designee determines it to be medically necessary to safeguard the health of the patient. 	<p>100% after deductible met</p>	<p>50% of the Allowed Charge (after deductible met) and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>
<p>Physician and Other Health Care Practitioner Services</p> <ul style="list-style-type: none"> Office, hospital and other health care facility of Physicians and other covered health care practitioners. <ul style="list-style-type: none"> Surgeon fees. Assistant surgeon (only if medically necessary). Anesthesia fees for Physicians (or Certified Registered Nurse Anesthetists (CRNA) only in conjunction with a surgical procedure). Pathologist fees. Radiologist fees. Nurse midwife. Physician assistant. Nurse practitioner. Circumcision for newborn males ages birth to 10 weeks of age. See also the Family Planning, Maternity and Wellness rows where certain women's preventive services are payable without cost-sharing when obtained from in-network providers. 	<ul style="list-style-type: none"> Some Physician and Health Care Practitioner services are subject to precertification, see the Utilization Management Program chapter for details. The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure. Assistant surgeon fees will be reimbursed for services to a maximum of 20% of the eligible allowed charge expenses payable to the primary surgeon. Nurse midwife fees are payable. Under this HDHP Plan, there is no requirement to select a primary care provider (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider. 	<p>100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
Allergy Services <ul style="list-style-type: none"> Allergy sensitivity testing, including skin patch or Rast/Mast blood tests. Desensitization and hyposensitization (allergy shots given at periodic intervals), including allergy antigen. 	<ul style="list-style-type: none"> Desensitization injections are covered only when provided by a licensed Health Care Practitioner. If desensitization shots are administered in the Primary Care Provider's office, only the coinsurance applies. The allowance for antigen is based on a 3-month supply and a per vial cost. 	100% after deductible met	50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.
Alternative Health Care Services <ul style="list-style-type: none"> Acupuncture. Chiropractic Services: Services performed by or under the direction of a chiropractor, acting within the scope of his or her license. Naturopathic services or supplies. 	<ul style="list-style-type: none"> Plan year maximum benefit for alternative health care services is 8 visits per person per plan year after the deductible is met. Alternative health care services may not be applied to other benefits noted in this Schedule. Services and supplies are covered only if the Plan Administrator or its designee determines that the practitioner is licensed or duly authorized to practice in the jurisdiction in which the services are provided. 	100% after deductible met	50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.
Ambulance Services <ul style="list-style-type: none"> Ground transportation (e.g., ambulance) to the nearest appropriate facility as medically necessary for treatment of medical emergency, acute illness or inter health care facility transfer. Air transportation only as medically necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the health status of the patient. 	<ul style="list-style-type: none"> No coverage is provided for non-emergency use of ambulance transportation services. See also the row titled Emergency Services in this Schedule of Medical Benefits. 	100% after deductible met	50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.
Ambulatory Surgicenter	<ul style="list-style-type: none"> See the row titled Specialized Health Care Facilities in this Schedule of Medical Benefits. 		

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p>Behavioral Health Services (EAP and Mental Health and Substance Abuse Services)</p> <p>EAP Program: The EAP Program offers up to 3 free visits per problem, per person with an EAP Counselor, regardless of whether employee is enrolled in the HDHP.</p> <p>Behavioral Health Services:</p> <ul style="list-style-type: none"> Outpatient visits, including Intensive Outpatient Program (IOP) Visits Inpatient admission including partial hospitalization Residential treatment program Psychological (Psychiatric) Testing. 	<ul style="list-style-type: none"> <u>Inpatient behavioral health admission, partial hospitalization and residential treatment program must be pre-approved</u> by the Utilization Management Program whose phone number is listed on the Quick Reference Chart in the front of this document. Behavioral Health residential treatment program for individuals needing treatment in a highly structured 24-hour therapeutic environment that cannot be safely, efficiently or effectively treated in a less intensive setting. A residential treatment facility must be properly licensed in the state in which the facility operates. <u>See the precertification requirements noted above.</u> 	<p><u>EAP Visits:</u> 100%, no deductible</p> <p>Outpatient Visits, Psych Testing, Inpatient Admission and Residential treatment program: 100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>
Birthing Center/Facility	<ul style="list-style-type: none"> See the row titled Specialized Health Care Facilities in this Schedule of Medical Benefits. 		
<p>Blood Transfusions</p> <ul style="list-style-type: none"> Blood transfusions and blood products and equipment for its administration. 	<ul style="list-style-type: none"> Covered only when ordered by a Health Care Practitioner. Expenses related to autologous blood donation (patient's own blood) when provided for a covered person for covered services arising from an illness or injury. 	<p>100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>
<p>Chemotherapy</p> <ul style="list-style-type: none"> Chemotherapy services and supplies are payable when ordered by a Health Care Practitioner. 	<ul style="list-style-type: none"> Payment for chemotherapy varies according to the Plan's allowable fees in the location where the service is rendered (e.g., hospital, ambulatory surgicenter, doctor's office, home, etc.). See other sections of this Schedule of Medical Benefits for payment guidelines. 	<p>100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>
Chiropractic Services	<ul style="list-style-type: none"> See the row titled "Alternative Health Care Services" in this Schedule of Medical Benefits. 		

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p>Corrective Appliances (Prosthetic and Orthotic Devices, other than Dental)</p> <ul style="list-style-type: none"> Coverage is provided for rental (payable only up to the allowed purchase price of the corrective appliance) or purchase of standard models, at the option of the Plan, and for medically necessary repair, adjustment, servicing and replacement of these devices. Replacement payable if due to a change in the covered person's physical condition or if the device cannot be satisfactorily repaired. Occupational therapy (orthotic) supplies needed to assist the person in performing activities of daily living, payable at the usual cost-sharing to a maximum of \$500 per person per plan year; thereafter the plan pays 10%. Colostomy or ostomy (orthotic) supplies. See also the Hearing Services section of this Schedule. 	<ul style="list-style-type: none"> See the specific exclusions related to corrective appliances in the Medical Exclusions chapter. To help determine what prosthetic or orthotic appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Definitions chapter. Corrective appliances are covered only when ordered by a Health Care Practitioner. For prosthetic devices the plan pays the usual cost-sharing up to \$30,000 per person per lifetime per limb or device for the appliance, including necessary supplies, repair, and servicing; thereafter the plan pays 10%. Foot orthotics (orthopedic or corrective shoes and other supportive appliances for the feet) are payable to a maximum of one pair per person per plan year. One pair of prescription contact lenses or eyeglasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular surgery. Anti-embolism (e.g. Jobst) garments limited to three pairs per person per plan year. Mastectomy bras and external silicone breast prostheses. 	<p>100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>
<p>Diabetes Education</p> <ul style="list-style-type: none"> Diabetes counseling sessions for the management of diabetes. Diabetes Education Benefit is payable to a maximum of 5 visits per person per lifetime. 	<ul style="list-style-type: none"> Covered when ordered by a Health Care Practitioner. 	<p>100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>
<p>Dialysis</p> <ul style="list-style-type: none"> Renal (kidney) dialysis services are covered in the inpatient, outpatient or home setting. 	<ul style="list-style-type: none"> Covered when ordered by a Health Care Practitioner. 	<p>100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p>Drugs and Medicines</p> <ul style="list-style-type: none"> • Coverage is provided only for FDA approved pharmaceuticals requiring a prescription and FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or other health care practitioner authorized by law to prescribe them. Coverage includes: prenatal vitamins and other prescription vitamins needed to treat a medical condition, FDA approved contraceptives, drugs required to be covered due to Health Reform, diabetic supplies, insulin, and insulin syringes. • Outpatient prescription drugs are administered by a Prescription Drug Program whose name, phone number and website are listed on the Quick Reference Chart. Contact the Prescription Drug Program for: <ol style="list-style-type: none"> a. drugs needing pre-approval by the clinical staff of the Prescription Drug Program, b. drugs on the list of preferred drugs (also called formulary) as selected by the Prescription Drug Program. A copy of the formulary is available from the Prescription Drug Program's website or your HR Office There is no payment for drugs not listed on the formulary. Physicians may appeal non-formulary drugs they believe are needed by a patient by calling the Prescription Drug Program. c. drugs with a quantity limit payable by the Plan or d. drugs under step therapy. e. Specialty drugs are products derived from living organisms used by individuals with unique health concerns and include items such as injectables for multiple sclerosis, rheumatoid arthritis or hepatitis. These drugs require precertification, are managed because they often require special handling, are date sensitive and usually available in a 30-day quantity. For specialty drugs call the Specialty Drug Pharmacy Center of the Prescription Drug Program noted on the Quick Reference Chart. 	<ul style="list-style-type: none"> • Retail Prescriptions (up to a 30 or 90-day supply): For the location of in-network retail pharmacies contact the Prescription Drug Program whose name & phone number are listed on the Quick Reference Chart in this document. • Mail Order Home Delivery: (up to a 90-day supply): To use mail order contact the Prescription Drug Program on the Quick Reference Chart in the front of this document or your Human Resource Dept. for a mail order packet of information. • Exclusions: some of the drugs excluded from coverage under this plan include hair growth, experimental, fertility/infertility, & weight control. See also the exclusions related to Drugs & Medicines in the Medical Exclusions chapter. • Smoking/Tobacco cessation benefit: Coverage is extended for smoking/tobacco cessation products (such as nicotine gum or patches) intended to assist an individual to stop smoking or using tobacco products. The drugs are payable through the Prescription Drug Program when you present a written prescription from a Health Care Practitioner for smoking/tobacco cessation products to the in-network retail pharmacist. • Drugs not yet FDA approved are not covered. New FDA-approved drugs will be covered unless an amendment states otherwise or the drug class is excluded. • FDA-approved contraceptives for females: 100%, no cost-sharing for generic drugs submitted with a prescription purchased at an In-network Retail or Mail Order location only. No charge for brand prescription contraceptive drug only if a generic contraceptive is unavailable or medically inappropriate. The attending Health Care Practitioner determines medical necessity for FDA-approved female contraceptives. No coverage from Out-of-Network retail pharmacy. • Certain CDC recommended vaccinations are payable at 100%, no cost sharing when obtained at an in-network retail pharmacy. Contact the Prescription Benefit Manager for information. • In accordance with Health Reform, certain over-the-counter (OTC) drugs are payable at no charge when prescribed by a Physician or Health Care Practitioner. For details, see the OTC section in Article V the "Medical Expense Benefits" chapter. • Certain Drugs to Reduce the Risk of Breast Cancer: no charge at an In-network Retail or Mail Order location for generic tamoxifen or raloxifene prescribed for women who are at increased risk of breast cancer and low risk for adverse medication effects. 	<p style="text-align: center;">The medical plan deductible must be met before the Plan pays 100% toward Outpatient Prescription Drug benefits.</p> <p style="text-align: center;">The Plan pays for prescription drugs obtained from a network retail or mail order pharmacy location.</p> <p style="text-align: center;">Certain OTC drugs and FDA approved contraceptives for all females are payable at no cost-sharing and without having to meet the deductible, when prescribed by a Physician or Health Care Practitioner and obtained from an in-network retail pharmacy location. Contact the Prescription Drug Program for information on these payable preventive drugs. After you meet your annual medical plan deductible the Outpatient Prescription Drug benefits are payable at no charge.</p> <p style="text-align: center;">As a reminder, your <u>least expensive drugs</u> are <u>Generic drugs</u> obtained at an In-network Retail pharmacy or through the plan's Mail Order service.</p>	<p style="text-align: center;">No coverage for drugs obtained from out-of-network pharmacy locations.</p>

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p>Durable Medical Equipment (DME)</p> <ul style="list-style-type: none"> Coverage is provided for rental (payable only up to the allowed purchase price of the durable medical equipment) or purchase of standard models, at the option of the Plan, and for medically necessary repair, adjustment, servicing and replacement of this equipment. Replacement payable if due to a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired. Benefits are payable for medically necessary oxygen, along with the medically necessary equipment and supplies required for its administration. Coverage is provided for diabetic glucose meter and other medically necessary diabetes durable medical equipment. 	<ul style="list-style-type: none"> See the specific exclusions related to durable medical equipment in the Medical Exclusions chapter. To help determine what durable medical equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions chapter. For example, no benefits are payable for the following items: exercise equipment, air cleaners, air filters, or motorized wheelchairs and carts, (except as determined by the Plan Administrator or its designee, that a standard wheelchair is not appropriate and the motorized chair functions as the sole means of transportation for that individual). Durable medical equipment is covered only when its use is medically necessary and it is ordered by a Health Care Practitioner. A statement is required from the prescribing Health Care Practitioner describing how long the equipment is expected to be necessary. This statement will assist in determining whether the equipment will be rented or purchased. For durable medical equipment (except oxygen) the first \$5,000 per person per plan year is payable at the usual cost-sharing; thereafter, the plan pays 10%. Charges in excess of \$1,000 must be precertified through the Utilization Management Company whose telephone number is listed on the Quick Reference Chart in this document. Oxygen and the equipment and supplies for its administration is payable up to \$3,000 per person per plan year at the usual cost-sharing; thereafter, the plan pays 10%. For females who are breastfeeding, coverage is provided for one standard manual or standard electric breast pump, plus necessary supplies to operate the breast pump. Rental, purchase and repair is payable as outlined to the left. Coverage is available at no cost from in-network providers only. Standard cost-sharing applies to use of out-of-network providers. 	<p>Breast pump and supplies: No charge</p> <p>All other services: 100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p>Emergency Room (ER) Facility, and Urgent Care Facility</p> <ul style="list-style-type: none"> Hospital emergency room for a medical emergency. Urgent care facility Ambulance: see the Ambulance row in this Schedule. Refer to the Physician Services row for information on how the professional fees associated with the ER, urgent care or ambulance are payable associated with these facility fees. 	<ul style="list-style-type: none"> See definition of "Emergency (Medical)" in the Definitions chapter. No coverage is provided for non-emergency use of emergency room services. There is no requirement to precertify (prior authorize) the use of a hospital-based emergency room visit. Also, the Plan will pay a reasonable amount for hospital-based emergency services performed Out-of-Network, in compliance with health reform Affordable Care Act regulations. See the definition of Allowed Charge or contact the medical plan Claims Administrator for more details on what the Plan allows as payment to Out-of-Network emergency service providers. Note that if you are admitted to an Out-of-Network hospital for emergency services, and are not yet ready for discharge, the UM Company will work with your Health Care Practitioner to have you transported into an In-Network hospital or other appropriate In-Network health care setting as soon as is possible. 	<p>For an emergency situation: Emergency Room facility and Physician fees associated with an emergency room visit: 100% after deductible met</p> <p>Urgent Care Facility: 100% after deductible met</p>	<p>For an emergency situation: Emergency Room facility and Physician fees associated with an emergency room visit: 100% after in-network deductible met</p> <p>Urgent care facility visit: 50% of the Allowed Charge after out-of-network deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>
<p>Family Planning Services</p> <ul style="list-style-type: none"> Sterilization services (e.g., vasectomy, tubal ligation, implants such as Essure). Fertility and infertility diagnostic services for the employee and spouse only. Fertility treatment and drugs are not covered. FDA approved contraceptives are payable including: oral birth control pills/patch, intrauterine devices (IUD), implantable birth control devices (e.g. Nexplanon), injectables (e.g. Depo-Provera, Lunelle) and diaphragms. Certain contraceptives are payable under the Prescription Drug Program. 	<ul style="list-style-type: none"> See the specific exclusions related to Family Planning in the Medical Exclusions chapter. No coverage for fertility and infertility treatment or treatment of sexual dysfunction. Patient education and counseling on contraceptive methods payable without cost-sharing for all females with reproductive capacity. 	<p>Female Contraceptives, Female sterilization procedures, and patient education and counseling: 100% no deductible.</p> <p>All other services: 100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p>Genetic Testing and Counseling</p> <p>The genetic testing payable under this Plan is for:</p> <ul style="list-style-type: none"> state-mandated newborn screening tests for genetic disorders (referred to as surrogate biochemical markers); fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Plan Administrator or its designee; tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity; genetic testing recommended by the American College of Obstetrics and Gynecology for pregnant women such as genetic carrier testing for cystic fibrosis; genetic testing (e.g. BRCA) and genetic counseling required as a Preventive service, in accordance with Health Reform regulations (see the Wellness row in this Schedule). the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants if <u>all</u> the following conditions are met: <ul style="list-style-type: none"> the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; <u>and</u> the covered individual displays clinical features/symptoms, or is at direct risk of developing the genetically linked heritable disease/condition in question (pre-symptomatic); <u>and</u> the results of the test will directly impact the clinical decision-making, clinical outcome or treatment being delivered to the covered individual. <p>Genetic Counseling is payable when ordered by a Health Care Practitioner and provided in conjunction with a genetic test that is payable by this Plan.</p>	<ul style="list-style-type: none"> See the definitions of Genetic Counseling and Genetic Testing in the Definitions chapter. See the Exclusions chapter for exclusions relating to Genetic Testing and Counseling, in addition to those indicated here: <ul style="list-style-type: none"> No coverage for pre-parental genetic testing (also called carrier testing) intended to determine if a prospective parent or parents have chromosomal abnormalities that are determined by the Plan Administrator or its designee to be likely to be transmitted to a child of that parent or parents. No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of individuals who are not covered under this Plan. Genetic testing costs may be covered for a non-covered individual only if such testing would directly impact the treatment of a covered plan participant. Plan participants can contact the Medical Plan Claims Administrator or Utilization Management Program to assist in determining if a proposed genetic test will be covered or excluded. 	<p>Health Reform required genetic tests & counseling: 100% no deductible</p> <p>All other services: 100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>
<p>Hearing Services</p> <ul style="list-style-type: none"> Hearing exam and hearing aid. 	<ul style="list-style-type: none"> Hearing exam and corrective hearing aid payable to a maximum of \$1,500 per person every three years. Implantable hearing devices (e.g. cochlear implant for individuals with profound hearing loss) covered under Prosthetics in the Corrective Appliance row this Schedule. 	<p>100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>

SCHEDULE OF MEDICAL BENEFITS

All benefits are subject to the deductible except where noted. All admissions, plus procedures/treatment over \$1,000 must be precertified. See the Utilization Management chapter for details. This chart lists what this Plan pays.

See the definition of Allowed Charge. See also the Medical Exclusions and Definition chapters of this document.

**REMINDER: Except in an emergency, Out-of-Network claims are paid in accordance with the Plan's definition of Allowed Charge.*

Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p>Home Health and Home Infusion Services</p> <ul style="list-style-type: none"> Part-time, intermittent skilled nursing care services and medically necessary supplies to provide home health care or home infusion therapy services, subject to a plan year maximum Plan benefit shown in the Explanations and Limitations column. Home services other than skilled nursing care are not covered. 	<ul style="list-style-type: none"> See the specific exclusions related to home health care and custodial care (including personal care and child care) in the Exclusions chapter of this document. Covered only when ordered by a Health Care Practitioner. Maximum Plan benefit for skilled nursing Care services and supplies to provide home health care and home infusion therapy services is 60 visits per plan year. Home hospice coverage is described in this Schedule under Specialized Health Care Facilities benefits. Home physical therapy services coverage is described in this Schedule under Rehabilitation Services benefits. Prescription drug coverage is described in this Schedule under Drugs and Medicines benefits. 	<p>100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>
<p>Hospice</p>	<ul style="list-style-type: none"> See the row titled Specialized Health Care Facilities in this Schedule of Medical Benefits. 		
<p>Laboratory Services (Outpatient)</p> <ul style="list-style-type: none"> Technical and professional fees. 	<ul style="list-style-type: none"> Covered only when ordered by a Health Care Practitioner. Refer also to the Physician and Other Health Care Practitioner Services section of this Schedule for information about lab performed in the Health Care Practitioner's office by an In-Network provider. 	<p>Hospital based lab services: 100% after deductible met</p> <p>Non-hospital based lab services: 100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>

SCHEDULE OF MEDICAL BENEFITS

All benefits are subject to the deductible except where noted. All admissions, plus procedures/treatment over \$1,000 must be precertified. See the Utilization Management chapter for details. This chart lists what this Plan pays.

See the definition of Allowed Charge. See also the Medical Exclusions and Definition chapters of this document.

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p>Maternity Services</p> <ul style="list-style-type: none"> Hospital and birthing center charges and Health Care Practitioner fees for medically necessary maternity services. For information on payable genetic testing, see the Genetic Testing row in this Schedule. Termination of pregnancy: is payable only when the attending Physician certifies that the female employee's or spouse's health would be endangered if the fetus were carried to term, or where medical complications arise from an abortion. No coverage for termination of pregnancy for dependent child. Breastfeeding equipment (breast pump) and supplies are payable as noted on the Durable Medical Equipment row of this Schedule. In conjunction with breastfeeding, the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) at 100%, no deductible, when provided by an in-network provider acting within the scope of his or her license. In-network providers are listed on the network directory described on the Quick Reference Chart. This Plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). 	<ul style="list-style-type: none"> Prenatal and postnatal care office visits and certain other preventive screening services are payable for all females (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits/ including but not limited to routine prenatal obstetrical office visits, screening for gestational diabetes, HPV testing starting at age 30, breastfeeding equipment and necessary supplies to operate the pump, and when breastfeeding, comprehensive lactation support and counseling). For all females, prenatal and postnatal visits obtained from an in-network provider are payable at no cost to you. Normal plan cost-sharing still applies to all other maternity related services including ultrasounds and delivery fees. However, under this Plan there is no coverage for prenatal ultrasounds or delivery expenses for a pregnant dependent child and their baby. When an in-network provider submits a bill to the plan with a global CPT code for the combination of prenatal/postnatal visits and delivery expenses, the Plan's claims administrator will process the claim applying no cost-sharing to 40% of the charges representing the prenatal/postnatal visit expenses, and normal cost-sharing to 60% of the charges representing the delivery expenses. No coverage for adoption expenses. You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. 	<p>Prenatal and postnatal visits: 100%, no deductible.</p> <p>Breastfeeding equipment and supplies: 100% no deductible.</p> <p>Lactation counseling: 100%, no deductible</p> <p>All other services including Delivery fees: 100% after deductible met</p>	<p style="text-align: center;">50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>

SCHEDULE OF MEDICAL BENEFITS

All benefits are subject to the deductible except where noted. All admissions, plus procedures/treatment over \$1,000 must be precertified. See the Utilization Management chapter for details. This chart lists what this Plan pays.

See the definition of Allowed Charge. See also the Medical Exclusions and Definition chapters of this document.

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p>Nondurable Medical Supplies</p> <p>Coverage is provided for:</p> <ul style="list-style-type: none"> • Sterile surgical supplies used immediately after surgery. • Supplies needed to operate or use covered durable medical equipment or corrective appliances. • Supplies needed for use by skilled home health or home infusion therapy personnel, but only during the course of their required services. 	<ul style="list-style-type: none"> • Diabetic supplies (e.g. test-strips, lancets) and insulin syringes for diabetics are covered under the Drugs and Medicines benefits. • To determine what nondurable medical supplies are covered, see the definition of "Nondurable Medical Supplies" in the Definitions chapter. 	<p>100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>
<p>Oral and Craniofacial Services</p> <ul style="list-style-type: none"> • Accidental Injury to Teeth/Jaw. • Oral and/or craniofacial surgery. • Oral surgery is limited to cutting procedures for removal of tumors, cysts, abscess, acute injury and impacted teeth partially or totally covered by bone. These services will first be considered under the dental plan and any services not payable under the dental plan will then be considered under the medical plan. In no event will services be paid in full under both plans. 	<ul style="list-style-type: none"> • See the specific exclusions related to dental services in the Dental Exclusions chapter. • Treatment of Accidental Injuries to the Teeth/Jaw: This medical plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan Administrator or its designee, all of the following conditions are met: <ul style="list-style-type: none"> • The accidental injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and • The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and • The dental treatment will return the person's teeth to their pre-injury level of health and function. See also the definition of Injury to Teeth in the Definitions chapter of this document. <p>These services will first be considered under the dental plan and any services not payable under the dental plan will then be considered under the medical plan.</p> <ul style="list-style-type: none"> • No coverage for surgical treatment of TMJ syndrome/dysfunction. Non-surgical treatment of TMJ syndrome/dysfunction, including appliances, is payable at the usual cost-sharing to a maximum of \$500 per person per plan year; thereafter the plan pays 10%. 	<p>100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>
<p>Outpatient Surgery Facility/Center</p>	<ul style="list-style-type: none"> • See the row titled Specialized Health Care Facilities in this Schedule of Medical Benefits. 		

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p>Radiology (X-Ray), Nuclear Medicine and Radiation Therapy Services (Outpatient)</p> <ul style="list-style-type: none"> Technical and professional fees associated with diagnostic and curative services, including radiation therapy. 	<ul style="list-style-type: none"> Covered only when ordered by a Health Care Practitioner. Some radiology procedures are covered under the Wellness Program (e.g., screening mammogram, CT scan for certain adults with a smoking history). Refer also to the Physician and Other Health Care Practitioners Services section of this Schedule regarding x-rays performed in the Health Care Practitioner's office by a Preferred PPO provider. 	<p>Annual Screening Mammogram: 100% no deductible</p> <p>All other services: 100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>
<p>Reconstructive Services</p> <ul style="list-style-type: none"> Includes expenses for reconstructive surgery, procedures or treatment intended to improve bodily function and/or correct a deformity resulting from disease, trauma, congenital anomalies or prior covered therapeutic procedure. This Plan complies with the Women's Health and Cancer Rights Act of 1998 and provides medical and surgical benefits in connection with a mastectomy and for certain reconstructive surgery, in a manner determined in consultation with the attending Health Care Provider and the patient, as follows: <ul style="list-style-type: none"> Reconstruction of the breast on which the mastectomy was performed. Surgery on the other breast to produce a symmetrical appearance. Prostheses and physical complications of all stages of mastectomy, including lymphedemas. 	<ul style="list-style-type: none"> See the specific exclusions related to Cosmetic Services (including reconstructive surgery) in the Medical Exclusions chapter. Most cosmetic and dental (including orthognathic) services are excluded from coverage. Contact the Claims Administrator to verify whether a proposed service is cosmetic or reconstructive. 	<p>100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>
<p>Rehabilitation Services (Cardiac and Pulmonary)</p> <ul style="list-style-type: none"> Cardiac rehabilitation is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.). Pulmonary rehabilitation is available to those individuals who are able to actively participate in a pulmonary rehabilitation program that is likely to improve their pulmonary condition, as determined by the Plan Administrator or its designee. 	<ul style="list-style-type: none"> Cardiac or pulmonary rehabilitation programs must be ordered by a Health Care Practitioner. For cardiac rehabilitation coverage is provided for a maximum of 12 weeks, not to exceed \$3,000 per person per cardiac incident at the usual cost-sharing, thereafter the plan pays 10%. For pulmonary rehabilitation coverage is provided for a maximum of 12 weeks not to exceed a total of \$1,500 per person per lifetime at the usual cost-sharing, thereafter the plan pays 10%. 	<p>100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>

SCHEDULE OF MEDICAL BENEFITS

All benefits are subject to the deductible except where noted. All admissions, plus procedures/treatment over \$1,000 must be precertified. See the Utilization Management chapter for details. This chart lists what this Plan pays.

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p>Rehabilitation Services (Physical, Occupational, and Speech Therapy)</p> <ul style="list-style-type: none"> Short-term active, progressive Rehabilitation services (occupational, physical, or speech therapy) performed by Health Care Practitioner. Rehabilitation services covered only when ordered by a Health Care Practitioner. Inpatient rehabilitation services in an acute hospital, rehabilitation unit or facility or skilled nursing facility for short term, active, progressive, rehabilitation services that cannot be provided in an outpatient or home setting. Outpatient physical therapy performed in conjunction with services ordered by or under the direction of a chiropractor are subject to the Plan's limitations for Chiropractic Services (as described in the row of this Schedule of Medical Benefits titled Alternative Health Care Services). 	<ul style="list-style-type: none"> Maintenance rehabilitation, habilitation services and coma stimulation services are not covered. See specific exclusions relating to Rehabilitation Therapies in the Medical Exclusions chapter. Inpatient rehabilitation admission requires precertification (see Article 6). Benefits for inpatient rehabilitation services are payable up to the overall rehab maximum noted above, not to exceed 60 consecutive days per person per injury or illness. Outpatient rehabilitation services (physical and occupational therapy) is payable up to 50 visits per person per injury or illness. Speech therapy is payable up to 8 visits per person per plan year and is covered if the services are provided by a Health Care Practitioner to restore speech or to correct dysphagic or swallowing defects and disorders lost due to illness, injury or surgical procedure. Speech therapy is not considered medically necessary and is not a covered benefit for self-correcting dysfunctions causing dysfluency or articulation disorders such as stuttering, stammering, lisping and tongue thrusting. 	<p>100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>
<p>Second and Third Physician Opinions</p> <ul style="list-style-type: none"> Includes only one office visit per opinion. 	<ul style="list-style-type: none"> See the Utilization Management Program chapter for details of the Second and Third Opinion Programs. Additional medically necessary tests are covered under other Plan provisions. Voluntary 2nd and 3rd physician opinions at the desire of the patient are paid per the Plan's normal physician payment as listed in the row of this Schedule called "Physician and Other Health Care Practitioner Services." 	<p>Plan required opinions paid at 100% after deductible met</p> <p>Patient requested opinions paid at 100% after deductible met</p>	<p>Plan required opinions paid at 100%, after deductible met.</p> <p>Patient requested opinions paid at 50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>
<p>Skilled Nursing Facility (SNF)</p>	<ul style="list-style-type: none"> See the row titled Specialized Health Care Facilities in this Schedule of Medical Benefits. 		

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
Sleep Disorders <ul style="list-style-type: none"> Sleep studies are payable when performed for the purpose of detecting sleep apnea. This benefit pays for medically necessary diagnosis and treatment of sleep apnea. 	<ul style="list-style-type: none"> Covered only when ordered by a Health Care Practitioner. Medically necessary treatment of sleep apnea will be considered for payment under the covered plan benefit associated with the service that is ordered as a treatment for sleep apnea (e.g., medical equipment is covered under the Durable Medical Equipment benefit, Dr. office visit covered under Physician services, etc.). 	100% after deductible met	50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.
Smoking/Tobacco Cessation Support	<ul style="list-style-type: none"> Screening for tobacco use of all individuals. For up to two tobacco cessation attempts per year: <ul style="list-style-type: none"> Four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization. See the Drug row for more information. 	100% no deductible applies	50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.
Specialized Health Care Facilities <ul style="list-style-type: none"> Ambulatory Surgical Facility (Outpatient Surgery) Birthing Center Hospice Skilled Nursing Facility (SNF) Subacute Care Facility also called Long Term Acute Care (LTAC) Facility. 	<ul style="list-style-type: none"> Admissions to some specialized health care facilities are subject to precertification. See the Utilization Management chapter for details and a discussion of the penalty for failure to precertify. Specialized health care facility services must be ordered by a Health Care Practitioner. To determine if a facility is a "Specialized Health Care Facility," see the Definitions chapter of this document. Benefits for skilled nursing facility or subacute facility confinement limited to 60 days per person per injury or illness. 	100% after deductible met	50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.
Spinal Manipulation Services	<ul style="list-style-type: none"> See the row titled "Alternative Health Care Services" in this Schedule of Medical Benefits. 		

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p>Transplantation (Organ and Tissue)</p> <ul style="list-style-type: none"> Coverage is provided only for eligible services directly related to medically necessary transplantation of human organs or tissue including: liver, heart, bone marrow, cornea, kidney, lung(s), pancreas, intestine including: <ul style="list-style-type: none"> Facility and professional services, FDA approved drugs, and medically necessary equipment and supplies. Organ or tissue procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor. Reasonable and necessary expenses incurred by a donor who is covered by the Plan, without any deductibles and coinsurance applicable to those expenses. Reasonable and necessary expenses incurred by a donor who is not covered by the Plan, without any deductibles and coinsurance applicable to those expenses, but only to the extent the donor is not covered by the donor's own insurance or health care plan. 	<ul style="list-style-type: none"> See the specific exclusions related to Experimental and/or Investigational Services and Transplantation in the Medical Exclusions chapter. Transplantation services are subject to precertification. See the Utilization Management Program chapter for details. Benefits are payable only if services are provided in a hospital or specialized health care facility approved by the Plan Administrator or its designee. Travel expenses payable only when the surgery is precertified and case managed by the Utilization Management Company. Travel expenses includes: <ul style="list-style-type: none"> Two round trip "coach" transportation charges for the patient and one family member or companion, to and from the transplant site. Lodging for two people (one room) as pre-approved by the Plan Administrator or its designee, and not to exceed \$150/day. Receipts are required when submitting lodging, and travel expenses for payment consideration. In accordance with IRS rules, meals are not reimbursed under this travel benefit. Travel expense benefit not to exceed \$10,000 per transplant. 	<p>100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>

SCHEDULE OF MEDICAL BENEFITS

All benefits are subject to the deductible except where noted. All admissions, plus procedures/treatment over \$1,000 must be precertified. See the Utilization Management chapter for details. This chart lists what this Plan pays.

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p>Weight Control Services</p> <ul style="list-style-type: none"> • Surgical treatment of morbid obesity (as defined by the Plan) including gastric restrictive procedures, gastric or intestinal bypass or reversal of a previously performed weight management surgery. • Surgical procedures to treat morbid obesity (including reversal) are payable to a maximum of \$20,000 per person per lifetime. 	<p>Morbidly Obese, Morbid Obesity is defined by the Plan Administrator or its designee, to mean the:</p> <ol style="list-style-type: none"> 1. Presence of morbid obesity that has persisted for at least 5 years, defined as either: <ol style="list-style-type: none"> a. body mass index (BMI) (<i>term defined at the end of this definition</i>) exceeding 40; or b. BMI greater than 35 in conjunction with ANY of the following severe co-morbidities: <ol style="list-style-type: none"> (1) coronary heart disease; or (2) type 2 diabetes mellitus; or (3) clinically significant obstructive sleep apnea; or (4) high blood pressure/hypertension (BP > 140 mmHg systolic and/or 90 mmHg diastolic) AND 2. Patient has completed growth (18 years of age or documentation of completion of bone growth); AND 3. Patient has participated in a Physician-supervised nutrition and exercise program (including dietitian consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record. This Physician-supervised nutrition and exercise program must meet ALL of the following criteria: <ol style="list-style-type: none"> a. Participation in nutrition and exercise program must be supervised and monitored by a Physician working in cooperation with dietitians and/or nutritionists; AND b. Nutrition and exercise program must be 6 months or longer in duration; AND c. Nutrition and exercise program must occur within the two years prior to surgery; AND d. Participation in Physician-supervised nutrition and exercise program must be documented in the medical record by an attending Physician who does not perform bariatric surgery. Note: A Physician's summary letter is not sufficient documentation. <p>NOTE: BMI is calculated by dividing your weight (in kilograms) by height (in meters) squared: $BMI = \frac{\text{weight in kilograms}}{\text{height in meters}^2}$ or compute using the Obesity Education Initiative website: http://www.nhlbi.nih.gov/about/org/oei. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by 0.0254.</p> <p>No coverage for post-weight loss skin reduction procedures/surgery.</p>	<p>100% after deductible met</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p><u>Wellness (Preventive) Program</u> <u>Well Child Examinations and Immunizations</u></p> <ul style="list-style-type: none"> Outpatient newborn and well child visits and routine childhood immunizations that are FDA approved and in accordance with the Centers for Disease Control (CDC) recommendations for children in the US, such as DPT, Polio, MMR, HIB, hepatitis, chicken pox, tetanus, influenza (flu) vaccine, HPV (e.g. Gardasil, Cervarix), etc. The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations as outlined to the right. Preventive services are payable without regard to gender assigned at birth, or current gender status. Childhood immunizations are also available through the Yavapai County Health Department whose phone number is listed on the Quick Reference Chart in the front of this document. Coverage is provided in primary care clinician visits for fluoride varnish applied to the primary teeth of children through age 5 years. For children age 6 years and older with obesity, the Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's in-network pediatrician. 	<p>The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures and the Centers for Disease Control and Prevention (CDC). This website lists the types of payable preventive services, including immunizations: https://www.healthcare.gov/what-are-my-preventive-care-benefits/ with more details at http://www.cdc.gov/vaccines/schedules/hcp/index.html, http://www.uspreventiveserviceslaskforce.org/BrowseRec/Index and http://www.hrsa.gov/womensguidelines/</p> <ul style="list-style-type: none"> In addition to the wellness services listed on the website above, the Plan will pay for these wellness services: well child office visits, well woman office visits, contraceptives, & certain over the counter drugs. When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g. coinsurance and deductible) for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g. coinsurance and deductible) will apply to the diagnostic or therapeutic services provided. Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than "wellness," claims will be processed under the Plan's usual deductible/copay/coinsurance. Services not covered under the wellness/preventive benefit may be covered under another portion of the medical plan. Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis are covered, subject to the Plan's Deductible and all other Plan provisions. If a Health Reform preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters. If there is no network a provider who can provide the wellness service, then the plan will cover the service when performed by an out-of-network provider without cost-sharing. See Article V the "Medical Expense Benefits" chapter for information on plan payment for certain over the counter (OTC) drugs in compliance with Health Reform. 	<p>100% no deductible applies</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanation and Limitations of Benefits	HDHP with Health Savings Account (HSA)	
		In-Network (BCBSAZ Preferred PPO Providers)	Out-of-Network (Non-Preferred Providers)
<p>Wellness (Preventive) Program: Adult Health Maintenance Examinations (Age 18 & up)</p> <ul style="list-style-type: none"> The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations as outlined to the right. Certain prescription and non-prescription drugs, required to be covered in compliance with Health Reform, are available through the Outpatient Prescription Drug program. Preventive services are payable without regard to gender assigned at birth, or current gender status. See also the Quick Reference Chart for information about the mobile onsite mammogram (MOM) program. If a Health Reform preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters. Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than "wellness," claims will be processed under the Plan's usual deductible and coinsurance. Services not covered under the wellness/preventive benefit may be covered under another portion of the medical plan. Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis are covered, subject to the Plan's Deductible and all other Plan provisions. If there is no network provider who can provide the wellness service, then the plan will cover the service when performed by an out-of-network provider without cost-sharing. As a preventive counseling benefit in compliance with Health Reform, the Plan covers the following services: For adults (1) with a body mass index of 30 kg/m² or higher, <u>OR</u> (2) who are overweight (defined as a BMI of 25 to 29.9 kg/m²) or obese (defined as a BMI of 30 kg/m² or higher) <u>AND</u> have additional cardiovascular disease (CVD) risk factors, the Plan covers Physician prescribed intensive behavioral counseling interventions. Intensive behavioral counseling interventions means the Plan will consider as medically necessary preventive services, up to a combined limit of 26 individual or group visits per 12-month period by an in-network provider. For children age 6 years and older with obesity, the Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's in-network pediatrician. 	<ul style="list-style-type: none"> The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures, & the Centers for Disease Control and Prevention (CDC). These websites list the types of payable preventive services (such as immunizations, mammogram, pap smear, colonoscopy with polyp removal): https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: http://www.cdc.gov/vaccines/schedules/hcp/index.html, http://www.uspreventiveservicestaskforce.org/BrowseRc/Index and http://www.hrsa.gov/womensguidelines/. In addition to the wellness services listed on the websites above, the Plan will pay for these wellness services: an annual wellness/physical exam for adults, well woman office visits, annual prostatic specific antigen (PSA) lab test for men, screening mammogram for women starting at age 30 years, bone density screening/osteoporosis screening, chest x-ray once/year, ear irrigations, electrocardiogram (EKG) annually. Certain additional preventive care expenses are payable for all covered females (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits including but not limited to well woman office visits, screening for gestational diabetes, BRCA breast cancer gene test, HPV testing at least every 3 years starting at age 30, counseling on sexually transmitted infections, annual HIV screening and counseling, breastfeeding equipment and necessary supplies to operate the pump, & lactation support). When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the preventive services. Preventive services are those services performed for screening purposes when the individual does not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the individual has a condition or an active symptom of a condition. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. The diagnosis and procedure codes submitted by the provider determine whether a service is considered preventive. Screening Colonoscopy is payable (at the frequency recommended by the American Cancer Society) beginning at age 50 and repeated every 10 years. The colonoscopy may be payable at a younger age or more frequently with proof of a first-degree relative with a history of colorectal cancer or a diagnosis of familial adenomatous polyposis or hereditary non-polyposis colorectal cancer. No charge for the bowel prep medication prescribed for use prior to a screening colonoscopy or for the cost of anesthesia, or polyps removed during a screening colonoscopy. Proctoscopy after age 50, once per plan year. Proctoscopy under age 50 if warranted by family history, once per plan yr. See Article V the "Medical Expense Benefits" chapter for information on plan payment for certain over the counter (OTC) drugs in compliance with Health Reform. 	<p>100% no deductible applies</p>	<p>50% of the Allowed Charge after deductible met and you may be responsible for the difference between the billed charges and the amount this Plan allows.</p>

ARTICLE 4: ELIGIBILITY

WHO IS ELIGIBLE FOR COVERAGE

Your Eligibility:

The employers participating in Yavapai Combined Trust determine full-time employee status in compliance with IRS regulations under the Affordable Care Act. These employers reserve the right to use a **Monthly Measurement Method** and/or a **Look Back Measurement Method** to determine if an employee reaches the level of a full-time employee, in accordance with IRS regulations under the Affordable Care Act. The Monthly Measurement Method identifies full-time employees based on the actual hours of service achieved for each calendar month. The Look-Back Measurement Method determines the status of a new employee or an ongoing employee as full-time or not for a future period (called a stability period) based on the average number of hours of service per week the employee attained in a prior period (called a measurement period). The specific duration of periods under the Look Back Measurement Method (when used) are addressed in policies/procedures in the Human Resource Department and can be changed on an annual basis as determined by the participating employer.

If you are an employee of a participating employer of the Yavapai Combined Trust as defined in this Plan and are:

1. regularly scheduled to work “full-time” as defined by your participating employer’s personnel policy; **or**
2. (while this Plan does not cover retirees, the following participants were accepted on the Plan at the inception of the Trust) a qualifying retiree of your participating employer if you were covered by your participating employer’s medical plan prior to November 1, 1992, and have elected to continue coverage with your participating employer prior to November 1, 1992. City of Prescott retirees will remain eligible under this Plan until they become eligible for Medicare. Employees retiring after November 1, 1992, are not eligible for coverage under this Plan; **or**
3. an elected member of governing bodies, while in office, as provided through the participating employer’s written policy; **then**

you are eligible for your own medical, dental and vision benefits coverage. Your coverage will become effective as of the first day of the month after you have been in a benefits-eligible position, for 30 days, but only if you complete and submit a written enrollment form. Enrollment forms are available from your Human Resource Department.

Hour(s) of Service: means, as determined by each participating employer of the Yavapai Combined Trust,

- (1) each hour for which an employee is paid, or entitled to payment, for the performance of duties for an employer; and
- (2) each hour for which an employee is paid, or entitled to payment by an employer on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

An hour of service does not include any hour of service performed as a bona fide volunteer, as part of a Federal Work-Study Program (or a substantially similar program of a State or political subdivision thereof) or (according to the final Shared Responsibility regulations) to the extent the compensation for services performed constitutes “income from sources without the United States”.

Your Dependents’ Eligibility: If you elect coverage for yourself, you are also eligible for medical, dental and vision coverage for your eligible dependents on the later of the day you become eligible for your own medical, dental and vision coverage; or the day you acquire an eligible dependent, either by marriage, birth, adoption or placement for adoption, but only if you have completed and submitted a written enrollment form within 31 days of the acquisition of a dependent or at open enrollment and if medical coverage is in effect for you on that day.

Your eligible dependents include your lawful spouse and your dependent child(ren). See the Definitions chapter of this document for definitions of “Dependent Child(ren)” and “Spouse.” Any person who does not qualify as a dependent child or spouse as those terms are defined by this Plan has no right to any coverage for Plan benefits or services under this Plan. Divorced spouses are not eligible for continued coverage as a dependent except as permitted under the COBRA provisions of this Plan.

EXTENSION OF ELIGIBILITY FOR SURVIVING SPOUSE AND SURVIVING DEPENDENT CHILD(REN)

The surviving lawful spouse and surviving dependent child(ren) of a deceased law enforcement officer who was employed with a participating employer of the Trust, are entitled to continue health coverage under the Plan after the death of the law enforcement officer, unless they no longer are eligible (see the section on “When Coverage Ends” for termination provisions). “Law enforcement officer” means (1) a peace officer who is certified by the Arizona peace officer standards and training board, (2) a firefighter, detention officer, corrections officer, probation officer or surveillance officer who is employed by the State of Arizona or a political subdivision of this State, or (3) a corrections officer or firefighter who works on behalf of State of Arizona or a political subdivision of this State through a contract with a private company.

To be eligible for this extended benefit, the law enforcement officer must have been killed in the line of duty or died from injuries suffered in the line of duty while employed with a participating employer of the Trust.

Premiums for this extended coverage will continue to the surviving lawful spouse and dependents at the same rate that applies to active employees (if single) or active employees and their families (if had family coverage).

Upon termination of extended coverage, the surviving lawful spouse and dependent(s) will have the opportunity to elect COBRA continuation of coverage.

The participating employer of the Trust is responsible to collect and submit the appropriate premium in a timely manner to the Yavapai Combined Trust.

ELIGIBILITY RESTRICTIONS

You may not participate in this Plan as **both** an employee and as a dependent. In addition, a person may not participate in this Plan as a dependent of more than one employee. Also, you may not enroll your dependent(s) without also enrolling yourself, the employee. You and your eligible dependents must be enrolled in the same plan benefits, including the same medical, dental and vision plan option.

ENROLLMENT AND START OF COVERAGE

There are three opportunities to enroll for coverage under this Plan: Initial Enrollment, Special Enrollment, and Open Enrollment. These opportunities are described further in this chapter.

Procedure to Request Enrollment:

Generally, an individual must call or walk into the Human Resource Department and indicate their desire to enroll in the Plan. (The address and phone number for the Human Resource Department is listed on the Quick Reference Chart in the front of this document.) Note that the Open Enrollment procedure can differ from this process and if so, the procedure on how to enroll at this time will be announced by the Plan at the beginning of the Open Enrollment period.

Once enrollment is requested, you will be provided with the **steps to enroll** that include all of the following:

- a. submit a completed written enrollment form (which may be obtained from and submitted to the Human Resource Department), and
- b. provide proof of Dependent status (as requested), and
- c. pay of any required contributions for coverage, and
- d. perform steps a through c above in a timely manner according to the timeframes noted under the Initial, Special, and Open enrollment provisions of this Plan.

Proper enrollment is required for coverage under this Plan.

Enrollment Is Required for Coverage: You and/or your eligible dependents may become covered under this Plan only upon completion of written enrollment for coverage on a form provided by the Plan. A person who is not duly enrolled, by completing such a form and submitting it to your Human Resource Department, has no right to any coverage for Plan benefits or services under this Plan.

PROOF OF DEPENDENT STATUS

Specific documentation to substantiate Dependent status may be required by the Plan and include a birth certificate, marriage license, proof of dependent's age, dependent's social security number and any of the following:

- **Marriage:** copy of the certified marriage certificate.
- **Birth:** copy of the certified birth certificate.
- **Stepchild:** copy of the certified birth certificate plus marriage certificate.
- **Adoption or placement for adoption:** court order paper signed by the judge.
- **Foster Child:** a copy of the foster child placement papers from a qualified state placement agency, or proof of judgment decree or court order of a court of competent jurisdiction, and proof of any state provided health coverage.
- **Legal Guardianship:** a copy of your court-appointed legal guardianship documents and a copy of the certified birth certificate.
- **Disabled Dependent Child:** Current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically disabled (as that term disabled is defined in this document) and is incapable of self-sustaining employment as a result of that disability; and the child's disability occurred prior to their 26th birthday for the medical Plan or 23rd birthday for the dental and vision plan, and dependent relies chiefly on you and/or your Spouse for support and maintenance. The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child.
- **Qualified Medical Child Support Order (QMCSO):** Valid QMCSO document or National Medical Support Notice.

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your Eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: <http://www.socialsecurity.gov/online/ss-5.pdf>. Applying for a social security number is FREE.

Failure to provide the SSN or failure to complete the CMS model form (form is available from the Claims Administrator or <http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedHICNSSF081809.pdf>) means that claims for eligible individuals may not be considered a payable claim for the affected individuals.

DECLINING MEDICAL COVERAGE

You may decline benefits coverage under this Plan for yourself, your Spouse or Dependent Child(ren). To do so, you must complete the declination portion of the enrollment form available from your Human Resource Department.

Note that if you do not enroll for coverage at the Initial Enrollment opportunity and do not qualify for the Special Enrollment provisions of this Plan you will have to wait until Open Enrollment to initiate enrollment in this Plan.

INITIAL ENROLLMENT

Initial Enrollment for Yourself and Your Eligible Dependents: You must enroll within 31 days after the date on which you become eligible for coverage. If you want dependent coverage, you must enroll your eligible dependents at the same time. See the section earlier in this chapter on the Procedure to request Enrollment.

When Coverage Begins Following Initial Enrollment: Your coverage begins on the first day of the month following 30 days of employment. Coverage of your enrolled spouse and/or dependent child(ren) begins on the date your coverage begins.

Failure to Enroll During Initial Enrollment: If you do not enroll yourself, or if you do not enroll any of your Eligible Dependents during the Initial Enrollment period, unless you and/or they qualify for Special Enrollment described in this chapter, you will have to follow the Open Enrollment procedure described in this chapter.

SPECIAL ENROLLMENT (for Yourself and Your Eligible Dependents)

A. Newly Acquired Spouse and/or Dependent Child(ren) (as these terms are defined under this Plan)

- If **you are enrolled** for individual coverage and if you acquire a spouse by marriage, or if you acquire any dependent children by birth, adoption or placement for adoption or marriage, you may request enrollment for your newly acquired spouse and/or any dependent child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption.
- If **you are not enrolled** for individual coverage and if you acquire a spouse by marriage, or if you acquire any dependent children by birth, adoption or placement for adoption or marriage, you may request enrollment for yourself and your newly acquired spouse and/or any dependent child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption.
- If **you did not enroll your spouse for coverage** within 31 days of the date on which he or she became eligible for coverage, and if you subsequently acquire a dependent child by birth, adoption or placement for adoption or marriage, you may request enrollment for your spouse together with your newly acquired dependent child within 31 days after the date of your newly acquired dependent child's birth or placement for adoption.

To request Special Enrollment follow the procedure described under Enrollment Procedure in this chapter. To obtain more information about Special Enrollment, contact your Human Resources Department.

B. Loss of Other Coverage:

If you did not request enrollment for yourself, your spouse and/or any dependent child(ren) for coverage within 31 days of the date on which coverage under the Plan was previously offered because you or they had health care coverage under any other health insurance policy or program or employer plan including COBRA continuation coverage, individual insurance, Medicare, or other public program; **and** you, your spouse and/or any dependent child(ren) cease to be covered by that other health insurance policy or plan, **then** you may request enrollment for yourself and/or that spouse and/or dependent child(ren) within 31 days after the termination of their coverage under that other health insurance policy or plan, either as a result of:

- of loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause); or
- of termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
- the health insurance was provided under COBRA Continuation Coverage, and the COBRA coverage was **"exhausted"**; or
- of moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
- of the other plan ceases to offer coverage to a group of similarly situated individuals; or
- of the loss of dependent status under the other plan's terms; or
- of the termination of a benefit package option under the other plan, unless substitute coverage offered; or
- of the loss of eligibility due to reaching the lifetime benefit maximum on all benefits under the other plan. For Special Enrollment that arises from reaching a lifetime benefit maximum on all benefits, an individual will be allowed to request Special Enrollment in this Plan within 31 days after a claim is denied due to the operation of a lifetime limit on all benefits.

Proof of the loss of other coverage must be provided to your Human Resources Department.

COBRA Continuation Coverage is “**exhausted**” if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
- when the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
- when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
- because the 18-month, 29-month or 36-month period of COBRA Continuation Coverage has expired.

C. Medicaid or a State Children’s Health Insurance Program (CHIP)

You and your dependents may also enroll in this Plan if you (or your eligible dependents):

- a. have coverage through **Medicaid or a State Children’s Health Insurance Program (CHIP)** and you (or your dependents) **lose eligibility for that coverage**. However, you must request enrollment in this Plan within **60 days** after the Medicaid or CHIP coverage ends; or
- b. become **eligible for a premium assistance program through Medicaid or CHIP**. However, you must request enrollment in this Plan within **60 days** after you (or your dependents) are determined to be eligible for such premium assistance.

When Coverage Begins Following Special Enrollment:

Except with respect to coverage of a newborn or newly adopted dependent child your coverage, your spouse’s coverage, and/or the coverage of your dependent child(ren) will become effective on the first day of the month following the date the Plan receives the request for Special Enrollment.

- **With respect to coverage of a newborn, newly adopted dependent child**, the dependent’s coverage will become effective as of the date of birth, adoption or placement for adoption if you properly enroll the child and follow the enrollment procedures described earlier in this chapter.
- **With respect to a new spouse due to marriage**, the spouse’s coverage will become effective on the first day of the month following the date the Plan receives the request for Special Enrollment, if you properly enroll the spouse and follow the enrollment procedures described earlier in this chapter.
- If the individual requests Special Enrollment **within 60 days** of the date of the Special Enrollment opportunity related to **Medicaid or a State Children’s Health Insurance Program (CHIP)**, generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity.

Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options (when such options exist) at the same costs and the same enrollment requirements, as are available to similarly-situated employees at Initial Enrollment.

When Coverage Begins Following a Special Enrollment Event <u>ONLY When</u> You Promptly Request Enrollment		
The chart outlines when coverage begins and premiums will be due once coverage is requested.		
Event	Coverage Begins	First Premium Due Date
Birth or Adoption and want to add new child to this Plan.	On the day of the event. <ul style="list-style-type: none"> • <i>Example:</i> birth on 3/16 then coverage begins on 3/16. 	Premium due for entire month in which event occurs. <ul style="list-style-type: none"> • <i>Example:</i> birth on 3/16 then premium due for entire month of March.

When Coverage Begins Following a Special Enrollment Event <u>ONLY When</u> You Promptly Request Enrollment		
The chart outlines when coverage begins and premiums will be due once coverage is requested.		
Event	Coverage Begins	First Premium Due Date
Marriage and want to add new spouse to this Plan.	The first day of the month following the date of marriage. <ul style="list-style-type: none"> <i>Example:</i> married on 3/16 and promptly request to add spouse, coverage begins on 4/1. 	Premium due for the month in which coverage begins. <ul style="list-style-type: none"> <i>Example:</i> married on 3/16, premium due on 4/1 for the month of April.
Spouse or Dependent child lose other health coverage and want to enroll in this Plan.	The first day of the month following the date the other health coverage was lost. <ul style="list-style-type: none"> <i>Example:</i> Other health coverage ends on 3/31, this coverage begins on 4/1. Other coverage ends 3/15, this coverage begins on 4/1. 	Premium due for the month in which coverage begins. <ul style="list-style-type: none"> <i>Example:</i> Lose other coverage on 3/15 or 3/31, premium due on 4/1 for the month of April.
Qualified Medical Child Support Order (QMCSO) to enroll child in this Plan.	Date QMCSO form is received by HR Department	Premium due for entire month of coverage in which QMCSO is received by the HR Department.
Lost eligibility for Medicaid or a State Children's Health Insurance Program (CHIP) and wants to enroll in this Plan. These programs are commonly called AHCCCS in Arizona. There is a 60-day enrollment opportunity so, for example, if a person loses eligibility for Medicaid or CHIP on 3/31, they have until June 30 th to request enrollment in this Plan.	The first day of the month following the date the Medicaid or CHIP eligibility ended. <ul style="list-style-type: none"> <i>Example:</i> Medicaid/CHIP coverage ends on 3/31, this coverage begins on 4/1. Medicaid/CHIP coverage ends 3/15, this coverage begins on 4/1. 	Premium due for the month in which coverage begins. <ul style="list-style-type: none"> <i>Example:</i> Lose other coverage on 3/15 or 3/31, premium due on 4/1 for the month of April.

Failure to Enroll During Special Enrollment:

If you fail to request enrollment for any of your eligible dependents within 31 days (or as applicable 60 days) after the date on which they first become eligible for Special Enrollment, you will not be able to enroll them until the next Open Enrollment period.

OPEN ENROLLMENT

Open Enrollment Period: Open enrollment is the period of time each Plan year, as designated by your participating employer, when you may add or delete yourself or your dependents from coverage under this Plan.

Restrictions on Elections During Open Enrollment: No dependent may be covered unless you are covered.

When Coverage Begins or Changes Following Open Enrollment: If you or your spouse or dependent child(ren) are enrolled for the **first time** during an open enrollment period, that person's coverage will begin on the first day of the Plan year following the open enrollment period. For those individuals with changes made during open enrollment, those changes will become effective on the first day of the Plan year following the open enrollment period.

Failure to Make a New Election During Open Enrollment: If you have been enrolled for coverage and you fail to make a new election during the open enrollment period, you will be considered to have made an election to retain the same coverages you had during the preceding Plan year.

Failure to Enroll During Open Enrollment: If you are not enrolled and fail to enroll yourself and/or any of your eligible dependents during open enrollment, unless your eligible dependents qualify for the special enrollment as described in this chapter, you will not be able to enroll yourself and/or them until the next open enrollment period.

LATE ENROLLMENT

There is no Late Enrollment provision in this Plan. See the Special Enrollment or Open Enrollment provisions described in this chapter.

NEWBORN DEPENDENT CHILDREN

Your newborn dependent child(ren) **will be covered from the date of birth, provided you request enrollment of that newborn dependent child for coverage within 31 days of the child's date of birth; and follow the Plan's procedure for enrollment** described earlier in this chapter. Submitting a claim to the Plan for maternity care/delivery or for care of a newborn child **is not considered proper enrollment** of that child for coverage under this Plan. Remember that you may not enroll a newborn Dependent Child for coverage unless you, the employee, are also enrolled for coverage. See also the Special Enrollment provisions in this chapter.

ADOPTED DEPENDENT CHILDREN

Your adopted dependent child will be covered from the date that child is adopted or “placed for adoption” with you, whichever is earlier, provided you follow the enrollment procedure in this Plan. A child is “placed for adoption” with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

- **A Newborn Child who is Placed for Adoption** with you within 31 days after the child was born will be covered from the date the child was placed for adoption if you comply with the Plan's requirements for obtaining coverage for a Newborn Dependent Child, described above in this chapter.
- **A Dependent Child adopted more than 31 days after the child's date of birth** will be covered from the date that child is adopted or “Placed for Adoption” with you, whichever is earlier, if you follow the Plan's enrollment procedures outlined earlier in this chapter, within 31 days of the child's adoption or placement for adoption.
- If the adopted Dependent child is not properly enrolled in a timely manner, you must wait until the next Open Enrollment period or Special Enrollment period, if applicable. However, if a child is Placed for Adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child. Remember that you may not enroll an adopted Child or a Child Placed for Adoption for coverage unless you, the employee, are also enrolled for coverage. See also the Special Enrollment provisions and Enrollment Procedure in this chapter.

NEWLY MARRIED SPOUSES

Your newly married spouse may be added to the Plan by requesting enrollment within 31 days of the date of marriage according to the procedure to request enrollment outlined earlier in this chapter. Failure to enroll your newly married spouse within 31 days of the date of marriage means the spouse will have to wait until open enrollment to enroll.

WHEN YOU AND ANY OF YOUR DEPENDENTS BOTH WORK FOR A PARTICIPATING EMPLOYER OF THE TRUST (Special Rule For Enrollment)

- **No individual may be covered under this Plan both as an employee and as a dependent, nor may any dependent child be covered as the dependent of more than one employee.**

If both you and your spouse are eligible employees of a participating employer of the Trust, you may each make an election for coverage under the plan as an employee. This also means that the employee and the spouse can each enroll in a different plan option. However, only one employee may add dependent children to their coverage.

- If both employees select a different plan option then the deductibles and out-of-pocket limits will not be able to be combined to satisfy the family deductible/out-of-pocket limit.
- If both employees select the same plan option then the deductibles and out-of-pocket limits will be able to be combined to satisfy the family deductible/out-of-pocket limit.

- You may also decide that instead of each employee electing coverage as an employee, one of you will elect coverage as the employee and the other will be the dependent spouse. In this way all family members will be able to be covered under the same plan options and the deductibles and out-of-pocket limits will be able to be combined to satisfy the family deductible/out-of-pocket limit.

However, if the spouse who selected coverage as an employee terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, the benefits-eligible employee who was covered as the spouse will immediately be deemed to have employee coverage, and the employee who had employee coverage will immediately be deemed to be covered as a spouse, and all dependent children will retain their coverage, only if you complete an enrollment form within 31 days of this event.

Contributions for dependent coverage will be deducted from the pay of the employee-spouse who is now deemed to be the eligible employee. As a result, neither employee will sustain a loss of coverage because of termination of employment or reduction in hours. The employee-spouse who is then deemed to be the eligible employee will have the option to terminate the coverage of the spouse or any dependent child provided such election is, in the judgment of the Plan Administrator or its designee, consistent with the change in the family's circumstances as a result of the termination of employment or reduction in hours.

If, while your family coverage is in effect, your dependent child becomes an employee of a participating employer of the Trust and becomes eligible for coverage as an employee:

- that child will cease to be a dependent child, and may enroll for coverage as an employee. Coverage as a dependent child will terminate as of the date coverage as a benefits-eligible employee becomes effective.
- If the employee-child terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage and still qualifies as a dependent child, the employee-child will immediately be deemed to be covered as a dependent child of the employee-parent, but only if you complete an enrollment form within 31 days of this event. As a result, the employee-child will not sustain a loss of coverage because of termination of employment or reduction in hours. Contributions for dependent coverage will be deducted from the pay of the employee-parent, and will be adjusted as may be required when a dependent child becomes an employee and ceases to have coverage as a dependent child, or when the employee-child ceased to be an employee and resumes coverage as a dependent child.

TRANSFERRING FROM ONE PARTICIPATING EMPLOYER TO ANOTHER

When transferring from one participating employer to another, the individual must complete a new enrollment form within 31 days of this transfer so that coverage can continue without a break. Failure to complete a new enrollment form will cause the individual to be treated as a new employee subject to the initial enrollment provisions.

**QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)
(Special Rule For Enrollment)**

This Plan will provide benefits in accordance with a **National Medical Support Notice**. In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. According to Federal law, a Qualified Medical Child Support Order, or QMCSO, is a child support order of a court or state administrative agency that usually results from a divorce or legal separation, that has been received by the Plan, and that:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care Plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or it requires an employee who is not covered by the plan to provide coverage for a dependent child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any of the employee's dependent children, the Human Resource Department of the participating employer or its designee will determine if the court order is a QMCSO as defined by federal law, and that determination will be binding on the employee, the other parent, the child and any other party acting on behalf of the child. If an order is determined to be a QMCSO, and if the employee is covered by the Plan, the Human Resource Department of the participating employer or its designee will so notify the parents and each child (if the child is not living with the parents) and advise them of the Plan's procedures that must be followed to provide coverage of the dependent child(ren). This Plan will also provide benefits in accordance with a National Medical Support Notice.

If the employee is a participant in the Plan, the QMCSO may require the Plan to provide coverage for the employee's dependent child(ren) and to accept contributions for that coverage from a parent who is not a Plan participant. The Plan will accept a special enrollment of the dependent child(ren) specified by the QMCSO from either the employee or the custodial parent. Coverage of the dependent child(ren) will become effective as of the date the enrollment is received by the Plan, and will be subject to all terms and provisions of the Plan.

If the employee is not a participant in the Plan at the time the QMCSO is received and the QMCSO orders the employee to provide coverage for the dependent child(ren) of the employee, the Plan will accept a special enrollment of the employee and the dependent child(ren) specified by the QMCSO. Coverage of the employee and the dependent child(ren) will become effective as of the date the enrollment is received by the Plan and will be subject to all terms and provisions of the Plan.

No coverage will be provided for any dependent child under a QMCSO unless the applicable employee contributions for that dependent child's coverage are paid, and all of the Plan's requirements for coverage of that dependent child have been satisfied. Coverage of a dependent child under a QMCSO will terminate when coverage of the employee-parent terminates for any reason, including failure to pay any required contributions, subject to the dependent child's right to elect COBRA continuation coverage if that right applies.

For additional information regarding the procedures for payment of claims under QMCSOs, see the Claims Administration chapter of this document or your Human Resource Department. For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact your Human Resource Department.

PAYMENT FOR YOUR COVERAGE

Your participating employer pays all or part of the cost of Plan coverage for the employee. Depending on your participating employer, you may have to make contributions to pay all or part of the cost of coverage for your dependents. The amount that you and other employees pay for coverage is based on the cost of the Plan for all of the people that it covers. The specific amount you must pay for the coverage you have selected is announced during the open enrollment period or can be obtained from the Human Resource Department.

CHANGING YOUR COVERAGE DURING THE YEAR

Government regulations generally **require that your Plan coverages remain in effect throughout the Plan year** (from July 1 through June 30). However, you may be able to make some changes during the Plan year (mid-year) if the Plan Administrator or its designee determines that you have a qualifying change in your status affecting your benefit needs. The following qualifying changes are the only ones permitted under the Plan:

- 1. Change in legal marital status**, including marriage, divorce, legal separation, annulment or death of a Spouse;
- 2. Change in number of Dependents**, including birth, adoption, placement for adoption, or death of a Dependent Child;
- 3. Change in employment status or work schedule**, including the start or termination of employment by you, your Spouse or any Dependent Child, a strike or lockout, or the start of or return from an unpaid leave of absence. In addition, any change in the employment status of you, your Spouse, or your Dependent that results in that individual losing or gaining eligibility under this Plan will constitute a change in status affecting your benefit needs.
- 4. Change in Dependent status under the terms of this Plan**, including changes due to attainment of age, or any other reason provided under the definition of Dependent in the Definitions chapter of this document;
- 5. Change of residence or worksite** that impairs the ability of you, your Spouse or any Dependent Child to access the services of In-Network Health Care Providers;

6. **Change required under the terms of a Qualified Medical Child Support Order (QMCSO)**, including a change to add coverage for the child to provide the coverage specified in the order, or to cancel coverage for the child if the order requires your former spouse to provide coverage for the child;
7. **Change consistent with your right to Special Enrollment** as described in the paragraph dealing with Loss of Coverage in the Eligibility chapter under Special Enrollment;
8. **Cancellation of your coverage or coverage of your Spouse or any Dependent Child who becomes entitled to coverage under Medicaid or Medicare** (except for coverage solely under the program for distribution of pediatric vaccines).
9. **Change in cost.**
 - (a) **Automatic changes for cost.** If the cost of this Plan increases (or decreases) during a Plan Year, and under the terms of the Plan, you are required to make a corresponding change in your payments, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in your elective contributions for the plan.
 - (b) **Significant changes in cost.** If the cost of a benefit package option **significantly** increases during a Plan Year, you may either make a corresponding prospective increase in your payments, or revoke your elections and, in lieu thereof, receive, on a prospective basis, coverage under another benefit package option providing similar coverage.
10. **Significant changes in coverage.**
 - (a) **Significant curtailment.** If the coverage under the Plan is significantly curtailed or ceases during a Plan Year, you may revoke your elections under the Plan. In that case, you may make a new election on a prospective basis for coverage under another benefit package providing similar coverage. Coverage is “significantly curtailed” only if there is an overall reduction in coverage provided to participants under the Plan so as to constitute reduced coverage to participants generally.
 - (b) **Addition or elimination of benefit package option providing similar coverage.** If during a Plan Year the Plan adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option) you may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.
11. **Changes in Spouse’s, Former Spouse’s or Dependent’s coverage.** You may make a change in coverage if it is on account of and corresponds with a change made under a plan of your Spouse, Former Spouse or Dependent for one of the following reasons:
 - (a) If the change is permitted under federal cafeteria plan regulations; or
 - (b) If the Plan of the Spouse, Former Spouse, or Dependent’s employer permits participants to make an election for a period of coverage that is different from the Plan Year under this Plan.

These rules apply to making changes to your benefit coverages during the year:

1. Any change you make to your benefits must be determined by the Plan Administrator or its designee to be necessary, appropriate to and consistent with the change in status; and
2. You must notify the Plan in writing within 31 days of the qualifying change in status. Otherwise, the request will not be considered to be made on account of your change of status and you will have to wait until the next Open Enrollment period to make your changes in coverage; and
3. If you have a qualifying change in status you can change who is covered under the medical, dental and vision coverages, but cannot change the type of plan option you selected until the next Open Enrollment period. You are only allowed to make changes to your coverage that are consistent with the change of status event.

Generally only coverage for the individual who has lost eligibility as a result of a change of status (or who has gained eligibility elsewhere and actually enrolled for that coverage) can be dropped mid-year from this Plan;
and

4. Coverage changes associated with a mid-year qualifying change of status opportunity **must be prospective** and are effective the first day of the month following the qualifying change, provided you submit a written change form to your Human Resource Department in a timely manner, except for:
- Newborns, who are effective on the date of birth;
 - Children adopted or placed for adoption, who are effective on the date of adoption or placement for adoption.

<p align="center">A Brief Summary of the More Common Change of Status Events and the Mid-Year Enrollment Changes Allowed Under This Plan</p> <p align="center">Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code. This chart is only a summary of some of the permitted medical plan changes and is not all inclusive. This chart should NOT be referenced for a Health FSA or Dependent Care Assistance Plan (DCAP).</p>		
If you experience the following Event....	You may make the following change(s)* within 31 days of the Event...	But, you may NOT make these types of changes....
<p align="center"><i>Reminder: Failure to notify the Plan within 60 days of the date of a divorce or the date a child loses eligibility will cause the individuals losing coverage to forfeit the right to elect COBRA continuation coverage.</i></p>		
Family Events		
Marriage	<ul style="list-style-type: none"> • Enroll yourself, if applicable • Enroll your new spouse and other eligible dependents • Drop health coverage (to enroll in your spouse's plan) • Change health plans, when options are available 	<ul style="list-style-type: none"> • Drop health coverage and not enroll in spouse's plan; if you do, you won't receive coverage.
Divorce	<ul style="list-style-type: none"> • Remove your spouse from your health coverage • Enroll yourself (and your children) if you or they were previously enrolled in your spouse's plan 	<ul style="list-style-type: none"> • Change health plans • Drop health coverage for yourself or any other covered individual
Gain a child due to birth or adoption	<ul style="list-style-type: none"> • Enroll yourself, if applicable • Enroll the eligible child and any other eligible dependents • Change health plans, when options are available 	<ul style="list-style-type: none"> • Drop health coverage for yourself or any other covered individuals
Child requires coverage due to a QMCSO	<ul style="list-style-type: none"> • Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled) • Change health plans, when options are available, to accommodate the child named on the QMCSO 	<ul style="list-style-type: none"> • Make any other changes, except as required by the QMCSO
Loss of a child's eligibility (e.g., child reaches the maximum age for coverage)	<ul style="list-style-type: none"> • Remove the child from your health coverage • Child will be offered COBRA. You may pay for dependent child's COBRA coverage on a pre-tax basis. 	<ul style="list-style-type: none"> • Change health plans • Drop health coverage for yourself or any other covered individuals
Death of a dependent (spouse or child)	<ul style="list-style-type: none"> • Remove the dependent from your health coverage <input type="checkbox"/> • Change health plans, when options are available 	<ul style="list-style-type: none"> • Drop health coverage for yourself or any other covered individuals
Covered person has become entitled to Medicaid or Medicare	<ul style="list-style-type: none"> • Drop coverage for the person who became entitled to Medicare or Medicaid 	<ul style="list-style-type: none"> • Drop health coverage for yourself or any other covered individuals
Employment Status Events		
Spouse becomes eligible for health benefits in another group health plan	<ul style="list-style-type: none"> • Remove your spouse from your health coverage, with proof of Spouse's other new plan coverage • Remove your children from your health coverage, with proof of children's other new plan coverage • Drop coverage for yourself only with proof that spouse added you to the spouse's new group health plan 	<ul style="list-style-type: none"> • Change health plans • Add any eligible dependents to your health coverage
Spouse loses employment or otherwise becomes ineligible for health benefits in another plan	<ul style="list-style-type: none"> • Enroll your spouse and, if applicable, eligible children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse's plan • Change health plans, when options are available 	<ul style="list-style-type: none"> • Drop health coverage for yourself or any other covered dependents
You lose employment or otherwise become ineligible for health benefits	<ul style="list-style-type: none"> • Enroll in your spouse's plan, if available • Elect temporary COBRA coverage for the qualified beneficiaries (you and your covered dependents) 	
<p align="center"><i>* Proof of status change may be required to make a corresponding change in coverage/enrollment.</i></p>		

REHIRED EMPLOYEES

- If you cease to be a benefits-eligible Employee and then **within 30 days** return to work in a benefits-eligible position, you will be required to take the same benefit election for the remaining portion of the Plan Year as you had before you terminated. Participation will be effective the first of the month following return to work.
- If you cease to be a benefits-eligible Employee and return to work in a benefits-eligible position **more than 30 days** following the termination, you must follow your employer's determination as to if or when you will become eligible for benefits, in accordance with IRS regulations under the Affordable Care Act.

WHEN COVERAGE ENDS

Your coverage ends on the last day of the month in which:

- your employment with a participating employer of the Trust ends; or
- you no longer are eligible to participate in the Plan; or
- you cease to make any contributions required for your coverage; or
- the Plan is discontinued.

Coverage of your covered Dependent(s) ends on the earliest of the last day of the month in which:

- your own coverage ends; or
- your covered spouse or dependent child(ren) no longer meet the Plan's definition of Spouse or Dependent Child(ren); or
- you cease to make any contributions required for their coverage; or
- the Plan is discontinued.

Coverage of a Surviving Dependent Child(ren) ends on the earliest of the last day of the month in which:

- the Surviving Dependent Child(ren) are no longer eligible to participate in the Plan; or
- the Surviving Dependent Child(ren) no longer meet the definition of Dependent Child(ren) as provided in the Definitions chapter of this document); or
- contributions required for coverage cease; or
- the date the Plan is discontinued.

Coverage of a Surviving Lawful Spouse ends on the earliest of the last day of the month in which:

- the Surviving Spouse remarries, becomes Medicare eligible or dies; or
- contributions required for coverage cease; or
- the Plan is discontinued.

RESCISSION OF COVERAGE

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage except when contributions are not timely paid, or in cases of fraud or intentional misrepresentation of material fact when 30 days advance notice is provided.

REQUIRED NOTICE TO THE PLAN

You, your spouse, or any of your dependent children **must** notify the Plan **preferable within 31 days but no later than 60 days** after the date of:

- Spouse ceases to meet the Plan's definition of Spouse (such as in a divorce);
- a dependent child reaches the Plan's limiting age;
- a dependent child reaches the Plan's limiting age and is disabled with a physical or mental disability or no longer disabled.

Failure to give this Plan a timely notice will cause your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage or will cause the coverage of a Dependent Child to end when it otherwise might continue because of a physical or mental disability.

See the Other Information chapter of this document for information regarding other notices you must furnish to the Plan. See also the chapter on COBRA.

SPECIAL CIRCUMSTANCES: LEAVE OF ABSENCE

Family and/or Medical Leave

In general, to be eligible for FMLA, an employee must have worked for their employer for at least 12 months, met the 1,250 hours of service requirement in the 12 months prior to the leave, and worked at a location where the employer employed at least 50 employees within 75 miles. If the employee is eligible for FMLA the employee is entitled by law to up to 12 weeks each year (in some cases, up to 26 weeks) of unpaid family or medical leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care of a Spouse, child or parent who is seriously ill, or for the employee's own serious illness.

For the calculation of the 12-month period used to determine employee eligibility for FMLA, this Plan uses a rolling 12-month period measured backward in time from the date the employee uses any FMLA leave.

The participating employer will continue plan contributions for the employee on the same basis as prior to the beginning of the leave. The employee will be responsible for making required monthly dependent contributions. Since you will not be paid while you are on a Family or Medical Leave, you must make arrangements with your participating employer to pay any required contributions while you are on a leave.

Any changes in the Plan's terms, rules or practices that went into effect while you were away on leave will apply to you and your Dependents in the same way they apply to all other employees and their Dependents. Contact your Human Resources Department for additional information on the Family and Medical Leave policies.

Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA? USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An employee's coverage under this Plan will terminate when the employee enters active duty in the uniformed services.

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for **up to 24 months** measured from the first date of the month following the month in which the employee stopped working.
- If the employee goes into active military service for **up to 31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.

Duty to Notify the Plan: The Plan will offer the employee USERRA continuation coverage only after the Plan Administrator has been notified by the employee in writing that they have been called to active duty in the uniformed services. The employee must notify the Plan Administrator (contact information is on the Quick Reference Chart in the front of this document) as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage: Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the

employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage.

Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected. Contact your Claims Administrator to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Paying for USERRA Coverage:

- If the employee goes into active military service for up to **31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.
- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the first date of the month following the month in which the employee stopped working.
- USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA chapter for more details.

In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces:

When the employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The employee must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated. Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to your Human Resources Department.

Employer-Approved Leave of Absence

Upon approval by the employer and in accordance with the employer's leave policies for its employees, an employee may be granted a leave of absence that is not on account of FMLA or USERRA. In these situations, the employer is to determine if benefits are to be continued for the employee during the Approved Leave of Absence. If not, COBRA Continuation Coverage will be offered. If so, the employer must make arrangements to collect and submit the appropriate premium contributions for the employee and any covered dependents during the leave period, in order for coverage to continue during the approved leave of absence. For details of the approved leave including income, accumulation of vacation or sick time, continuation of applicable life insurance and/or disability benefits, refer to the employer's leave policies.

Reinstatement of Coverage After a Leave of Absence

If your coverage ends while you are on an approved leave of absence other than family, medical, or military leave, your coverage will be reinstated on the first day of the month following your return to active service if you return immediately after your leave of absence ends, subject to any accumulated maximum Plan benefits that were incurred prior to the leave of absence.

If your coverage ends while you are on an approved leave of absence other than family, medical or military leave, and is not reinstated within 62 days, the period of leave will be counted as a break in coverage as defined in this chapter. Questions regarding your entitlement to such a leave and to the continuation of coverage should be referred to your Human Resource Department. For College employees with questions as to whether medical benefits are continued during a sabbatical, contact the Human Resource Department of the College.

EXTENSION OF BENEFITS

There is no extension of benefits provision under this Plan. See the chapter describing COBRA for an explanation of when and how you may temporarily continue your coverage under this Plan.

ARTICLE 5: MEDICAL EXPENSE COVERAGE

ELIGIBLE MEDICAL EXPENSES

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called “eligible medical expense.” Eligible medical expenses are determined by the Plan Administrator or its designee, and are limited to those that are:

1. **“Medically Necessary,”** but only to the extent that the charges are **“Allowed Charges”** (as those terms are defined in the Definitions chapter of this document); and
2. **not services or supplies that are excluded** from coverage (as provided in the Exclusions chapter of this document); and
3. **not services or supplies in excess** of a Maximum Plan Benefit as shown in the Schedule of Medical Benefits; and
4. **for the diagnosis or treatment of an injury or illness** (except where wellness/preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this document).

The Plan will not reimburse you for any expenses that are not eligible medical expenses. That means you are responsible for paying the full cost of all expenses that are not determined to be Medically Necessary, determined to be in excess of the Allowed Charge, not covered by the Plan, in excess of a Maximum Plan Benefit or payable on account of a penalty because of failure to comply with the Plan’s Utilization Management requirements as described later in this document.

The Plan reserves the right to evaluate the credibility of expenses submitted by relatives of a plan participant.

You are covered for expenses you incur for most, but not all, medical services and supplies. Generally, **the Plan will not reimburse you for all Eligible Medical Expenses.** Usually, you will have to satisfy some Deductibles and pay some Coinsurance, or make some Copayments toward the amounts you incur that are Eligible Medical Expenses.

NON-ELIGIBLE MEDICAL EXPENSES

The Plan will not reimburse you for any expenses that are not Eligible Medical Expenses. That means you are responsible for paying the full cost of all expenses that are not Eligible Medical Expenses. Additionally, for the Premier Plan and HDHP, all charges above an Allowed Charge incurred at an Out-of-Network Provider are your sole responsibility.

MEDICAL PLAN OPTIONS

The Plan offers you three medical plan options: Premier Plan, Basic Plus Plan and the High Deductible Health Plan (HDHP) with Health Savings Account (HSA). You and your dependents may select any of these options at the time of Initial Enrollment. However, all members of the same family must be enrolled in the same medical plan option.

At Open Enrollment or if you have a change in status that affects your benefit needs, you and your covered dependents may change medical plan options. The cost of the monthly premium you will need to pay for the different Plan options is provided to you during Open Enrollment.

The medical plan options are described briefly below:

- **Premier Plan:** offers coverage for both in-network and out-of-network health care providers. This plan option offers you the highest level of benefits as compared to the Basic Plus Plan option. This Premier Plan also offers the lowest out of pocket cost with lower deductibles, lower out-of-pocket limits and significant coverage when using in-network providers. Under this Premier Plan option you have the choice to use out-of-network providers at a lower reimbursement level.
- **Basic Plus Plan:** offers coverage for major medical expenses when you use in-network providers only. There is no coverage provided for out-of-network providers, except for emergency care which is covered as an

in-network event when deemed a true emergency by the Plan. The Basic Plus Plan offers almost the same benefits as the Premier Plan but your reimbursement for expenses is less.

- **HDHP with HSA:** This is a high deductible health plan (HDHP) that is designed to be in compliance with government regulations so that this plan option can be paired with a Health Savings Account (HSA). Although the deductible is high, once you pay the deductible each plan year, the plan pays 100% of additional covered expenses you receive from an in-network provider. This HDHP option offers coverage for both in-network and out-of-network health care providers. With the HDHP, you can set aside money pre-tax into your health savings account to cover the deductible each year.

The HDHP plan option is considered to be a non-grandfathered plan in compliance with Health Reform so you will see that some of the preventive/wellness benefits of the HDHP plan option are enhanced as compared to the preventive/wellness benefits offered in the two grandfathered medical plan options, the Premier Plan and the Basic Plus Plan. For instance, some of the preventive/wellness benefit enhancements include that the HDHP is required to cover comprehensive screening services, prenatal services, BRCA genetic testing and certain over the counter (OTC) drugs at no cost when obtained from in-network providers. This information is explained in more detail in the Schedule of Medical Benefits.

PREFERRED PROVIDER ORGANIZATION (PPO)

Health Care Providers who have agreements with the Plan's Preferred Provider Organization (PPO), also called in-network providers, preferred providers or PPO providers, will provide health care services and supplies to plan participants for a favorable negotiated discount fee. The Preferred Provider Organization (PPO) is designed to maximize health care benefits and minimize out-of-pocket expenses.

The PPO is made up of a large but select number of preferred Physicians and other Health Care Providers who have agreed to reduce their charges on services provided to participants who use PPO providers, allowing benefits to remain high while costs remain affordable.

Show your ID card to the health care provider every time you use services so they know that you are enrolled under this Plan, where to send their bills, and which services require precertification.

You may obtain health care services from in-network or out-of-network health care providers; however your out-of-pocket costs will vary accordingly. Below is an overview of your costs when you use in-network and out-of-network providers:

- **“PPO Preferred” Providers (also called In-Network providers)** are providers (hospitals and Physicians) that have agreed to a special reduction in fees to PPO network subscribers. Use of a preferred provider will typically result in a greater reimbursement from the Plan toward allowed charges, after the deductible has been met.

A unique feature of the use of preferred providers is that for select, commonly visited Physicians there is no deductible applied and you may only have a copay per visit. See the Schedule of Medical Benefits under Physician and Other Health Care Practitioner Services for more detail.

Remember, since the fees to use a PPO Preferred Provider have been reduced in most cases, your coinsurance (when applicable) will be less!

IMPORTANT NOTE: Because providers are added to and dropped from the PPO network periodically throughout the year it is best if you ask your Health Care Provider IF they are still participating with the PPO or contact the network each time BEFORE you seek services.

- **Out-of-Network/Non-Network Providers (also called Non-PPO, Non-Participating, or Non-Preferred Providers:** are providers in Arizona or outside Arizona that have no special fee arrangements with the PPO organization.

Caution About the Use of Out-of-Network Providers:

- Use of Out-of-Network providers will result in higher costs to you and the Plan. Reimbursement by the medical plan options is a lower percentage of the Allowed Charge (as defined in the Definitions chapter in this Plan). **Plus under the Premier Plan there is no out-of-pocket limit on the use of out-of-network providers meaning there is no point at which the Plan begins to pay 100% of your eligible expenses.**
- **In addition, the Out-of-Network provider may bill you for the difference between actual charges and those considered allowable by this Plan (also called balance billing), except for emergency services performed in an emergency room under the HDHP.**
- If an individual resides in a location that has no preferred providers, the Plan will pay benefits under the Out-of-Network arrangement described above. See also the Schedule of Medical Benefits.

NOTE:

Basic Plus Plan benefits are payable only when you use the health care providers contracted with the Preferred PPO Provider network as described above, except for emergency care. **No coverage for care provided by an out-of-network provider and all costs are the responsibility of the member.**

DIRECTORIES OF IN-NETWORK PROVIDERS

A directory of in-network health care providers is available on the website (www.yctrust.net). There is no cost to you for access to the provider directory. See also the website of the Medical PPO Network (listed on the Quick Reference chart in the front of this document).

Physicians and health care providers who participate as in-network providers are added and deleted during the year. At any time, you can find out if any health care provider is in the network by asking the provider, calling your Human Resource Department, or visiting the YCT website (as listed on the Quick Reference Chart in the front of this document) and clicking on the word “Network.”

OVERVIEW OF AMOUNTS NOT PAYABLE BY THE PLAN

Generally, the Plan will not reimburse you for all Eligible Medical Expenses. Usually you will have to satisfy some deductibles and pay some coinsurance, or make some copayments toward the amounts you incur that are eligible medical expenses. However, once you have incurred a maximum out-of-pocket cost (applicable to in-network services only), no further coinsurance will be applied.

In addition, there are certain maximum Plan benefits applicable to each Plan participant with respect to certain eligible medical expenses. The following sections describe these features in detail and set forth the applicable amounts for each of them. See also the Schedule of Medical Benefits for information specific to each medical plan option.

Generally, if you receive services or supplies from in-network health care providers, your out-of-pocket costs will be lower. Also, if you do not follow the Utilization Management Program, you may incur substantially greater out-of-pocket costs. See the Utilization Management Program chapter for details. Finally, certain medical expenses are not covered by the Plan at all. See the chapters titled Medical Exclusions and Dental Exclusions for details about excluded expenses.

OUT-OF-NETWORK/NON-PPO BENEFIT PAYMENT

Premier Plan:

Out-of-Network benefits are generally payable at 60% of the Allowed Charge amount. Excess charges over the amount that is allowed will NOT apply toward the deductible. These excess charges will be the responsibility of the covered individual.

Under the Premier Plan there is no out-of-pocket limit on care/services obtained from out-of-network providers.

Basic Plus Plan:

No coverage for care/services obtained from an out-of-network provider.

High Deductible Health Plan (HDHP) Plan:

Out-of-Network benefits are generally payable at 50% of the Allowed Charge amount. Excess charges over the amount that is allowed will NOT apply toward the deductible. These excess charges will be the responsibility of the covered individual.

SPECIAL REIMBURSEMENT PROVISION

The following chart explains the Plan's special reimbursement for services when certain Out-of-Network providers are used. The Plan Administrator or its designee determines if and when the following special reimbursement circumstance applies to a claim. Medical records may be requested in order to assist with a determination on the need for a special reimbursement provision. Allowed charge is defined in the Definitions chapter of this document.

<p style="text-align: center;">SPECIAL REIMBURSEMENT PROVISION</p> <p style="text-align: center;">This chart explains the Plan's special reimbursement provision if the services of certain Out-of-Network Providers are used. The Plan Administrator or its designee determines if/when the following reimbursement applies to a claim.</p>	<p style="text-align: center;">WHAT THE PLAN PAYS (toward eligible claims submitted by an Out-of-Network provider)</p>
<ul style="list-style-type: none"> a) The HDHP does not have an in-network provider qualified or available to provide the preventive services required by Health Reform so the participant must use the services of an out-of-network provider and claims will be reimbursed without any participant cost-sharing, in the same manner as if an in-network provider had been used. b) Child over 19 resides temporarily outside the service area while attending college. c) Child resides outside the service area under a QMCSO. d) If the individual resides outside the State of Arizona. e) The individual had care for a medical emergency (as emergency is defined in this Plan) at a provider outside the In-Network service area for either the Premier or Basic Plus Plan, or for the HDHP at an Out-of-Network Provider. f) The individual was treated/confined in an In-Network facility but an Out-of-Network provider (outside the patient's control) performed certain Medically Necessary covered services such as emergency room visit, pathology, laboratory, radiology, anesthesia, or assistant surgeon services. g) There is no In-Network provider qualified by area of professional specialty or practice available to provide Medically Necessary eligible health care services. h) The individual was treated by an Out-of-Network facility/professional because of the lack of availability of an In-Network facility/professional. i) Ancillary services (such as lab or x-rays) received from an Out-of-Network provider in connection with a visit to an In-Network provider, if the choice of the Out-of-Network provider who performed ancillary services was outside the patient's control. For example, the In-Network provider accidentally sends the patient's lab work to an Out-of-Network lab for processing. 	<p style="text-align: center;">As if the care was provided In-Network including deductible, coinsurance, copays and Out-of-Pocket Limit and the allowance for bills will be reimbursed according to the billed charge for Out-of-Network providers minus your usual in-network cost-sharing.</p> <p style="text-align: center;">The Plan reserves the right to have the billed amount of a claim negotiated for a discount and/or reviewed by an independent medical review firm/provider to assist in determining if the charges are medically necessary and/or for a medical emergency.</p> <p style="text-align: center;">See the definition of Allowed Charge in the Definitions chapter of this Plan.</p>

<p style="text-align: center;">SPECIAL REIMBURSEMENT PROVISION</p> <p>This chart explains the Plan's special reimbursement provision if the services of certain Out-of-Network Providers are used. The Plan Administrator or its designee determines if/when the following reimbursement applies to a claim.</p>	<p style="text-align: center;">WHAT THE PLAN PAYS (toward eligible claims submitted by an Out-of-Network provider)</p>
<p>j) Use of an Out-of-Network provider when an In-Network provider was available to be used.</p>	<p>As if the care was provided Out-of-Network including deductible, coinsurance, copays and Out-of-Pocket Limit.</p> <p>The Plan reserves the right to have the billed amount of a claim negotiated for a discount and/or reviewed by an independent medical review firm/provider to assist in determining if the charges are medically necessary and/or for a medical emergency.</p>

DEDUCTIBLES

Individual and Family Deductibles: Each Plan year, you (and **not** the Plan) are responsible for paying all of your eligible medical expenses until you satisfy the deductible. Then, the Plan begins to pay benefits. There are two types of deductibles: Individual and Family.

- The **individual deductible** is the maximum amount one covered person has to pay before Plan Benefits begin. The Plan's individual deductible is outlined in the chart above.
- The **family deductible** is the maximum amount that a family of two or more is responsible for paying before Plan benefits begin. The Plan's family deductible is outlined in the chart above.

If both the husband and wife are covered employees, credit will be given toward the family deductible; however, when two covered individuals (who have each satisfied their Plan year deductible) get married, the satisfaction of these two deductibles may not be combined to meet the family deductible unless the individual deductible has been satisfied after the date of such marriage.

Additionally, **whenever a covered individual is hospitalized on the date the Plan year ends** all charges for the continued inpatient hospital and inpatient professional fees shall be considered in the plan year in which the patient was admitted. The new plan year deductible will not begin for that individual until the date he/she is discharged from the hospital.

SPECIAL NOTE:

For families enrolled in the HDHP with HSA option, IRS regulations require that the family (including any individual in the family) must meet the family deductible (e.g. \$5,000) before any reimbursement is made for eligible medical expenses (other than for preventive/wellness care).

Under the HDHP Plan option, both in-network and out-of-network covered provider services accumulate to meet the annual deductible. The HDHP option cannot pay ANY benefits (except certain preventive/wellness care outlined in the Wellness rows of the Schedule of Medical Benefits and prescriptions for preventive purposes such as for high blood pressure, high cholesterol, asthma) until your deductible has been met.

Under the Premier Plan and the Basic Plus plan options, Coinsurance and Copayments are not applied to meet the plan's medical plan deductible. **Under the HDHP plan,** coinsurance and copayments are applied to meet the plan's medical plan deductible. **Under the Premier Plan, the deductible for in-network providers does not accumulate to meet the deductible for out-of-network providers and vice versa.**

If you are required to pay a financial penalty because you or any of your covered dependents failed to comply with the Plan's Utilization Management Program, the excess amount you are required to pay will not count toward the plan year deductible.

Common Accident Deductible:

When two or more covered persons in your family are injured in the same accident, only one deductible must be met before the Plan will consider the accident-related benefits.

Expenses Not Subject to Deductibles:

Certain eligible medical expenses are not subject to deductibles. These expenses may be covered 100% by the Plan, or they may be subject to copayments (explained below). See the Schedule of Medical Benefits chapter to determine when eligible medical expenses are not subject to deductibles.

COINSURANCE

Once you've met your plan year deductible, the Plan generally pays a percentage of the eligible medical expenses, and you (and **not** the Plan) are responsible for paying the rest. The part you pay is called the coinsurance. If you use the services of a preferred health care provider who is a member of the Plan's PPO, your costs will be less.

Coinsurance When You Don't Comply with the Utilization Management Program:

If you fail to follow the Plan's Utilization Management Program, under certain circumstances you will have to pay a financial penalty equal to \$150. This provision is described in the Utilization Management chapter of this document.

COPAYMENT

A copayment (copay) is a set dollar amount you (and **not** the Plan) are responsible for paying when you incur an eligible medical expense. When copayments apply, there are generally no deductibles, unless the Plan specifically provides otherwise.

- Copayments apply to certain benefits as indicated on the Schedule of Medical Benefits.
- Copayments are not credited to satisfy a deductible or out-of-pocket limit under the Premier Plan or Basic Plus Plan.
- Under the Premier Plan or Basic Plus Plan, Copayments will continue to be your responsibility even after you reach your annual out-of-pocket limit.

OUT-OF-POCKET EXPENSES FOR THE PREMIER PLAN AND BASIC PLUS PLAN

Out-of-Pocket Limit Applies Only to Coinsurance:

Each plan year, after an individual or family incurs a maximum out-of-pocket cost for coinsurance (as noted in the Schedule of Medical Benefits for the Premier Plan and Basic Plus Plan), no further coinsurance will apply to covered eligible medical expenses. As a result, the Premier Plan and Basic Plus Plan will pay 100% of all covered eligible medical expenses that are incurred during the remainder of the plan year after the out-of-pocket limit has been reached. However, you will still be responsible for paying all of the expenses described below, when applicable.

Expenses Not Subject to the Out-of-Pocket Limit:

These are the expenses for medical services and supplies that you are **always** responsible for paying yourself. Under the Plan, each plan year, whether you use in-network or out-of-network services, you will be responsible for paying out of your own pocket, the following:

1. Your individual or family **deductible** and any **copayments**.
2. All expenses for **medical services or supplies that are not covered** by the Plan, such as Out-of-Network expenses under the Basic Plus Plan.
3. All **charges in excess of the Plan's allowed charge amount**.
4. All **charges in excess of a maximum Plan benefit**.

5. Any additional expenses applicable because you **failed to comply with the Utilization Management Program** set forth in the Utilization Management Program chapter of this document.
6. All expenses for medical services or supplies incurred with respect to **outpatient prescription drugs**.
7. **Wellness expenses in excess of \$300 per person per year**.
8. **Expenses from out-of-network providers if you are enrolled in the Premier Plan.** Under the Premier Plan, expenses for out-of-network providers do not accumulate to meet the out-of-pocket limit for in-network providers.
9. **Under the Basic Plus Plan** there is no out-of-pocket limit on out-of-network expenses because the Basic Plus Plan does not cover any services from an out-of-network provider except in an emergency. In this case the out-of-network claims for an emergency do accumulate to the in-network Out-of-Pocket limit.

OUT-OF-POCKET LIMIT FOR THE HDHP PLAN

The HDHP Plan with Health Savings Account has an Out-of-Pocket Limit which limits your annual cost-sharing related to Medical Plan deductibles, coinsurance, and copayments. The Out-of-Pocket Limit is the most you pay during a one year period (the plan year) before your health plan starts to pay 100% for covered essential health benefits. The amount of the Out-of-Pocket Limit for the HDHP is listed on the Schedule of Medical Benefits.

- The Out-of-Pocket Limit is accumulated on a plan year basis.
- Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan.
- The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount that is consistent with regulations published by the Department of Health and Human Services.
- Out-of-Pocket Limits are NOT interchangeable, meaning you may not use a portion of an In-Network Out-of-Pocket Limit to meet an Out-of-Network Out-of-Pocket Limit and vice versa, except that emergency services performed in an Out-of-Network Emergency Room will apply to meet the in-network Out-of-Pocket Limit.
- In accordance with law, the family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than \$5,000 per year when using in-network providers.

Expenses Not Subject to the Out-of-Pocket Limit:

The HDHP Plan's Out-of-Pocket Limit **does not include or accumulate:**

- a. **Premiums** for coverage,
- b. Expenses for **medical services or supplies that are not covered** by the Plan,
- c. **Charges in excess of the Allowed Charge** determined by the Plan which includes balance billed amounts for out-of-network providers,
- d. **Penalties** for non-compliance with Utilization Management programs,
- e. **Charges in excess of the Medical Plan's maximum benefits.**

MAXIMUM PLAN BENEFITS

Limited Overall Maximum Plan Benefit:

Plan benefits for certain medical expenses are subject to limited overall maximums for each covered individual. Once the Plan has paid the limited overall maximum Plan benefits for certain services or supplies on behalf of any covered individual, it will not pay any further Plan benefits for those services or supplies on account of that individual. Refer to the Schedule of Medical Benefits.

Plan Year Maximum Plan Benefit:

Plan benefits for certain medical expenses are subject to maximums per covered individual or family during each Plan year. Once the Plan has paid the Plan year maximum Plan benefits for any of the following services or supplies on behalf of any covered individual or family, it will not pay any further Plan benefits for those services or supplies on account of that individual or family for the balance of the Plan year. Refer to the Schedule of Medical Benefits for information on which benefits are subject to a plan year maximum.

INFORMATION ABOUT MEDICARE PART D PRESCRIPTION DRUG PLANS FOR PEOPLE WITH MEDICARE

If you and/or your Dependent(s) are enrolled in either Part A or B of Medicare, you are also eligible for Medicare Part D Prescription Drug benefits. It has been determined that the prescription drug coverage in the **Premier Plan, the Basic Plus Plan and the HDHP Plan is “creditable.”** “Creditable” means that the value of this Plan’s prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

- Because this Plan’s prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Prescription Drug Plan during Medicare’s annual enrollment period (October 15th through December 7th of each year).
- You can keep your current medical and prescription drug coverage with this **Premier Plan, Basic Plus Plan or HDHP Plan** and you do not have to enroll in Medicare Part D. If however you keep this **Premier Plan, Basic Plus Plan or HDHP Plan** coverage and also enroll in a Medicare Part D prescription drug plan you will have dual prescription drug coverage and this Plan will coordinate its drug payments with Medicare.

IMPORTANT NOTE: If you are enrolled in the High Deductible Health (HDHP) Plan with the Health Savings Account (HSA) **you and your employer may not continue to make contributions to your HSA** once you are enrolled in Medicare including being enrolled in a Medicare Part D drug plan. If you want to continue to make contributions to your HSA account, you will NOT want to enroll in a Medicare Part D plan.

- See the Coordination of Benefit chapter for more details on how the Plan coordinates with Medicare. If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.
- Note that you may not drop just the prescription drug coverage under this Plan. That is because prescription drug coverage is part of the entire medical plan. Generally you may only drop medical plan coverage at this Plan’s next Open Enrollment period.

For more information about creditable coverage or Medicare Part D coverage see the Plan’s Notice of Creditable Coverage (a copy is available your Human Resource Department at their number located on the Quick Reference Chart in the front of this document). See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

The High Deductible Health Plan (HDHP) listed in this document is intended to comply with Code §223(c)(2) to allow your employer (when applicable) and eligible employees to make contributions to a Health Savings Account (HSA). The High Deductible Health Plan has a specific design for the Deductible and Out-of-Pocket Limit and this design is adjusted annually as necessary to comply with IRS rules.

A Health Savings Account is an account owned by an employee. Money deposited into the health savings account can be used (tax-free) by the employee only for **qualified medical expenses**. To be reimbursed on a tax-free basis, qualified medical expenses must be incurred **after** the HSA has been established. Qualified medical expenses are those expenses that would generally qualify for the medical and dental expenses deduction for you, your Spouse and tax-qualified dependent children.

The IRS determines the types of eligible medical expenses that are permitted for tax-free withdrawals from the HSA and it is ultimately your responsibility to assure that you are complying with IRS rules. The account can also

be used to buy non-qualified medical expenses but then the employee is required to pay applicable taxes and a financial penalty to the IRS.

Note that the IRS code was not amended by PPACA Health Reform regulations to expand the definition of eligible dependents under Health Savings Accounts (HSA) to age 26. This means that employees may only be reimbursed from their tax-free HSA accounts for dependent children who meet the Internal Revenue Code definition of tax dependent (qualifying child or qualifying relative), which is a narrower definition than the applicable definition for federal Health Reform. Money withdrawn from the HSA account for dependent children who are not tax-qualified could cause the employee to be subject to income tax and a 20% penalty. The HSA participant is responsible for filing and payment of taxes on taxable amounts.

Under this HDHP Plan both you and your employer can contribute to the HSA account. However, your employer cannot begin to contribute to your HSA until you take the necessary steps to open a health savings account. Annually, your employer reserves the right to start, stop or adjust any contributions to a Health Savings Account. The amount of your employer's contribution, if any, will be in accordance with permissible government guidelines and is announced at the Open Enrollment period each year.

Each tax year the IRS announces the maximum amount of money that can be contributed to an individual's account (e.g. in 2016 the maximum is \$3,350/individual or \$6,750/family). Individuals age 55 and older can make additional "catch-up" contributions each year (for example, in 2016, the catch-up contributions cannot exceed \$1,000). Unused money in the health savings account can grow the account balance because it can be rolled over year after year. The HSA is portable, meaning that the account belongs to you even if you change employers or leave the workforce.

IMPORTANT:

In order to open a Health Savings Account (HSA) and have tax-free contributions made to that account, you must be "HSA Eligible." **IRS guidelines define an HSA Eligible individual as a person who:**

- **is covered under a HSA-qualified high deductible health plan (HDHP), and**
- **has "no other health coverage" (except what is permitted by the IRS), and**
- **is not enrolled in Medicare, and**
- **cannot be claimed as a dependent on someone else's tax return.**

"No other health coverage" means you cannot also be covered under your spouse's medical plan or any general purpose Health Flexible Spending Account (Health FSA) that reimburses medical expenses before the deductible is met under the HDHP, a Health Reimbursement Arrangement (HRA) or covered by another plan that pays medical benefits. You could be enrolled in a Dental Plan, Vision Plan, a "limited purpose" Health Flexible Spending Account (Health FSA) that reimburses only dental and vision expenses, or a Dependent Care Flexible Spending Account Plan, and also could have automobile, disability or long-term care insurance coverage.

Note that individuals who have a health savings account and are enrolled in Medicare can no longer contribute (or have employer contributions made) to the health savings account but can use the money they have accumulated in that account.

In order to open a Health Savings Account (HSA) and have tax-free contributions made to that account, you must be "HSA eligible."

Note about Use of an HSA Account for Dependent Child Expenses: To use funds in a health savings account to reimburse eligible medical expenses for a dependent child, the IRS requires that a HSA account holder must be able to "claim" the child as a dependent on their tax return. If the account holder cannot claim the child as a dependent, then HSA dollars cannot be used to pay for/reimburse services provided to that child. This means that you could cover your 24 year old child on the High Deductible Health Plan but not be able to use funds in your health savings account for that child if the child is not your tax-qualified dependent.

Information about Health Savings Account Contributions and Prorating the Maximum Yearly Contribution: If you aren't certain you'll be enrolled in a HDHP during the entire next tax year, you can contribute a prorated amount for the months you're actually eligible in the current tax year. To do this, divide the

yearly allowable maximum contribution by 12, then multiply the result by the number of months you're enrolled in a HDHP during that tax year.

Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your HDHP. If you are enrolled in the HDHP as of December 1, you are considered to be an eligible individual for HSA contributions for the entire tax year and you are not required to prorate your contributions to your health savings account. However, if you base an entire tax year's contribution on your status on December 1 and you cease to be an eligible individual before the end of the following year, any funding of the health savings account over the prorated amount (for December) is considered an excess health savings account contribution and the excess amount is subject to a penalty and income tax.

It is advisable to discuss with your tax advisor about joining a HDHP with HSA. Remember, **it is your responsibility to assure that you are an "HSA eligible" individual while contributions are made to your HSA account.**

Questions about the High Deductible Health Plan described in this document and Health Savings Accounts can be directed to the Claims Administrator whose contact information is listed on the Quick Reference Chart in the front of this document.

FOR THE HDHP PLAN OPTION: COVERAGE OF CERTAIN OVER-THE-COUNTER (OTC) DRUGS

For an over-the-counter drug to be covered by the HDHP, the drug must be:

1. obtained through the outpatient Prescription Drug Program at a participating network retail pharmacy and
2. presented to the pharmacist with a prescription for the OTC drug from your Physician or Health Care Practitioner.

(Note that while these OTC drugs require a prescription, certain types of insulin are payable by the Plan without a prescription).

The following chart outlines the OTC drugs that are payable by the HDHP Plan option, **at no charge when purchased at a network retail pharmacy location**, in accordance with Health Reform regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations. Where the information in this document conflicts with newly released Health Reform regulations affecting the coverage of OTC drugs, this Plan will comply with the new requirements on the date required.

OTC Drug Name	Who Is Covered for this Drug?	Your Cost-Sharing?	Payment Parameters for Generic OTC Drugs in the HDHP Plan when prescribed by your Physician or Health Care Practitioner:
Aspirin	For men 45-79 years of age to reduce chance of a heart attack, for women 55-79 years of age to reduce the chance of a stroke, or for pregnant women who are at high risk for pre-eclampsia.	None, if payment parameters are met	For non-pregnant adults, since dosage is not established by USPSTF, plan covers up to one bottle of generic 100 tablets every 3 months For pregnant women at high risk for preeclampsia: plan covers daily low dose aspirin (81mg) as preventive medication after 12 weeks gestation.
OTC Contraceptives for females, such as spermicidal products and sponges.	All females	None, if payment parameters are met	Up to a month's supply of prescription contraceptives per purchase (or 3 month supply of certain 90-day dosed contraceptives like Seasonale) are payable under the plan's Prescription Drug Program for females younger than 60 years of age. Generic FDA approved contraceptives are at no cost to the plan participant. Brand contraceptives are payable only if a generic alternative is medically inappropriate. The attending Health Care Practitioner determines medical necessity for FDA-approved female contraceptives.
Folic acid supplements containing 0.4 - 0.8mg of folic acid	All females planning or capable of pregnancy should take a daily folic acid supplement.	None, if payment parameters are met	Excludes women >55 years of age, and products containing > 0.8mg or < 0.4mg of folic acid. Plan covers generic folic acid up to one tablet per day.

OTC Drug Name	Who Is Covered for this Drug?	Your Cost-Sharing?	Payment Parameters for Generic OTC Drugs in the HDHP Plan when prescribed by your Physician or Health Care Practitioner:
Iron supplements	For children ages 6-12 months who are at increased risk for iron deficiency.	None, if payment parameters are met	OTC coverage excludes intravenous iron products and bulk iron products.
Vitamin D supplements	For adults age 65 and older who are at increased risk for falling.	None, if payment parameters are met	Since dosage is not established by USPSTF, plan covers up to one bottle of generic 100 tablets every 3 months
Tobacco cessation products	All individuals who use tobacco products.	None, if payment parameters are met	Prescription tobacco cessation drugs are payable under the plan's Prescription Drug Program, up to two 12-week courses of treatment per year, which applies to all products.
Fluoride supplements	For preschool children older than age 6 months when recommended by provider because primary water source is deficient in fluoride.	None, if payment parameters are met	Plan covers generic versions of systemic dietary fluoride supplements (tablets, drops or lozenges) available only by prescription for children to age 6 years. Excludes products for individuals age 6 and older, topical fluoride products like toothpaste or mouthwash and excludes brand name fluoride supplements.
Preparation "prep" Products for a Colon Cancer Screening Test	For individuals receiving a preventive colon cancer screening test	None, if payment parameters are met	Plan covers the over-the-counter or prescription strength products prescribed by a Physician or Health Care Practitioner as preparation for a payable preventive colon cancer screening test, such as a colonoscopy for individuals age 50-75 years.

NONDISCRIMINATION IN HEALTH CARE AS RELATES TO THE HDHP PLAN

In accordance with the Affordable Care Act (aka Health Reform), to the extent an item or service is a covered benefit under the HDHP, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the HDHP will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. The HDHP is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the plan. The HDHP is permitted to establish varying reimbursement rates based on quality or performance measures.

GRANDFATHERED HEALTH PLAN UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (THE AFFORDABLE CARE ACT)

This group health plan believes that **the Premier Plan and the Basic Plus Plan options** offered under the Yavapai Combined Trust (YCT) plan are considered to be "**grandfathered health plans**" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that 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 preventive 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 essential benefits.

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 your employer's Human Resources/Benefits Department (at the address listed on the Quick Reference Chart in the front of this document.)

ARTICLE 6: UTILIZATION MANAGEMENT PROGRAM

PURPOSE OF THE UTILIZATION MANAGEMENT PROGRAM

Your Plan is designed to provide you and your eligible family members with financial protection from significant health care expenses. The development of new medical technology and procedures and the ever-increasing cost of providing health care may make it difficult for the Trust to afford the cost of maintaining your Plan.

To enable your Plan to provide coverage in a cost-effective way, your Plan has adopted a Utilization Management Program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the Trust is better able to afford to maintain the Plan and all its benefits.

If you follow the procedures of the Plan's Utilization Management Program, you may avoid some out-of-pocket costs. However, if you don't follow these procedures, your Plan provides reduced benefits, and you'll be responsible for paying more out of your own pocket.

MANAGEMENT OF THE UTILIZATION MANAGEMENT PROGRAM

The Plan's Utilization Management Program is administered by an independent Utilization Management Company operating under a contract with the Plan (hereafter referred to as the UM Company). Their name and phone number are listed on the chart in the Quick Reference chapter of this document. The health care professionals in the UM Company focus their review on the necessity and appropriateness of hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical or surgical services.

In carrying out its responsibilities under the Plan, the UM Company has been given discretionary authority by the Plan Administrator to determine if a course of care or treatment is medically necessary with respect to the patient's condition and within the terms and provisions of this Plan.

VERY IMPORTANT INFORMATION ABOUT THE UTILIZATION MANAGEMENT PROGRAM

The fact that your Physician recommends surgery, hospitalization, confinement in a specialized health care facility, or that your Physician or other health care provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be an eligible expense or be considered medically necessary for determining coverage under the medical plans.

The Utilization Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The certification that a service is medically necessary doesn't mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.

All treatment decisions rest with you and your Physician (or other health care provider). You may elect to follow whatever course of treatment you and your Physician (or other health care provider) believe to be the most appropriate, even if the UM Company does not certify a proposed surgery, treatment, service or admission as medically necessary. However, the benefits payable by the Plan may be affected by the determination of the UM Company.

With respect to the administration of this Plan, the participating employer, the Plan and the UM Company are **not** engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the UM Company as medically necessary, or for the results if the patient chooses not to receive health care services that have not been certified by the UM Company as medically necessary.

Precertification of a service does not guarantee that the Plan will pay benefits for that service because, other factors, such as ineligibility for coverage on the actual date of service, the information submitted during precertification varies from the actual services performed on the date of service, and/or the service performed is not a covered benefit, may be a factor in non-payment of a service.

COMPONENTS OF THE UTILIZATION MANAGEMENT PROGRAM

The Plan's Utilization Management Program consists of:

1. **Precertification (Preservice) Review:** Review of proposed health care services **before** the services are provided;
2. **Concurrent (Continued Stay) Review:** Ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or specialized health care facility;
3. **Second and Third Opinions:** Consultations and/or examinations designed to take a second, and, when required, a third look at the need for certain elective health care services;
4. **Retrospective Review:** Review of health care services **after** they have been provided; and
5. **Case Management:** A process whereby the patient, the patient's family, Physician and/or other health care providers and the Trust work together under the guidance of the Plan's independent medical review companies to coordinate a quality, timely and cost-effective treatment plan. Case Management services may be particularly helpful for patients who require complex, high-technology medical services and who may therefore benefit from professional assistance to guide them through the maze of choices of health care services, providers and practices.

PRECERTIFICATION (PRESERVICE) REVIEW

Precertification Review is a procedure, administered by independent medical review companies to assure that the admission and length of stay in a hospital or specialized health care facility, surgery, and other health care services are medically necessary. The independent medical review company's medical staff use established medical standards to determine if recommended hospitalizations, confinements in specialized health care facilities, surgery and/or other health care services meet or exceed accepted standards of care. See the section titled Very Important Information About the Utilization Management Program.

What Services Must Be Precertified (Pre-approved)?

Services that must be approved **BEFORE** they are provided are noted below:

Call the Utilization Management (UM) Company to precertify the following services:

- Any procedure or treatment in excess of \$1,000.
- Any Durable Medical Equipment (DME) over \$1,000.
- All non-emergency hospital admissions, including an admission to an inpatient rehabilitation facility, skilled nursing facility and/or subacute facility. (Note: for pregnant women, precertification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery or 96 hours for a C-section);
- All non-emergency inpatient behavioral health (mental health and/or substance abuse) admissions, including partial hospitalizations.
- All admissions to a behavioral health residential treatment program.
- For HDHP plan participants who will participate in a clinical trial, precertification is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.

Prior notification does not mean benefits are payable in all cases. Coverage depends on the services that are actually provided, your eligibility status at the time service is provided, and any benefit limitations.

How to Request Precertification:

You or your Physician must call the UM Company at their telephone number shown on your insurance ID card and also on in the Quick Reference Chart in the front of this document. Whenever possible, calls for elective services should be made at least seven days before the expected date of service.

The caller should be prepared to provide all of the following information:

- the participating employer's name;
- the employee's name, address and phone number;
- the patient's name and Social Security number, address and phone number;
- the Physician's name, address and phone number;
- the name of any hospital, specialized health care facility or any other health care provider providing services;
- the reason for the health care services or supplies; and
- the proposed date for performing the services or providing the supplies.

If additional information is needed, the UM Company will advise the caller. The UM Company will review the information provided, will verify the request against the plan document and will let your Physician and the hospital, specialized health care facility, any other health care provider, and the Claims Administrator know whether or not the proposed health care services have been certified as medically necessary. The UM Company will usually respond to your treating Physician or other health care provider by telephone within three (3) working days (max 15 days) after it receives the request and any required medical records and/or information, and its determination will then be confirmed in writing. See also the chapter on Appealing a UM Decision.

CONCURRENT (CONTINUED STAY) REVIEW

When you are receiving medical services in a hospital or specialized health care facility, the UM Company may contact your Physician or other health care providers to assure that continuation of medical services is medically necessary; and help coordinate your medical care with the benefits available under the Plan. Concurrent Review may include such services as:

- coordinating home health care or the provision of durable medical equipment;
- assisting with discharge plans;
- determining the need for continued medical services; and/or
- advising your Physician or other health care providers of the various options and alternatives available under this Plan for your medical care.

See the section titled Very Important Information About the Utilization Management Program.

See also on Article 13 on Appealing a UM Decision under the Urgent Care, Concurrent or Preservice Review sections.

EMERGENCY HOSPITALIZATION

If an emergency requires hospitalization, there may be no time to contact the UM Company before you are admitted. If this happens, the UM Company must be notified of the hospital admission within 48 hours. Your Physician, a family member, friend, hospital admitting clerk, ER Physician, etc. can make that phone call. This will enable the UM Company to assist with discharge plans, determine the need for continued medical services, and/or advise your Physician or other health care providers of the various recommendations, options and alternatives for your medical care.

Note that if you are admitted to an Out-of-Network hospital for emergency services, and are not yet ready for discharge, the UM Company will work with your physician to have you transported into an In-Network hospital or other appropriate In-Network health care setting as soon as is possible.

PREGNANCIES

It is recommended that pregnant women notify the UM Company as soon as possible once they know they are pregnant.

SECOND AND THIRD OPINIONS

How the Second and Third Opinion Process Works: At any time during the review process, you may be asked by the UM Company to obtain a second opinion about a proposed health care service to help determine if the health care service is medically necessary, or if an alternative effective approach to the individual patient's health care management exists. A second opinion may be requested when it appears that:

- there may be a question regarding the effectiveness or reliability of a proposed service;

- the proposed service involves a high risk in relation to the anticipated benefit; or
- there appear to be conflicting diagnoses, vague indications, or possible inadequate clinical management.

If a second opinion is required, the UM Company will arrange for an examination by a Physician who:

- is certified by the American Board of Medical Specialists in the field related to the proposed service;
- is independent of the Physician who proposed the service; and
- will not be eligible to perform the service.

The second opinion Physician may review past medical records along with clinical findings from his or her own examination of the patient, and will report his or her findings to the UM Company.

If the second opinion recommendation differs from the treating Physician's recommendation, you may be required to obtain a third opinion from another Physician who will be selected in the same manner as the second opinion Physician. The results of the third opinion will be reviewed by the UM Company, and the recommendation of the majority of the Physicians (the attending Physician, and the second and third opinion Physicians) will prevail. If, as a result of the second and/or third opinion, it is determined that the procedure recommended by the treating Physician is not medically necessary, no benefits will be payable if you choose to undergo the procedure. See the section titled Very Important Information About the Utilization Management Program of this chapter.

Patient-Requested Second and Third Opinions: If the UM Company does not require a second opinion, but you or your covered dependent requests one, you or your covered dependent may get the second opinion as outlined in the Schedule of Medical Benefits chapter of this document. If the second opinion differs from the treating Physician's recommendation, you may request a third opinion in the manner described above.

See also on Article 13 on Appealing a UM Decision under the Urgent Care, Concurrent or Preservice Review sections.

Cost of the Second and Third Opinions: The Plan will pay the full cost for any second and third opinion required by the UM Company. Any second and third opinion not required by the Plan but requested by the patient will be reimbursed according to the Schedule of Medical Benefits. Fourth or more opinions are not covered by this Plan.

RETROSPECTIVE REVIEW

All claims for medical services or supplies that have not been reviewed under the Plan's Precertification Review, Concurrent (Continued Stay) Review, or Second and Third Opinion programs may be subject to Retrospective Review, at the option of the Claims Administrator, to determine if they are medically necessary. If the Claims Administrator determines that the services or supplies were not medically necessary, no benefits will be provided by the Plan for those services or supplies. After your claim has been processed, you may request a review of the claim decision.

For complete information on claim review, see the Claims Administration chapter of this document.

CASE MANAGEMENT

Case Management is a process, administered by the UM Company. Its medical professionals work with the patient, family, caregivers, health care providers, Claims Administrator and the Trust to coordinate a timely and cost-effective treatment program.

Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential health care providers. See the section titled Very Important Information About the Utilization Management Program in this chapter.

Working with the Case Manager: Any Plan participant, Physician or other health care provider can request Case Management services by calling the UM Company at the telephone number shown in the latest version of the Quick Reference Chart in this document. However, in most cases, the UM Company will be actively searching for those cases where the patient could benefit from Case Management services, and it will initiate Case Management services automatically.

The Case Manager of the UM Company will work directly with your Physician, hospital, and/or other specialized health care facility to review proposed treatment plans and to assist in coordinating services and obtaining discounts

from health care providers as needed. From time to time, the Case Manager may confer with your Physician or other health care providers, and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services.

You, your family, or your Physician may call the Case Manager at any time at the telephone number shown under Utilization Management Program in the Quick Reference Chart in this document to ask questions, make suggestions, or offer information.

FAILURE TO FOLLOW REQUIRED UTILIZATION MANAGEMENT PROCEDURES

If you don't follow the Precertification Review, Concurrent (Continued Stay) Review, or Case Management procedures, or if you fail to obtain a required Second or Third Opinion before incurring medical expenses, or if you undergo a medical procedure that has not been determined to be medically necessary under the Second or Third Opinion Program, the Claims Administrator will refer your claim for benefits to the UM Company for a retrospective review to determine if the services were medically necessary.

1. If the medical review company determines that the services were not medically necessary, no Plan benefits will be payable for those services.
2. If the medical review company determines that the services were medically necessary, Covered Expenses **will be reduced by \$150**. The difference between the amount you would be responsible for paying based on the benefits that would be payable if the precertification procedure had been followed and the actual benefits payable because the precertification procedure was not followed will not count toward the Plan's deductible or plan year out-of-pocket limit.

APPEALING A UM DECISION

Note that the kind of claim that is subject to this appeal procedure is a claim that involves the potential for future care or services as part of the Plan's utilization management process.

You may request an appeal of any adverse review decision made during the precertification (urgent review or preservice review), concurrent review, retrospective review, Case Management or second opinion review process described in this chapter.

To appeal a denied claim/bill, see Article 13 in this document.

ARTICLE 7: MEDICAL EXCLUSIONS

The following is a list of medical services and supplies or expenses **not covered** by any medical plan option. The exclusions applicable to the dental plan appear in the dental expense coverage chapter of this document. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the medical plan has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

GENERAL EXCLUSIONS

1. **Autopsy:** Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.
2. **Costs of Reports, Bills, etc.:** Expenses for preparing forms and medical reports/medical records, bills, disability/sick leave/claim forms and the like; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, e-mailing charges, prescription refill charges, disabled plates/automotive forms/interest charges, late fees, mileage costs, provider administration fees, concierge/retainer agreement/membership fees and/or photocopying fees.
3. **Educational Services:** Even if they are required because of an injury, illness or disability of a Covered Individual, the following expenses are not payable by the Plan: educational services, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aides, vision therapy, auditory or speech aids/synthesizers, auxiliary aids such as communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices. However, educational services related to lactation, smoking cessation, and/or diabetes nutrition are covered under the HDHP, check the Schedule of Medical Benefits for more information.
4. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan benefit limitation as described in the medical expense coverage chapter of this document, or are used to satisfy a deductible.
5. **Expenses Exceeding PPO Contract Fee Schedule or Allowed Charges:** Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the PPO contract fee schedule or Allowed Charge as defined in the Definitions chapter of this document.
6. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party. See the provisions relating to third party liability in the Coordination of Benefits chapter of this document for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
7. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the medical plan; or after the date the patient's coverage ends, except under those conditions described in the COBRA chapter.
8. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be experimental and/or investigational as defined in the Definitions chapter of this document.
9. **Illegal Act:** Expenses incurred by any covered individual for injuries resulting from or sustained as a result of commission or attempted commission of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which firearm, explosive or other weapon likely to cause physical harm or death is used by the covered individual; unless such injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor. The Plan Administrator's discretionary determination that this exclusion applies shall not be affected by any subsequent acquittal of the

covered individual of any criminal charges or by any other determination by a court regarding the nature of the act involved or the use by the covered individual of a firearm, explosive or other weapon.

10. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a covered individual.
11. **Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Physician or other health care provider, covered person or family member of a covered person, unless those expenses have been pre-approved by the Plan Administrator or its designee, except as defined in the Transplantation benefits in the Schedule of Medical Benefits.
12. **Physical Examinations or Tests for Employment, School, etc.:** Expenses for physical examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, or by any third party, except as may be performed in conjunction with the plan year wellness allowance as noted in the Schedule of Medical Benefits.
13. **Private Room in a Hospital or Specialized Health Care Facility:** The use of a private room in a Hospital or other specialized health care facility, unless its use is certified as medically necessary by the Plan Administrator or its designee.
14. **Services Covered by Workers' Compensation:** Expenses for the treatment of conditions covered by workers' compensation or occupational disease law.
15. **Services for Patient Convenience:** Expenses for patient convenience, including, but not limited to, care of family members while the covered individual is confined to a hospital or other specialized health care facility or to bed at home, guest meals, television, DVD/CD or similar device, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.
16. **Non-routine services and supplies associated with an approved clinical trial:** For the HDHP Plan, expenses for non-routine services and supplies associated with an approved clinical trial, such as: (1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis. For individuals who will participate in a clinical trial, precertification is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.
17. **Services Not Medically Necessary:** Services or supplies determined by the Plan Administrator or its designee not to be medically necessary as defined in the Definitions chapter of this document, except for wellness/preventive services as outlined in the Schedule of Medical Benefits.
18. **Services Not Prescribed by a Physician or Health Care Practitioner:** Expenses for services rendered or supplies provided that are not recommended or prescribed by a Physician or Health Care Practitioner, except for covered services provided by a behavioral health practitioner, naturopath, nurse practitioner, Physician assistant, nurse midwife, chiropractor or podiatrist.
19. **Services Performed by Certain Health Care Practitioners:**
 - **Medical Students or Interns:** Expenses for the services of a medical student or intern.
 - **Stand-By Physicians or Health Care Providers:** Expenses for any Physician or other health care provider who did not directly provide or supervise medical services to the patient, even if the Physician or health care provider was available to do so on a stand-by basis.
20. **Services Provided by Employer:** Expenses for services rendered through a medical/health department, clinic or similar facility provided or maintained by the Trust, or if benefits are otherwise provided under this Plan or any other plan that the Trust contributes to or otherwise sponsors, such as HMOs.
21. **Military service related Injury/Illness:** If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan.
22. **Services Provided Outside the United States:** Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical emergency or accidental injury, as defined in the Definitions chapter of this document.

23. **Services Provided Without Cost to Recipient:** Expenses for services rendered or supplies provided for which a covered person is not required to pay or which are obtained without cost; or there would be no charge if the person receiving the treatment were not covered under this Plan, such as immunizations provided by the State/County.
24. **Telephone Calls:** Any and all telephone calls between a Physician or other health care provider and any patient, other health care provider, Utilization Management Company, or any representative of the Plan (except the EAP Program) for any purpose whatsoever, including, without limitation:
 - Communication with any representative of the Plan or its Utilization Management Company for any purpose related to the care or treatment of a covered individual.
 - Consultation with any health care provider regarding medical management or care of a patient.
 - Coordinating medical management of a new or established patient.
 - Coordinating services of several different health professionals working on different aspects of a patient's care.
 - Discussing test results.
 - Initiating therapy or a plan of care that can be handled by telephone.
 - Providing advice to a new or established patient.
 - Providing counseling to anxious or distraught patients or family members.
25. **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.
26. **Any Other:** Any medical service, supply, drug or equipment not specifically noted as covered.
27. **Internet/Virtual Office Visit:** Expenses related to an online internet consultation with a Physician or other Health Care Practitioner, also called a virtual office visit/consultation, Physician-patient web service or Physician-patient e-mail service, including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online internet provider.
28. **Complications:** Expenses associated with complications of a non-covered service, except complications arising from an abortion performed for the covered Participant and/or Participant's spouse as explained in the Maternity row on the Schedule of Medical Benefits.
29. **Leaving a Hospital Contrary to Medical Advice:** Hospital or other Health Care Facility expenses if you leave the facility against the medical advice of the attending Physician within 72 hours after admission.
30. **Expenses for and related to Service animals,** including an animal that has been individually trained to do work or perform tasks for the benefit of an individual with a disability, such as seeing eye dogs, hearing/disability assistance dogs/birds/miniature horses and the like, seizure detection animals, diabetes/low blood sugar detection animals, service monkeys, etc. The Plan also excludes service animal supplies, transportation and veterinary expenses.
31. **For the HDHP Plan, expenses for non-routine services and supplies associated with a clinical trial,** such as: (1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis. For individuals who will participate in a clinical trial, precertification is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.
32. **Untimely Filed Claims:** Expenses for services or supplies that would otherwise be covered by the Plan will not be covered or payable by the Plan if a claim for payment of such services is not submitted to the Claims Administrator within 12 months from the date that the service is rendered or the supply provided.

Alternative Health Care Exclusions

1. Expenses for acupressure and massage therapy.
2. Expenses for chelation therapy, except as may be medically necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron, except as payable under the naturopathic services as described in the Schedule of Medical Benefits.

3. Expenses for prayer, religious healing, or spiritual healing including the services of a Christian Science practitioner.
4. Expenses for homeopathic services or supplies if enrolled in the Premier Plan or Basic Plus Plan. Expenses for homeopathic supplies if enrolled in the HDHP plan.

Behavioral Health Care Exclusions

1. Expenses for hypnosis, hypnotherapy and/or biofeedback.
2. Expenses for behavioral health care services related to the following, **except if such services are available through the EAP Program** (see the Quick Reference Chart for the phone number to the EAP program):
 - adoption counseling;
 - (Note that the medical plan does cover Physician visits for medication evaluation as well as medications to treat ADD or ADHD when prescribed by a Physician. Drugs are payable under the Drugs and Medicines benefit in the Schedule of Medical Benefits);
 - court-ordered behavioral health care services (unless the services are determined by the Plan Administrator or its designee, to be medically necessary in the absence of a court order and such services are a covered benefit under the Plan);
 - custody counseling;
 - family planning counseling; pregnancy counseling; marriage, couples, and/or sex counseling;
 - transsexual counseling; vocational disabilities.
3. Expenses for Applied Behavioral Analysis (ABA) Therapy (as defined in the Definitions chapter of this document) and related services.

Corrective Appliances and Durable Medical Equipment Exclusions

1. Expenses for replacement of lost, missing, or stolen corrective appliances, including orthotic devices and/or prosthetic appliances, or durable medical equipment.
2. Expenses for duplicate corrective appliances, including orthotic devices, and/or prosthetic appliances, or durable medical equipment, except for necessary external breast prostheses or mastectomy bras.
3. Expenses for services or supplies designed to personalize or characterize any corrective appliance, including orthotic devices, and/or prosthetic appliance, or durable medical equipment.
4. Expenses for corrective appliances and durable medical equipment to the extent they exceed the cost of standard models of such appliances or equipment.
5. Expenses for air or water filtering devices, equipment or supplies.
6. Transportation equipment such as motorized carts, except medically necessary wheelchairs.

Cosmetic Services Exclusions

1. Surgery or medical treatment to improve or preserve physical appearance, but not physical function, as distinguished from medically necessary surgery or treatment to correct defects resulting from trauma, illness or other diseases, or the consequences of treatment of trauma, illness or other diseases, or to correct a congenital disease or anomaly of a covered dependent child that causes a functional defect.
2. Cosmetic surgery or treatment includes, but is not limited to removal of tattoos, breast augmentation, or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. Breast reduction is only payable when determined by the Plan Administrator or its designee to be medically necessary.
3. However, the Medical Plan **does** cover medically necessary reconstructive surgery. See the Reconstructive Services benefit in the Schedule of Medical Benefits. Covered individuals should use the Plan's precertification procedure to determine if a proposed surgery will be considered cosmetic surgery or medically necessary.

Custodial Care Exclusions

1. Expenses for custodial care, as defined in the Definitions chapter of this document, whether provided in the home or in any facility whatsoever that is determined by the Plan Administrator or its designee to be primarily domiciliary or custodial, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, except when custodial care is provided as part of a covered hospice program.
2. Services required to be performed by Physicians, nurses or other Health Care Practitioners are **not** considered to be provided for custodial care services, and are covered if they are determined by the Plan Administrator or its designee to be medically necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician, nurse or other skilled health care provider are **not covered**, even if they are medically necessary.

Dental Services Excluded in the Medical Plan Benefits (See also the Dental Exclusions chapter)

1. Expenses for dental prosthetics or dental services or supplies of any kind, even if they are necessary because of symptoms, illness or injury affecting another part of the body. Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat:
 - teeth;
 - the gums and tissues around the teeth;
 - the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges);
 - the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint);
 - bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or
 - teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection.
2. Expenses for the surgical treatment of Temporomandibular Joint (TMJ) Syndrome/dysfunction.
3. Expenses for orthognathic and other craniomandibular or maxillary disorders, including but not limited to orthodontia and treatment of prognathism and retrognathism.
4. Expenses for oral surgery for removal of impacted teeth, removal of wisdom teeth, gingivectomies, treatment of dental abscesses, and root canal (endodontic) therapy. See also the Dental Expense Coverage chapter.
5. Expenses for dental services may be covered under the medical plan if they are incurred for the repair or replacement of accidental injury to the teeth or restoration of the jaw if damaged by an external object or extrinsic force in an accident. For the purposes of this coverage by the Plan, an accident does not include any injury caused by biting or chewing. See the Oral and Craniofacial Services benefit of the Schedule of Medical Benefits.
6. Expenses covered under the dental plan, and all expenses excluded under the dental plan (unless coverage is specifically provided under the medical plan such as accidental injury to teeth).

Drugs, Medicines and Nutrition Exclusions

1. Pharmaceuticals requiring a prescription that:
 - have not been approved by the U.S. Food and Drug Administration (FDA); or
 - are not approved by the FDA for the condition, dose, route or frequency for which they are prescribed; or
 - are experimental and/or investigational as defined in the Definitions chapter of this document.
2. Foods and nutritional/dietary supplements including, but not limited to, home meals, formulas, foods, diets, vitamins and minerals (whether they can be purchased over-the-counter or require a prescription), except when provided during Hospitalization, and except certain over-the-counter(OTC) medication and other services prescribed by a Physician or Health Care Practitioner to be covered without cost-sharing in accordance with Health Reform regulations, and except for prenatal vitamins or minerals or other prescription vitamins needed to treat a medical condition requiring a prescription.
3. Drugs, medicines or devices for:
 - Non-prescription (or non-legend or over-the-counter) drugs or medicines or devices except certain over-the-counter(OTC) medication prescribed by a Physician or Health Care Practitioner to be covered without cost-sharing in accordance with Health Reform regulations;
 - Homeopathic substances.
 - Hair growth and hair removal.

- Prescription drugs available over the counter at a lower strength.
 - Fertility and infertility.
 - Fluoride preparations for dental purposes, except certain over-the-counter(OTC) medication and fluoride dental varnish prescribed by a Physician or Health Care Practitioner, to be covered without cost-sharing in accordance with Health Reform regulations.
 - Growth hormone, unless precertified by the Prescription Drug Program.
 - Vitamin A derivatives for dermatologic use including but not limited to Retin A, Renova for patients over the age of 25.
 - Weight management drugs.
 - Anabolic steroids.
4. Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal or state law.
 5. Take-home drugs or medicines provided by a hospital, emergency room, ambulatory surgical center, or other health care facility.
 6. Vaccinations, immunizations, inoculations or preventive injections, needed due to foreign/international travel such as for yellow fever. Note that certain vaccinations/immunizations are payable when required for the treatment of an injury or because of the participant's exposure to disease/infection (such as anti-rabies, tetanus, anti-venom, or immunoglobulin) and those routine immunizations provided under the Wellness benefits for children and/or adults as described in the Schedule of Medical Benefits in this document.

Durable Medical Equipment (see Corrective Appliances & Durable Medical Equipment Exclusions in this chapter)

Family Planning (Fertility and Reproductive) Services Exclusions

1. Expenses for the treatment of infertility and complications thereof, including, but not limited to, services, drugs and procedures or devices to achieve fertility; in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, fetal implants, fetal reduction, and reversal of sterilization procedures.
2. Expenses for medical or surgical treatment of sexual dysfunction or inadequacy including, but not limited to, penile prosthetic implants, prescription drugs/medicines and any complications thereof.
3. Expenses for medical or surgical treatment related to transsexual (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.
4. Expenses related to non-prescription contraceptive drugs and devices for males, such as condoms.
5. Expenses for elective induced abortion (termination of pregnancy) unless the attending Physician certifies that the health of the woman would be endangered if the fetus were carried to term (including that the abortion is necessary to save the life of the woman or the abortion is necessary to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion). Medical complications arising from an abortion will be covered for the Participant and/or Participant's Spouse only, but not for Dependent Children.
6. Expenses for pregnancy for dependent children, except for females in the HDHP Plan where prenatal and postnatal visits performed by a Physician or Health Care Practitioner will be covered without cost-sharing from in-network providers in accordance with Health Reform regulations.
7. Expenses for and related to adoption.

Foot Care Exclusion

1. Expenses for foot care including, but not limited to, trimming toenails, removal of calluses, and preventative care, unless the Plan Administrator or its designee determines such care to be medically necessary.

Genetic Service Exclusion

1. **Genetic Testing:** The following expenses for genetic tests, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, except as listed as payable in the Genetic Testing row in the Schedule of Medical Benefits and as required under Health Reform, are not covered. Genetic services that are **not covered** include:
 - a. **Pre-parental genetic testing** (also called carrier testing) intended to determine if an individual (such as a prospective parent) is at risk of passing on a particular genetic mutation (at risk for producing affected children);
 - b. Expenses for **Pre-implantation Genetic Diagnosis (PGD)** where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal in connection with in vitro fertilization;
 - c. **Prenatal genetic testing** intended to determine if a developing fetus is a risk for inheriting identifiable genetic diseases or traits **except** certain genetic testing that is described in the Genetic Testing row of the Schedule of Medical Benefits;
 - d. **Genetic testing and non-covered individuals:** No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the treatment of a plan participant;
 - e. **Home genetic testing kits/services** are not covered.

See the Genetic Services row of the Schedule of Medical Benefits for a description of the genetic services that are covered by the Plan.

Plan Participants can contact the Medical Plan Claims Administrator or Utilization Management program for assistance in determining if a proposed Genetic Test will be covered or excluded.

2. **Genetic Counseling:** Expenses for genetic counseling are not covered, unless these conditions are met:
 - a. **For the Premier and Basic Plus Plans:** it is ordered by a Physician, performed by a qualified genetic counselor and performed in conjunction with a genetic test that is payable by this Plan.
 - b. **For the HDHP:** it is ordered by a Health Care Practitioner and performed in conjunction with a genetic test that is payable by this Plan.

Hair Replacement Procedures, Medications and Devices (Wigs) Exclusions

1. Expenses for hair removal or hair transplantation and other procedures to replace lost hair or to promote the growth of hair, for the use of Rogaine or other prescription drugs or medicines used to promote the growth of hair, or for hair replacement devices including, but not limited to, wigs, toupees and/or hairpieces, except that the Plan will provide benefits for a single wig or toupee (one per lifetime) if it is required to replace hair lost as a result of chemotherapy.

Home Health Care Exclusions

1. Expenses for any home health care services other than part-time, intermittent skilled nursing services and supplies.
2. Expenses under a home health care program for services that are provided by someone who ordinarily lives in the patient's home or is a parent, spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a Physician.
3. Expenses for a homemaker, custodial care, child care, adult care or personal care attendant, except as provided under the Plan's hospice coverage.

Nursing Care Exclusion

1. Expenses for services of private duty nurses except where the Plan Administrator or its designee determines that private duty nursing care is "medically necessary" as defined in the Definitions chapter of this document.

Rehabilitation Therapies (Inpatient or Outpatient) Exclusions

1. Expenses for educational, job training and/or vocational rehabilitation or massage therapy.
2. Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious; comatose; or in the judgment of the Plan Administrator or its designee, is otherwise incapable of participating in a purposeful manner with the therapy services including, but not limited to, coma stimulation programs and services.
3. Expenses for maintenance rehabilitation and habilitation services as defined in the Definitions chapter of this document.
4. Speech therapy is not considered medically necessary and is not a covered benefit for self-correcting dysfunctions causing dysfluency or articulation disorders such as stuttering, stammering, lisping and tongue thrusting.

Sleep Disorders

1. Expenses related to sleep disorders for the treatment of snoring alone without significant obstructive sleep apnea are excluded. The Plan covers medically necessary diagnosis and treatment of sleep apnea.

Transplantation (Organ and Tissue) Exclusions

1. Expenses for human organ and/or tissue transplants that are experimental and/or investigational as determined by the Plan Administrator and its designees.
2. Expenses for human organ and/or tissue transplants or implants including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplantation, post-operative services and drugs or medicines, and all complications thereof, except transplants that are payable as noted in the Schedule of Medical Benefits.
3. Expenses related to non-human (xenografted) organ and/or tissue transplants or implants, except heart valves.
4. Donor expenses incurred by a covered person who donates their organ or tissue to a non-covered person.

Vision Care Exclusions

1. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, radial keratotomy (RK), automated lamellar keratoplasty (ALK), or laser assisted in situ keratoplasty (LASIK).
2. Expenses for diagnosis and treatment of refractive errors, except one pair of eyeglasses or contact lenses provided as a prosthetic device following ocular surgery as described in the Corrective Appliances section of the Schedule of Medical Benefits.) See the Vision Plan for vision benefits.
3. Vision therapy and supplies, and orthoptics.
4. Sunglasses, safety goggles/glasses, photosensitive lenses (except as payable by the vision plan), anti-reflective lenses, drugs or medicine for the purpose of an eye exam or tonometry, or subnormal vision aids.
5. Replacement of lost, stolen or broken frames or lenses unless purchased within the timeframes outlined under the Vision Plan.

Weight Management and Physical Fitness Exclusions

1. Expenses for medical treatment of obesity, including, but not limited to weight loss programs; dietary instructions, except as required by Health Reform for the HDHP plan. See the Weight Control Services section of the Schedule of Medical Benefits. No coverage for post-weight loss skin reduction procedures/surgery.
2. Expenses for medical or surgical treatment of severe underweight, including, but not limited to, high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of an individual diagnosed with a mental health or substance abuse condition. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by Physicians to determine normal body weight.
3. Expenses for memberships in or visits to health clubs, exercise programs (including programs to strengthen muscles or improve athletic performance), gymnasiums, and/or any other facility for physical fitness programs.
4. Expenses for exercise equipment and supplies, exercise/activity/health monitoring/tracking devices, or software applications including smartwatches/jewelry and wireless, wearable sensors/trackers.

ARTICLE 8: VISION PLAN

The following **vision benefits apply to Yavapai College, the Town of Chino Valley and Yavapai County employees only**. These vision benefits do not apply to the **City of Prescott** employees. To verify if these benefits apply to employees of other participating employers of this Trust, contact your Human Resource Department.

Individuals are eligible for Vision Plan benefits described in this chapter only if the individual is properly enrolled in the Vision Plan.

Vision Plan benefits are treated as a stand alone (or excepted) benefit under HIPAA and the PPACA.

A separate election or opt out is required for vision benefits and vision plan premiums are adjusted for individuals that opt in or out of coverage.

Vision services can be obtained from any qualified vision provider (ophthalmologist, optometrist or dispensing optician).

While there is no special network of contracted vision providers, **if you receive vision services from a provider who is contracted with the medical plan's PPO network (such as from an optometrist, optician or ophthalmologist) this may save you money because these PPO network providers generally perform their services with a deeper discount as compared to out-of-network vision providers.**

For a current list of network vision providers contact the Medical Preferred Provider Network listed on the Quick Reference Chart in the front of this document.

Covered expenses, as noted under the Schedule of Vision Benefits section of this chapter, refer to the Allowed Charges as payable under this Vision Plan.

Bills from any vision provider should be submitted to the Claims Administrator according to the guidelines in the Claims Administration chapter of this document.

DEFINITION OF TERMS USED IN THIS VISION PLAN

- **A vision exam** includes a professional examination and an eye refraction including case history, exam for pathological abnormalities of the eyes and lids, ranges of clear single vision and balance and coordination of muscles for far-seeing and near-seeing and special working distances.
- **Dispensing optician** means a person qualified to manufacture and sell eyeglasses and/or contact lenses.
- **Optometrist** is a person licensed to practice optometry.
- **Ophthalmologist** is a Physician licensed to practice ophthalmology.

SCHEDULE OF VISION BENEFITS

The following vision services are payable by the plan to a maximum of \$300 per person per plan year.

Vision Exam:

Vision examinations are payable. Vision exam to include case history, visual acuity (clearness of vision), external exam and measurement, interior exam with ophthalmoscope, pupillary reflexes and eye movements, retinoscopy (shadow test), subjective refraction, coordination of movement far and near, tonometry (glaucoma test) medicating agents for diagnostic purposes and analysis of findings with recommendations and prescription, if required.

Eyeglass Frames and/or Lenses:

Frames and/or lenses are payable including:

- a. Single vision lenses.
- b. Bi-focal lenses.
- c. Tri-focal lenses.
- d. Lenticular lenses.
- e. Safety glasses.

A gradient tint equal to Tint #1 or #2 may be added to the lenses.

Protective lens coating payable.

Prescription sunglasses are allowed under this benefit.

Contacts:

Contacts are payable (including disposable lenses).

VISION PLAN EXCLUSIONS

The Vision Plan is designed to cover visual needs rather than cosmetic materials. When a covered person selects any of the following extras, the Vision Plan will pay the cost of the allowed vision service/supply and the covered person will pay the additional cost for the extras, such as:

1. Vision services and supplies that cost more than the Plan's allowance as noted in the Schedule of Vision Benefits.
2. Orthoptics or vision training and any associated supplemental testing.
3. Plano (non-prescription) lenses.
4. Medical or surgical treatment of the eyes, including, but not limited to, refractive keratoplasty (RK), automated keratoplasty (ALK) or laser assisted in situ keratoplasty (LASIK).
5. Services or materials provided as a result of any workers' compensation law, or similar legislation or obtained through or required by any government agency or program, whether federal, state or any subdivision thereof.
6. Services or supplies received for an illness that is a result of war, whether declared or undeclared.
7. Experimental and/or investigational treatment or procedure.
8. Any service or material provided by any other vision care plan or group benefit plan containing benefits for vision care.
9. Benefits incurred beyond the termination date of the Plan, unless COBRA coverage is in place.

For medically necessary eye surgery such as a cataract extraction, refer to the Medical Plan benefits.

ARTICLE 9: DENTAL EXPENSE COVERAGE

ELIGIBLE DENTAL EXPENSES

You are covered for expenses you incur for most, but not all, dental services and supplies provided by a dentist or dental hygienist, that are determined by the Plan Administrator or its designee to be medically necessary, **but only to the extent** that the Plan Administrator or its designee determines that the services are the most cost effective ones that meet acceptable standards of dental practice and would produce a satisfactory result; **and** the charges for them are considered Allowed Charges. See the Definitions chapter of this document for the definitions of “Medically Necessary” and “Allowed Charge.”

NOTE: When dental services are eligible to be paid under either the medical or the dental plan, the benefits will be payable under the plan design which is most financially beneficial to the covered person, but not under both plans.

Dental plan benefits are treated as a stand alone (or excepted) benefit under HIPAA and the PPACA.

A separate election or opt out is required for dental plan benefits and dental plan premiums are adjusted for individuals that opt in or out of coverage.

DENTAL PLAN OPTIONS

Under this Dental Plan there are two Dental Plan Options. Comprehensive Dental Plan and Preventative Dental Plan. These benefits are described further in the Schedule of Dental Benefits chapter.

- The **Comprehensive Dental Plan** covers Preventive, Basic, Major and Orthodontia services.
- The **Preventative Dental Plan** covers Preventive services only.

Note that under either of these two dental plan options you may choose any dentist.

You can only elect the Comprehensive Dental Plan option if you are a new employee electing dental coverage for the first time with this Plan or if you had dental coverage with the Trust’s Plan during the previous plan year.

EXPENSES THAT ARE NOT ELIGIBLE DENTAL EXPENSES

The Plan will not reimburse you for any expenses that are not eligible dental expenses. That means you must pay the full cost for all expenses that are not covered by the Plan, as well as any charges for eligible dental expenses that exceed the amount determined by the Plan to be an Allowed Charge.

DEDUCTIBLES

Under the Comprehensive Dental Plan, each Plan year, you are responsible for paying all your eligible dental expenses until you satisfy the Plan year deductible. Then, the Plan begins to pay benefits. There are two types of deductibles: individual and family.

- The individual deductible is the maximum amount one covered person has to pay before Plan benefits begin.
- The family deductible is the maximum amount that a family of three or more has to pay before Plan benefits begin.

The Plan’s individual and family deductibles are listed on the chart titled “Overview of the Dental Benefit Plan Design” in this chapter.

Expenses Not Subject to Deductibles (Preventive Services): Eligible dental expenses incurred for preventive services are not subject to deductibles.

Common Accident Deductible: When two or more covered persons in your family are injured in the same accident, only one deductible must be met before the Plan will consider benefits for expenses incurred as a result of the accident.

COINSURANCE

Under the Comprehensive Dental Plan, once you’ve met your plan year deductible, the Plan pays a percentage of the eligible dental expenses, and you are responsible for paying the rest. The part you pay is called the coinsurance.

OUT-OF-POCKET EXPENSES

These are the expenses for dental services and supplies that you pay yourself. Under this Plan, each plan year, you will be responsible for paying out of your pocket:

1. Your individual or family deductible.
2. Any applicable coinsurance, subject to the Annual Dental Maximum Plan Benefit or the Lifetime Maximum Orthodontia Plan Benefit.
3. All expenses for dental services or supplies that are not covered by the Plan.
4. All charges in excess of the Allowed Charge determined by the Plan Administrator or its designee.

(LIFETIME) ORTHODONTIA MAXIMUM PLAN BENEFITS (Comprehensive Plan Only)

The maximum Plan benefit payable for orthodontia services for individuals enrolled in the Comprehensive Dental Plan Option and any previous dental expense plan or program provided to that individual by your participating employer is \$1,500.

PLAN YEAR MAXIMUM DENTAL BENEFITS

The Plan year maximum benefits payable for dental services, except orthodontia services, for any covered individual is listed in the chart below titled “Overview of the Dental Benefit Plan Design.”

Overview of the Dental Benefit Plan Design		
Deductible	Annual Dental Maximum Plan Benefit	Lifetime Maximum Orthodontia Plan Benefit
What you must pay each Plan year if enrolled in the Comprehensive Dental Plan before the Plan pays dental benefits.	The most the Dental Plan Option will pay for all dental expenses (except orthodontia) for one person per Plan year.	The most the Comprehensive Dental Plan will pay for all covered orthodontia expenses for one person per lifetime.
Comprehensive Dental Plan: \$50/individual; \$150/family Preventative Plan: No deductible.	Comprehensive Dental Plan: \$1,500/individual per Plan year. Preventative Plan: \$250/individual per Plan year.	Comprehensive Dental Plan: \$1,500/individual for orthodontia Preventative Plan: Not applicable as no orthodontia benefit in the Preventative Plan.

GUIDELINES TO DENTAL PAYMENT

An eligible dental charge is considered under the following circumstances:

- at the time the impression is made for an appliance or modification of an appliance;
- at the time a tooth or teeth are prepared for a crown, bridge or gold restoration;
- at the time the pulp chamber is opened for root canal therapy; or
- for all other dental charges, at the time the dental service is rendered or the supply is furnished.

ARTICLE 10: SCHEDULE OF DENTAL BENEFITS

SCHEDULE OF DENTAL BENEFITS			
This chart shows what the Dental Plan pays according the Dental Plan Option you choose. See the Dental Exclusions and Definitions chapters of this document for important information on Dental Plan benefits.			
Benefit Description	Explanations and Limitations	Comprehensive Dental Plan	Preventative Dental Plan
Preventive Services <ul style="list-style-type: none"> • Oral examination. • Prophylaxis (cleaning of the teeth). • Bitewing x-rays. • Full-mouth x-rays. • Topical application of sodium or stannous fluoride. 	<ul style="list-style-type: none"> • <u>Preventive services are subject to the Annual Dental Maximum Plan Benefits.</u> • Oral examination payable twice a plan year. • Prophylaxis, scaling, cleaning and polishing payable twice a plan year. • Bitewing x-rays payable once in a period of 12 consecutive months. • Full-mouth x-rays payable once in a period of 24 consecutive months. • Fluoride treatment payable twice in a plan year. 	100%, no deductible	100%, no deductible
Basic Services <ul style="list-style-type: none"> • Examination for consultation purposes. • Examination in connection with emergency palliative treatment. • Dental x-rays as required for diagnosis of a specific dental condition. • Application of sealants on bicuspid and posterior teeth (molars). • Injection of necessary antibiotic drugs by the attending dentist. • Tooth extractions. • Space maintainers. • Amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration for decayed or broken teeth. • Occlusal adjustment, only in connection with periosurgery. • Oral surgery, including extractions and surgical procedures. • Administration of local, general anesthesia and/or intravenous sedation in connection with oral surgery and covered dental services. • Endodontic treatment, including root canal therapy. • Laboratory services, including cultures necessary for diagnosis and/or treatment of a specific dental condition. • Study models. • Harmful habit appliances. 	<ul style="list-style-type: none"> • <u>Basic services are subject to the Annual Dental Maximum Plan Benefits.</u> • Application of sealants limited to permanent bicuspids and molars, once in a period of 36 consecutive months, for children under the age of 19. • Space maintainers for the premature loss of posterior primary teeth, limited to children under the age of 14. • Oral surgery is limited to removal of impacted teeth, wisdom teeth or as necessary for teeth covered partially or totally by bone; root canal treatment or gingivectomy. 	80% after deductible met.	No coverage

SCHEDULE OF DENTAL BENEFITS

This chart shows what the Dental Plan pays according the Dental Plan Option you choose.
See the Dental Exclusions and Definitions chapters of this document for important information on Dental Plan benefits.

Benefit Description	Explanations and Limitations	Comprehensive Dental Plan	Preventative Dental Plan
<p>Major Services</p> <ul style="list-style-type: none"> • Periodontal prophylaxis, appliances, and the treatment of periodontal and other diseases of the gums and supporting structures of the mouth (gingiva and/or alveolar bone). • Onlays and crowns, including porcelain, ceramic, metal and porcelain-fused-to-metal. • Repair or re-cementing of crowns, inlays or onlays. • Initial installation of fixed bridgework, dentures and cast inlays. • Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace natural teeth. • Adjusting, relining or re-basing of removable dentures. • Replacement of an existing partial or full removable denture or fixed bridgework; addition of teeth to an existing partial or removable denture; bridgework to replace teeth that were extracted if evidence, satisfactory to the Plan Administrator or its designee, is presented that the conditions shown to the right have been satisfied. • Precision or semi-precision attachments for prosthetic devices. • Gold restorations. • Tooth implants (artificial root structure placed into the jaw to support bridgework or dentures). Bone graft when performed in conjunction with a dental implant. 	<ul style="list-style-type: none"> • <u>Major services are subject to Annual Dental Maximum Plan Benefits.</u> • Periodontal prophylaxis limited to once every 3 months not to exceed 4 times per plan year. • Initial installation of bridgework or partial or fixed dentures (initial placement will be considered only if they are not replacing an existing bridge or denture) will be eligible if: <ul style="list-style-type: none"> • placement is due to the extraction of one or more natural, injured or diseased teeth and • the placement of bridge or denture included replacement of extracted tooth. • Replacement of an existing fixed bridge or partial or full denture will be eligible if: <ul style="list-style-type: none"> • bridge or denture to be replaced. As placed at least 5 years ago and cannot be made satisfactory and the covered person was eligible for two years under this Plan; or • addition of teeth is needed to replace one or more natural teeth extracted; or • replacement of existing fixed bridge or denture is due to accidental injury requiring oral surgery. 	<p>50% after deductible met.</p>	<p>No coverage</p>

SCHEDULE OF DENTAL BENEFITS

This chart shows what the Dental Plan pays according the Dental Plan Option you choose.
See the Dental Exclusions and Definitions chapters of this document for important information on Dental Plan benefits.

Benefit Description	Explanations and Limitations	Comprehensive Dental Plan	Preventative Dental Plan
<p>Orthodontia Services</p> <ul style="list-style-type: none"> • Orthodontia benefits are provided to individuals up to the age of 18, and only if the individual has been a participant in this dental plan for 24 consecutive months. • Necessary services related to an active course of orthodontia treatment include diagnosis, evaluation and pre-care. • The initial installation of orthodontic appliances for an active course of orthodontia treatment. • Adjustment of active orthodontia appliances. • This orthodontia benefit is for non-surgical services provided to correct malocclusion (alignment of the teeth and or jaws) that significantly interferes with their function. 	<ul style="list-style-type: none"> • <u>Orthodontia services are subject to an overall lifetime maximum Plan benefit of \$1,500 and are not subject to the annual dental maximum.</u> • Payment for orthodontia benefits will not continue if treatment ceases for any reason. • Repair or replacement of orthodontia appliances are not covered. • Conditions Required for Coverage of Orthodontia: • Expenses related to orthodontia will be covered only when one or more of the conditions below have been satisfied: <ul style="list-style-type: none"> • The existence of an extreme buccolingual version of the teeth, either unilateral or bilateral. (The teeth are pushed out toward the cheek or in toward the tongue on one or both sides.) • A protrusion of the upper teeth of more than 3 millimeters. • A protrusion or retrusion of the upper and lower teeth relation of the maxillary or mandibular arch. 	<p>50% after deductible met.</p>	<p>No coverage</p>

ARTICLE 11: DENTAL EXCLUSIONS

The following is a list of dental services and supplies or expenses **not covered** by any Dental Plan Option. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the dental plan has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

GENERAL EXCLUSIONS

1. **Costs of Reports, Bills, etc.:** Expenses for preparing dental reports, bills or claim forms; mailing, shipping or handling expenses; and charges for failure to keep appointments, telephone calls and/or photocopying fees.
2. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan benefit limitation, maximum Plan benefits, or overall maximum Plan benefits as described in the Dental Expense Coverage chapter of this document, or used to satisfy any Plan deductible.
3. **Expenses Exceeding Allowed Charges:** Any portion of the expenses for covered dental services or supplies that are determined by the Plan Administrator or its designee to exceed the Allowed Charge as defined in the Definitions chapter of this document.
4. **Expenses for Orthodontia That Started Before Coverage is Effective:** Expenses for any dental services relating to any active course of orthodontia treatment that began prior to the date the person became eligible for orthodontia benefits (as described in the Dental Expenses Coverage chapter), even if those services are provided after the effective date of coverage under this benefit.
5. **Expenses for Which a Third Party is Responsible:** Expenses for dental services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party. See the provisions relating to Third Party Liability in the Coordination of Benefits chapter of this document for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
6. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the dental plan; or after the date the patient's coverage ends, except under those conditions described in the COBRA Continuation of Coverage chapter.
7. **Expenses Related to Teeth Lost Before Coverage Began:** Expenses for the initial installation of dentures or bridgework replacing a tooth or a group of teeth lost before the patient becomes covered under this Plan, or that were ordered while the individual was covered under this Plan but were finally installed or delivered more than 31 days after termination of coverage.
8. **Experimental and/or Investigational Services:** Expenses for any dental services and supplies that are determined by the Plan Administrator or its designee to be experimental and/or investigational as defined in the Definitions chapter of this document, or does not meet the standards of the American Dental Association (ADA).
9. **Illegal Act:** Expenses incurred by any covered individual for injuries resulting from or sustained as a result of commission or attempted commission of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which firearm, explosive or other weapon likely to cause physical harm or death is used by the covered individual. The Plan Administrator's discretionary determination that this exclusion applies shall not be affected by any subsequent acquittal of the covered individual of any criminal charges or by any other determination by a court regarding the nature of the act involved or the use by the covered individual of a firearm, explosive or other weapon.
10. **Travel and Related Expenses:** Expenses for and related to any travel or transportation (including lodging, meals, emergency and related expenses) of a dentist or other dental care provider, covered person or family member of a covered person.
11. **Services and Supplies Covered by Workers' Compensation:** Expenses for the treatment of conditions covered by workers' compensation or occupational disease law.

12. **Services Not Medically Necessary:** Services or supplies determined by the Plan Administrator or its designee not to be medically necessary as defined in the Definitions chapter of this document.
13. **Services Not Performed by a Dentist or Dental Hygienist:** Expenses for dental services not performed by a dentist (except for services of a dental hygienist that are supervised and billed by a dentist and are for cleaning or scaling of teeth or for fluoride treatments).
14. **Military service related injury/illness:** If an eligible individual under this Plan receives services in a U.S. Department of Veteran Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan.
15. **Services Provided Outside the United States:** Expenses for dental services or supplies rendered or provided outside the United States, except for treatment for an accidental injury or dental emergency as defined in the Definitions chapter of this document.
16. **Services Provided Without Cost to Recipient:** Expenses for dental services or supplies for which a covered person is not required to pay or which are obtained without cost; or there would be no charge if the person receiving the treatment were not covered under this Plan.
17. **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared; war-like act; riot; insurrection; rebellion; or invasion; except as required by law.
18. **Analgesia, Sedation, Hypnosis, Hospital Expenses, etc.:** Expenses for analgesia, sedation, hypnosis and/or related services provided for apprehension or anxiety or hospital expenses, except as stated as payable in the Schedule of Medical Benefits.
19. **Cosmetic Services:** Expenses for dental surgery or dental treatment for cosmetic purposes, as determined by the Plan Administrator or its designee, including, but not limited to, bleaching, whitening, veneers and facings. However, the following will be covered if they otherwise qualify as covered dental expenses and are **not covered** under your Medical Expense Coverage:
 - Reconstructive dental surgery when that service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part.
 - Surgery or treatment to correct deformities caused by sickness.
 - Surgery or treatment to correct birth defects outside the normal range of human variation.
 - Reconstructive dental surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional disorder.
20. **Drugs and Medicines:** Expenses for prescription drugs, medications, vitamins, minerals and supplements for dental care except as payable under the Drugs and Medicines benefit described in the Schedule of Medical Benefits, and for any other dental services or supplies if benefits are otherwise provided:
 - under the Plan's medical expense coverage; or
 - under any other plan or program that your participating employer contributes to or otherwise sponsors (such as HMOs); or
 - through a medical or dental department, clinic or similar facility provided or maintained by the Trust.
21. **Duplicate or Replacement of Lost, Missing or Stolen Bridges, Dentures or Appliances:** Expenses for any duplicate or replacement bridge, denture or orthodontic appliance, except as covered under the Major Services section of the Schedule of Dental Benefits.
22. **Duplication of Dental Services:** If a person covered by this Plan transfers from the care of one dentist to the care of another dentist during the course of any treatment, or if more than one dentist renders services for the same dental procedure, the Plan will not be liable for more than the amount that it would have been liable had but one dentist rendered all the services during each course of treatment, nor will the Plan be liable for duplication of services.
23. **Orthognathic Services and Gnathologic Recordings:** Expenses for gnathologic recordings for jaw movement and position and expenses related to orthognathic surgery or treatment.
24. **Home Use Supplies:** Home use supplies, including, but not limited to, toothpaste, toothbrush, water-pick, fluoride, mouthwash, dental floss, etc.

25. **Hospital Expenses:** Except as payable under the medical plan under Hospital Services in the Schedule of Medical Benefits.
26. **Mouth Guards:** Expenses for athletic mouth guards, stress-breakers and associated devices, except harmful habit appliances as payable under the Schedule of Dental Benefits.
27. **Myofunctional Therapy:** Expenses for myofunctional therapy.
28. **Oral Hygiene and/or Dietary Instruction:** Expenses for oral hygiene and/or education or dietary instruction, or for a plaque control program (instructions on the care of the teeth).
29. **Periodontal Splinting:** Expenses for periodontal splinting.
30. **Personalized Bridges, Dentures, Retainers, Prosthetic Devices or Appliances:** Expenses for personalization or characterization of any dental prosthesis, including, but not limited to, any bridge, denture, retainer or appliance.
31. **Sealants:** Expenses for sealants (materials other than fluorides painted on the grooves of the teeth to prevent decay), except as payable under the Schedule of Dental Benefits.
32. **Services or Appliances Subject to Orthodontia Benefit:** Expenses for any dental services or appliances including, but not limited to, items to increase vertical dimension, restore occlusion, stabilize tooth structure.
33. **Space Maintainers:** Expenses for anterior space maintainers.
34. **Treatment of Jaw or Temporomandibular Joints:** Expenses for treatment, by any means, of jaw joint problems including Temporomandibular Joint dysfunction, disturbance, or syndrome and any other craniomandibular disorders or other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues relating to that joint.
35. **Initial Installation of Dentures and/or Bridgework** (including crowns and inlays forming abutments): When the charges are incurred for teeth extracted prior to the effective date of coverage under this Plan.
36. **Orthodontia Treatment:** For cases in which, in the opinion of the Plan Administrator or its designee, the desired results are unlikely to be obtained, such as those with severe periodontal problems, poor bone structure or extremely short roots; the patient has severe medical condition(s) which may prevent satisfactory results; or the treatment plan is unlikely to produce professionally acceptable corrections of existing malocclusion.
37. Charges related to **dental services from a hospital or surgical facility.**
38. Expenses associated with **complications of a non-covered service.**
39. **Any other medical or dental service, supply, drug or equipment not specifically noted as covered in this Plan document.**

ARTICLE 12: SHORT TERM DISABILITY BENEFITS COVERAGE

The following **disability benefits apply to Yavapai College, Yavapai County and the City of Prescott employees only**. These disability benefits **do not apply to the Town of Chino Valley** employees. To verify if these benefits apply to employees of other participating employers of this Trust, contact your Human Resource Department.

Short Term Disability benefits provide temporary income replacement (weekly payments to an eligible employee) if the employee cannot work due to a non-occupational illness or injury. This means that short term disability benefits can pay a portion of an employee's income if they are unable to work for several weeks.

REFERENCE CHART OF DISABILITY INCOME BENEFITS

Elimination Period: Employees eligible for this benefit, who become totally disabled due to non-occupational injury or illness are eligible to receive monthly payments on the first day following 90 days of total disability, for employees of Yavapai College and Yavapai County, and 14 days of total disability for employees of the City of Prescott, as outlined in the following chart.

Disability Income Benefits	For Yavapai College and Yavapai County Employees	For City of Prescott Employees
Monthly Benefit:	66% of weekly salary	66% of weekly salary
Maximum Weekly Benefit:	\$1,500	\$1,500
Minimum Monthly Benefit:	\$50	\$50
Maximum Benefit Period:	90 days	90 days
Elimination Period:	90 days	14 days

DISABILITY BENEFITS

- **Benefit Payment:** After the Plan receives satisfactory evidence from you or your Physician that you have been totally disabled for 90 (or 14 days as applicable for the City of Prescott employees) consecutive days, as noted in the chart above, (called the elimination period) due to a non-occupational, accidental injury or illness (including pregnancy), the Plan will pay the weekly disability income benefit for which you are eligible as outlined on the Reference Chart of Disability Income Benefits. You must be under a Physician's regular care and attendance to receive benefits. Payments will be made to you and will continue until you have recovered or reached your benefit maximum.
- **Successive Disabilities:** Successive periods of total disability due to the same or related causes will be considered one period of disability, unless separated by your return to active, full-time service for at least 10 consecutive days. Once you have returned to work for 10 consecutive days, any subsequent total disability will be covered as a new disability irrespective of cause.
- **Limitations:** Only one benefit is paid for disability due to both an accidental injury and illness, or two or more injuries and illnesses. Reoccurrence of a disability that was originally due to an accident is considered an illness. A disability that happens more than 72 hours after an accident is considered an illness.

EXPENSES NOT COVERED

The benefit described does not include:

- Disability occurring as a result of intentional self-inflicted injury or illness while sane or insane.
- Any condition, disability or expense sustained as a result of being engaged in an illegal occupation; commission or attempted commission of an assault or other illegal act; participation in a civil revolution or a riot; duty as a member of the armed forces of any state or country; or a war or act of war which is declared or undeclared.
- Any condition or disability sustained as a result of being engaged in an activity primarily for wage, profit or gain, or that could entitle the covered person to a benefit under the Workers' Compensation Act or similar legislation.

TERMINATION OF DISABILITY COVERAGE

Your coverage under this Plan ends when the group plan ends, your employee class is excluded, contributions stop, you are no longer eligible, or you are laid-off, dismissed, retired or leave employment. For a leave of absence other than a disability leave, coverage ends the day prior to the day the leave starts.

EXTENSION OF BENEFITS

If coverage ends while you are receiving benefit payments, payments will continue until you recover or have reached your benefit maximum.

REDUCTION OF BENEFITS

If you are totally disabled and are receiving other income benefits while receiving disability income benefits from the Yavapai Combined Trust, your benefits under this Plan will be reduced by an amount equal to the sum of the other income benefits received. Other income benefits that will reduce the amount of your disability income benefit include Social Security benefits, State disability benefits, employer-sponsored sick leave program benefits, or other group insurance benefits.

TIME LIMIT AND REQUIREMENTS FOR FILING DISABILITY BENEFIT CLAIMS

Notice of short term disability (STD) benefit claims (applicable to **College and County employees**) must be submitted no later than 90 days after the date on which the sickness or injury began or else benefits will not be payable. Proof of disability must be submitted no later than 90 days after the end of the period for which short term disability benefits are payable.

For employees of the City of Prescott, notice of short term disability (STD) benefit claims must be submitted no later than 45 days after the date on which the sickness or injury began or else benefits will not be payable. Proof of disability must be submitted no later than 45 days after the end of the period for which short term disability benefits are payable. Additionally the City will not require exhaustion or use of leave banks prior to STD. If the employee has no accruals, the employee will be on leave without pay for the first 14 days of their disability elimination period. Once an employee has chosen to use personal leave accruals and has already been paid by utilizing personal leave accruals during the STD eligibility period, although they may still apply for disability benefits for future compensation within the allowable timeframe, the employee may not reverse the decision to be paid by disability benefits for the time already compensated by leave accruals.

If you don't provide notice or proof of disability within the times specified, you can still claim full benefits if you can show that the notice or proof was furnished as soon as reasonably possible. The Plan has the right to have a Physician or Physicians of its choice examine you at the Plan's expense as often as is reasonable:

1. while a claim for short term disability benefits is pending; or
2. during the period short term disability benefits continue to be paid.

See Article 13 for information on how to appeal an adverse benefit decision (a denial) related to a disability claim.

ARTICLE 13: CLAIMS ADMINISTRATION AND CLAIM APPEALS

PAYMENT OF MEDICAL AND DENTAL BENEFITS IN GENERAL

All Plan benefits are considered for payment on the receipt of a written proof of claim. A completed claim form usually contains the necessary proof of claim, but sometimes additional information or records may be required. However, if medical services are provided through the Preferred Provider Organization (PPO), the PPO health care provider may submit proof of claim directly to the Plan.

Generally, Plan benefits payable on account of expenses for a hospital or specialized health care facility will be paid directly to the institution providing the services. Likewise, Plan benefits payable on account of expenses for surgery will be paid directly to the surgeon or anesthesiologist providing the services. However, if, at the time you submit your claim, you furnish evidence acceptable to the Plan Administrator or its designee that you or your covered dependent paid some or all of those charges, Plan benefits will be paid to you. When deductibles, coinsurance or copayments apply, you are responsible for paying your share of the charges.

If medical services are provided through the PPO, the PPO health care provider may submit the proof of claim directly to the Plan, or may complete the necessary claim form and return it to you for submission to the Plan. However, you will be responsible for the payment to the PPO health care provider of any applicable deductible and/or coinsurance.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

A Qualified Medical Child Support Order (QMCSO) may require the Plan to pay Plan benefits on account of expenses incurred by or on behalf of the dependent child(ren) covered by the Plan either to the health care provider who rendered the services or to the custodial parent of the dependent child(ren).

If coverage of the dependent child(ren) is actually provided by the Plan, and if the Plan Administrator or its designee determines that it has received a QMCSO, it will pay Plan benefits on account of expenses incurred by or on behalf of the dependent child(ren) to the extent otherwise covered by the Plan as required by that QMCSO. **For additional information regarding QMCSOs, see the Eligibility chapter of this document.**

WHEN YOU MUST REPAY PLAN BENEFITS

If it is found that the Plan benefits paid by the Plan are too much because:

1. some or all of the medical or dental expenses were not paid or payable by you or your covered dependent; **or**
2. you or your covered dependent received the money to pay some or all of those medical or dental expenses from a source other than the Plan; **or**
3. you or your covered dependent achieve any recovery whatsoever, through a legal action or settlement in connection with any sickness or injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the medical or dental expenses for which Plan benefits were paid; **or**
4. the Plan erroneously paid benefits to which you were not entitled under the terms and provisions of the Plan, **then**

the Plan will be entitled to:

- recover overpayments from the entity to which the overpayment was made or from the participant directly;
- a refund from you or your health care provider for the difference between the amount of Plan benefits actually paid by the Plan for those expenses and the amount of Plan benefits that should have been paid by the Plan for those expenses based on the actual facts;
- offset future benefits (that would otherwise be payable on behalf of you or your dependents) if necessary in order to recover such expenses; and/or
- its attorney's fees, costs and expenses incurred in recovering monies that were wrongfully paid.

For additional information on the procedures that may be followed by the Plan to recover these amounts, see the provision regarding Third Party Liability in the Coordination of Benefits chapter.

HOW TO FILE A CLAIM

Where to Get Claim Forms: You can get claim forms from your Human Resource Department or the website of the Claims Administrator listed on the Quick Reference Chart in the front of this document.

How to Complete a Claim Form: Complete the employee part of the claim form in full. Answer every question, even if the answer is “none” or “not applicable” (N/A).

The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your Physician or dentist can complete the health care provider part of the claim form, or you can attach the bill for professional services if it contains **all** of the following information:

- A description of the services or supplies provided.
- Details of the charges for those services or supplies, including the appropriate medical/dental codes.
- Diagnosis.
- Date(s) the services or supplies were provided.
- Patient’s name.
- Provider’s name, address, phone number, professional degree or license, and federal tax identification number.

Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the Claims Administrator. This can reduce costs to you and the Plan. Complete a separate claim form for each person for whom Plan benefits are being claimed.

How to file a claim that was incurred outside the U.S.: For claims incurred outside the United States (U.S.) in most cases you will have to pay the provider at the time of service. Then, at a later date, you can submit the foreign claim and your proof of payment to this Plan for consideration of reimbursement in accordance with Plan rules outlined in this document. If the provider located outside the U.S. does not require payment at the time of service, payment for covered services will be sent to the plan participant. The claims administrator will determine the daily rate of exchange between the U.S. dollar and the applicable foreign currency. Then payment will be made to you so that you can forward payment to the appropriate provider outside the U.S. Payment is not made by this plan to a provider outside the U.S.

WHERE TO SEND THE CLAIM FORM

Send the completed claim form and any other required information to the Claims Administrator whose address is listed on the chart in the Quick Reference chapter of this document.

EXPLANATION OF BENEFITS (EOB)

Each time you visit your provider and a claim is made you will receive a document called an Explanation of Benefits or EOB. The EOB will include the deductible accumulation, the amount of the claim paid by the Plan, to whom payment was made, any outstanding balance that you may be responsible to pay, and if there is a denial of a payment, the EOB will include information about the denial, reason for a denial and how to appeal a denial.

TIME LIMIT FOR FILING ALL CLAIMS

All medical, dental and prescription claims must be submitted to the Plan **within 12 months** of the date of service. No Plan benefits will be paid for any claim not submitted within this period.

CLAIM INQUIRIES

Generally claims are paid within 30 days of the Claims Administrator’s receipt of a clean claim. To answer questions about how to file a claim, the status of a pending claim or any action taken on a claim, call or write the Claims Administrator.

TIME LIMIT AND REQUIREMENTS FOR FILING DISABILITY BENEFIT CLAIMS

See the Short Term Disability chapter for this information.

CLAIM PROCESSING AND APPEALS INFORMATION

The Plan takes steps to assure that **Plan provisions are applied consistently** with respect to you and other similarly situated Plan participants. The claims procedures outlined in this chapter are designed to **afford you a full, fair and fast review of the claim to which it applies**.

This chapter also discusses the process the Plan undertakes on certain appealed claims, to consult with a Health Care Professional with appropriate training and experience when reviewing an Adverse Benefit Determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary, is experimental or investigational).

ADDITIONAL INFORMATION NEEDED

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after these stated time frames.

COORDINATION OF BENEFITS (COB) PROVISION

This Plan contains a Coordination of Benefits (COB) provision to prevent double payment for covered expenses. This provision works by coordinating the benefits under this Plan with other similar plans under which a person is covered so that the total benefits available will not exceed one hundred percent of allowable expenses. You may be asked to submit information about any additional coverage you have available to you so that this Plan knows whether and how much it should pay toward your eligible services. Without your cooperation in forwarding information on additional coverage to this Plan, the Plan may deny claims until the requested information is obtained. See the Coordination of Benefits chapter for more information.

WHEN YOU MUST GET PLAN APPROVAL IN ADVANCE OF OBTAINING HEALTH CARE

Some Plan benefits are payable without a financial penalty only if the Plan approves payment **before** you receive the services. These benefits are referred to as pre-service claims (also known as preauthorization or precertification). See the definition of pre-service claims in this chapter. You are not required to obtain approval in advance for emergency care including care provided in a hospital Emergency Room, or hospital admission for delivery of a baby.

KEY DEFINITIONS

Days: For the purpose of the claim filing and appeal procedures outlined in this chapter, “days” refers to calendar days, not business days.

Adverse Benefit Determination: For the purpose of the initial and appeal claims processes, an Adverse Benefit Determination for a health care claim is defined as:

- a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual’s eligibility to participate in this Plan or a determination that a benefit is not a covered benefit; and
- a reduction in a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate; or
- a Rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

Claim: For purposes of benefits covered by these procedures, a claim is a request for a Plan benefit made by an individual (commonly called the “claimant” but hereafter referred to as “you”) or that individual’s authorized representative (as defined later in this chapter) in accordance with the Plan’s claims procedures, described in this chapter.

There are **five types of claims** covered by the procedures in this chapter: **Pre-service, Urgent, Concurrent, and Post-service and Disability**, described later in this chapter. The type of claim is determined as of the time the claim or review of denial of the claim is being processed.

A claim must include the following elements to trigger the Plan’s claims processing procedures:

- a. be **written or electronically** submitted (oral communication is acceptable only for urgent care claims);
- b. be **received by the Appropriate Claims Administrator** as that term is defined in this chapter;
- c. **name a specific individual including their social security number or Medicare HICN number;**
- d. **name a specific medical condition or symptom;**
- e. **name a specific treatment, service or product** for which approval or payment is requested;
- f. **made in accordance with the Plan’s claims filing procedures** described in this chapter; and
- g. **includes all information required by the Plan and it’s Appropriate Claims Administrator, such as the existence of additional health coverage that would assist the Plan in coordinating benefits.**

A claim is NOT:

- a. a request made by **someone other than** the individual or his/her authorized representative;
- b. a request made by a **person who will not identify himself/herself** (anonymous);
- c. a **casual inquiry about benefits** such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- d. a request for **prior approval of Plan benefits where prior approval is not required** by the Plan;
- e. an **eligibility inquiry that does not request Plan benefits**. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an Adverse Benefit Determination and the individual will be notified of the decision and allowed to file an appeal;
- f. a **request for services and claims for a work-related injury/illness**, unless the Workers’ Compensation program has provided a written confirmation that the injury/illness is not compensable as a work-related claim;
- g. a **submission of a prescription** with a subsequent Adverse Benefit Determination at the point of sale at a retail pharmacy or from a mail order service.

Appropriate Claims Administrator: means the companies/organizations and types of claims outlined in the chart below. (See the Quick Reference Chart in this document for the contact information for these Appropriate Claims Administrators)

Appropriate Claims Administrator	Types of Claims Processed
Claims Administrator	<ul style="list-style-type: none"> • Medical, dental and vision post-service claims.
Utilization Management Company	<ul style="list-style-type: none"> • Urgent, Concurrent and Pre-service claims
Prescription Drug Program	<ul style="list-style-type: none"> • Pre-service drugs as described in the Drug row of the Schedule of Medical Benefits chart. • Post-service claims for out-of-network retail drugs as noted in in the Drug row of the Schedule of Medical Benefits chart.
Disability Claims Administrator	<ul style="list-style-type: none"> • Disability claims for Short Term Disability (STD) benefits

Pre-Service Claim: A pre-service claim is a request for benefits under this group health Plan where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care. The services that require precertification (also called prior authorization) are listed in the Utilization Management chapter and from the Prescription Drug Program whose contact information is listed in the Quick Reference Chart in the front of this document.

The Plan Administrator may determine, in its sole discretion, to pay benefits for the services needing precertification (that were obtained without prior approval) if you were unable to obtain prior approval because circumstances existed that made obtaining such prior approval impossible, or application of the pre-service (precertification) procedure could have seriously jeopardized the patient’s life or health.

Urgent Care Claim: An urgent care claim is a claim (request) for medical care or treatment in which applying the time periods for precertification, as determined by your Health Care Professional:

- could seriously jeopardize the life or health of the individual or the individual’s ability to regain maximum function, or

- in the opinion of a physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, or is a claim involving urgent care.

The services that require precertification (also called prior authorization) are listed in the Utilization Management chapter and from the Prescription Drug Program whose contact information is listed in the Quick Reference Chart in the front of this document.

Concurrent Care Claim: A concurrent care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short. The services that will receive concurrent care review are listed in the Utilization Management chapter in this document.

Post-Service Claim: A post-service claim is a claim for benefits under the Plan that is not a pre-service claim. Post-service claims are claims that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim and an electronic bill, submitted for payment after services have been provided, are examples of post-service claims. A claim regarding rescission of coverage will be treated as a post-service claim.

Disability Claim: A disability claim is a claim for benefits under the Plan to which the Plan conditions the availability of the benefit on proof of a claimant's disability.

Health Care Professional: Means a Physician or other Health Care Professional licensed, accredited or certified to perform specified health services consistent with State law.

Tolled: Means stopped or suspended, particularly as it refers to time periods during the claims process.

Rescission: Means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required premiums or contributions. The Plan is permitted to rescind your coverage if you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of this Plan.

Independent Review Organization or IRO: Means an entity that conducts independent external reviews of Adverse Benefit Determinations in accordance with the Plan's external review provisions and current federal external review regulations.

REVIEW OF ISSUES THAT ARE NOT A CLAIM AS DEFINED IN THIS CHAPTER

A Plan participant may request review of an issue (that is not a claim as defined in this chapter) by writing to the Board of Trustees whose contact information is listed on the Quick Reference Chart in this document. The request will be reviewed and the participant will be advised of the decision within 90 days of the receipt of the request.

AUTHORIZED REPRESENTATIVE

This Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an Adverse Benefit Determination under this Plan (because of your death, disability or other reason acceptable to the Plan). An authorized representative under this Plan also includes a Health Care Professional. Under this Plan you do not need to designate in writing that the Health Care Professional is your authorized representative if that Health Care Professional is part of the claim appeal.

The Plan requires a written statement from an individual that he/she has designated an authorized representative (except for a health care professional who does not require a written statement in order to appeal a claim for a plan participant) along with the representative's name, address and phone number. To designate an authorized representative, you must submit a completed authorized representative form (available from the Appropriate Claims Administrator).

Where an individual is unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g.* notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the individual's legal spouse, parent, grandparent or child over the age of 18).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative and not the individual. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. A participant may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Appropriate Claims Administrator.

In the case of an urgent care claim, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), such Health Care Professional will be considered by this Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

HOW TO FILE A CLAIM FOR DISABILITY INCOME BENEFITS (DISABILITY CLAIM PROCESS)

A claim for disability benefits is a request for disability plan benefits made by you (an individual covered under the Disability Plan) or your authorized representative (as defined in this chapter) in accordance with the Plan's disability claims procedures, described below in this chapter. See also the "Key Definitions" section of this chapter for a definition of a "claim" and the information on what is and is not considered a claim.

Eligible employees who become totally disabled from a non-occupational illness should apply (file a claim) for disability benefits within with timeframe outlined in the Short Term Disability benefits chapter of this document.

1. Disability claims will be determined no later than 45 calendar days after receipt of the claim for disability benefits by the Appropriate Claims Administrator.
2. You will be notified if you did not follow the disability claim process or if you need to submit additional medical information or records to prove a disability claim and provided 45 calendar days in which to obtain this additional information.
 - Proof of disability must be provided to the Plan in accordance with the provisions outlined in the Disability chapter in this document. If you do not provide proof of disability within the time specified, you can still claim full benefits if you can show that proof was furnished as soon as reasonably possible.
 - The Plan reserves the right to have a Physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefits is pending or payable.
3. The Plan Administrator (the Board of Trustees) determines if employees are eligible to receive disability benefits under this Plan. The Plan will review your disability claim and notify you or your authorized representative in writing (or electronically, as applicable) no later than 45 calendar days from the date the Appropriate Claims Administrator receives the claim.
 - This 45-day period may be **extended for up to 30 calendar days** provided the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond their control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 45-day period, that additional time is needed to process the claim, the special circumstances for this extension and the date by which it expects to render its determination.
 - If, prior to the end of this first 30 day extension, the Appropriate Claims Administrator determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided you are notified prior to the first 30-day extension period of the circumstances requiring the second extension and the date a decision is expected to be rendered.
 - A Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and the additional information needed to resolve those issues. **If the Appropriate Claims Administrator needs additional information from you to make its decision**, you will have at least 45 calendar days to submit the additional information. (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.

4. Disability benefits begin when the claim for disability benefits has been determined to meet the definition of total disability under this Plan and it is determined that Plan disability exclusions do not apply to the claim.
5. **If the claim for disability benefits is approved**, you will be notified in writing (or electronically, as applicable) and benefit payments will begin.
6. **If the claim for disability benefits is denied** in whole or in part, a notice of this initial denial (Adverse Benefit Determination) will be provided to the employee in writing (or electronically, as applicable). This notice of initial denial will:
 - give the specific reason(s) for the denial;
 - reference the specific Plan provision(s) on which the determination is based;
 - contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
 - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
 - provide an explanation of the Plan's appeal procedure along with time limits;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request; and
 - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.
7. **If you disagree with a denial of a disability claim**, you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A DISABILITY CLAIM

1. Appeals must be submitted in writing to the Claims Administrator whose contact information is listed on the Quick Reference Chart in this document. You will be provided with:
 - upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
 - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
 - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
 - a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
 - in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Plan Administrator will:
 - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
 - provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.
2. A determination on the appeal will be made no later than 45 calendar days from receipt of the appeal.
3. **The Plan may obtain a 45-day extension if** you are notified of the need and reason for an extension before expiration of the initial 45-day period. (If a period of time is extended due to failure to submit information, the

time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.)

4. You will receive a notice of the appeal determination no later than 5 calendar days after the benefit determination is made. If that determination is adverse, it will include:
 - the specific reason(s) for the adverse appeal review decision;
 - reference the specific Plan provision(s) on which the determination is based;
 - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
 - a statement of the voluntary Plan appeal procedures, if any;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
 - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
 - the statement that “You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency.”
5. This concludes the disability appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

HOW TO FILE A POST-SERVICE CLAIM FOR BENEFITS UNDER THIS PLAN

A claim for post-service benefits is a request for Plan benefits (that is not a pre-service claim) made by you or your authorized representative, in accordance with the Plan’s claims procedures, described in this chapter. See also the “Key Definitions” section of this chapter for a definition of a “claim” and the information on what is and is not considered a claim.

1. Plan benefits for post-service claims are considered for payment upon receipt of a **written** (or electronic where appropriate) proof of claim, commonly called a bill. A completed claim usually contains the necessary proof of claim but sometimes additional information or records may be required. The Appropriate Claims Administrator will not accept a balance due statement, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim.
2. Generally, Plan benefits for a Hospital or Health Care Facility will be paid directly to the facility. Plan benefits for surgery will usually be paid directly to the surgeon and anesthesiologist providing the services. This is because the Plan’s financial responsibility for eligible benefits is generally automatically assigned to the provider of the service unless the claim is marked that the bills have been paid by the covered person. For eligible claims, the Plan pays their portion of the billed services and you, the covered person, are responsible to pay your portion of the claim to the provider.
3. When health care services are provided through the Preferred Provider Organization (PPO), the PPO Health Care Facility/Provider will usually submit the written proof of claim directly to the PPO Network for repricing or to the Appropriate Claims Administrator.
4. If you pay for non-PPO health care services at the time services are provided, you may later submit the bill to the Appropriate Claims Administrator. At the time you submit your claim you must furnish evidence acceptable to the Appropriate Claims Administrator that you or your covered dependent paid some or all of those charges. If non-PPO Plan benefits will be paid to you, they will be paid up to the amount allowed by the Plan for those expenses.
5. The Appropriate Claims Administrator will review your post-service claim no later than 30 calendar days from the date the claim is received. You will be notified if you did not properly follow the post-service claims process.
 - This 30-day period may be extended one time for up to 15 additional calendar days if the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond its control, the date

by which it expects to make a decision and notifies you prior to the expiration of the initial 30 day period using a written Notice of Extension.

- The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. You will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
 - (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.)
 - The Appropriate Claims Administrator will then make a claim determination no later than 15 calendar days from the earlier of the date the Plan receives the additional information or the date displayed in the Notice of Extension on which the Plan will make a decision if no additional information is received.
 - **Proof of Dependent Status:** (See also the following two sections of the Eligibility chapter of this document: Proof of Dependent Status section and Failure to Provide Proof of Dependent Status under the Initial Enrollment section).
 - When processing claims submitted on behalf of a **Newborn Dependent Child** the Appropriate Claims Administrator must receive confirmation of the child's eligibility for coverage (e.g. copy of certified birth certificate for newborn).
 - When processing claims submitted on behalf of a **Dependent Child who is age 26 or older**, the Appropriate Claims Administrator must receive confirmation of the child's eligibility (e.g. disabled adult child verification).
 - If claims are submitted on behalf of a **Dependent for whom the Plan has not yet received proof of dependent status**, the Appropriate Claims Administrator must receive the proof of eligibility, or confirmation from the Plan Administrator of the child's eligibility for coverage, before the claim can be considered for payment.
 - When processing claims submitted on behalf of a **new Spouse**, the Appropriate Claims Administrator must receive confirmation of the Spouse's eligibility (e.g. copy of marriage certificate).
 - When processing **claims related to an accident** the Appropriate Claims Administrator will need information about the details of the accident in order to consider the claim for payment.
6. The Plan will provide you, automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable time to respond prior to that date.
7. **If the post-service claim is approved**, you will be notified in writing (or electronically, as applicable) on a form commonly referred to as an Explanation of Benefits or EOB. The provider of service (or you when applicable) will be paid according to Plan benefits.
8. **If the post-service claim is denied** in whole or in part, a notice of this initial denial will be provided to you in writing (or electronically, as applicable) in addition to the Explanation of Benefits or EOB form. This notice of initial denial will:
- identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
 - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal review;
 - give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;

- reference the specific Plan provision(s) on which the determination is based;
 - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
 - provide an explanation of the Plan's internal appeal procedure along with time limits and information regarding how to initiate an appeal and information on any external review processes and time limits such as for the HDHP plan;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request; if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
 - disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.
9. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
- SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-879-8500.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-879-8500.
10. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.
11. **If you disagree with a denial of a post-service claim**, you or your authorized representative may ask for a post-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A POST-SERVICE CLAIM

1. This Plan maintains a 2 level appeals process. Appeals must be submitted in writing to the Appropriate Claims Administrator for the first level of appeal review and to the Board of Trustees (in care of the Claims Administrator) for the second level appeal review, both of whom have their contact information listed on the Quick Reference Chart in this document. You will be provided with:
- upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
 - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
 - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
 - free of charge and automatically, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable time to respond prior to that date.
 - a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

- in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Plan Administrator will:
 - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
 - provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.
2. Under this Plan's 2 level appeal process, the Plan routes the first level of review to the Appropriate Claims Administrator who will make the first level determination on the post-service appeal no later than 30 calendar days from receipt of the appeal.
 - There is **no extension permitted** in the first or second level of the appeal review process.
 - You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.
 - If still dissatisfied with the initial appeal level determination you will have 180 calendar days under this Plan from receipt of the first level review determination to request a second level appeal review by writing to the Plan Administrator whose contact information is listed on the Quick Reference Chart in this document.
 - The Plan Administrator then will make a second level determination no later than 30 calendar days from receipt of the second level appeal.
 - You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person other than the person that originally denied the claim and who is not subordinate to the person who originally denied the claim.
 3. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit, the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
 4. You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:
 - information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
 - the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level of appeal review;
 - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
 - reference the specific Plan provision(s) on which the determination is based;
 - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
 - an explanation of the Plan's 2nd level appeal review process, along with any time limits and information regarding how to initiate the next level of review, and information on any external review processes and time limits such as for the HDHP plan, as well as a statement of the voluntary Plan appeal procedures, if any;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;

- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
 - the statement that “You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;” and
 - disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.
5. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
 - SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-879-8500.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-879-8500.
 6. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.
 7. This concludes the post-service appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

HOW TO FILE AN URGENT CARE CLAIM FOR BENEFITS UNDER THIS PLAN

If your claim involves urgent care (as defined earlier in this chapter and as determined by your attending Health Care Professional), you may file the claim or the Plan will honor a Health Care Professional as your authorized representative in accordance with the Plan’s urgent care claims procedures described below.

1. Urgent care claims (as defined previously in this chapter) may be requested by you orally or by writing to the Appropriate Claims Administrator (Utilization Management Company or Prescription Benefit Program) whose contact information is listed on the Quick Reference Chart in this document.
2. In the case of an urgent care claim, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), the Health Care Professional will be considered by this Plan to be the authorized representative bypassing the need for completion of the Plan’s written authorized representative form.
3. The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable time to respond prior to that date.
4. You will be notified of the Plan’s benefit determination as soon as possible but **no later than 72 hours** after receipt of an urgent care claim by the Utilization Management Company or Prescription Drug Program. You will be notified if you fail to follow the urgent care claim procedures or fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan.
5. **If you fail to provide sufficient information to decide an urgent care claim**, you will be notified as soon as possible, but no later than 24 hours after receipt of the urgent care claim by the Utilization Management Company or Prescription Drug Program, of the specific information necessary to complete the urgent care claim and you will be allowed not less than 48 hours to provide the information. You will then be notified of the Plan’s benefit determination on the urgent care claim as soon as possible but no later than 48 hours after the

earlier of the receipt of the needed information **or** the end of the period of time allowed to you in which to provide the information.

6. **If the urgent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.
7. **If the urgent care claim is denied** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice provided no later than 3 calendar days after the oral notice. The notice of initial urgent care claim denial will:
 - identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
 - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal review;
 - give the specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;
 - reference the specific Plan provision(s) on which the determination is based;
 - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
 - provide an explanation of the Plan's internal appeal procedure review process along with time limits and information regarding how to initiate an appeal, including a description of the expedited appeal review process for urgent care claims and information on any external review processes and time limits such as for the HDHP plan;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
 - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request, and
 - disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.
8. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
 - SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-879-8500.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-879-8500.
9. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.
10. **If you disagree with a denial of an urgent care claim**, you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF AN URGENT CARE CLAIM

1. You may request an appeal review of an urgent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator (Utilization Management Company or Prescription Drug Program), whose contact information is listed on the Quick Reference Chart in this document.
2. You will be provided with:
 - upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;

- the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
 - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
 - free of charge and automatically, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable time to respond prior to that date;
 - a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
 - in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Plan will:
 - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
 - provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.
3. The Plan will make a determination on the appeal (without the opportunity for an extension) as soon as possible but no later than 72 hours after receipt of the appeal.
4. The notice of appeal review of an urgent care claim will be provided orally with written confirmation (or electronic, as appropriate). You will receive a notice of the appeal determination. If that determination is adverse, it will include:
- information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
 - a statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level appeal review;
 - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
 - reference the specific Plan provision(s) on which the determination is based;
 - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
 - an explanation of the Plan's 2nd level appeal review process, along with any time limits and information regarding how to initiate the next level of review, and information on any external review processes and time limits such as for the HDHP plan, as well as a statement of the voluntary Plan appeal procedures, if any;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
 - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;

- the statement that “You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;” and
 - disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.
5. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
 - SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-879-8500.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-879-8500.
 6. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.
 7. This concludes the urgent care claim appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

HOW TO FILE A CONCURRENT CLAIM FOR BENEFITS UNDER THIS PLAN

If your claim involves concurrent care (as that term is defined earlier in this chapter), you may file the claim by writing (orally for an expedited review) to the Appropriate Claims Administrator whose contact information is listed on the Quick Reference Chart in this document.

1. If a decision is made to reduce or terminate an approved course of treatment, you will be provided notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination of that Adverse Benefit Determination before the benefit is reduced or terminated.
2. The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable time to respond prior to that date.
3. Concurrent claims that are an urgent care claim will be processed according to the initial review and appeals procedures and timeframes noted under the Urgent care claim section of this chapter.
4. Concurrent claims that are not an urgent care claim will be processed according to the initial review and appeals procedures and timeframes applicable to the claims as noted under the Pre-service or Post-service claim sections of this chapter.
5. **If the concurrent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.
6. **If the concurrent care claim is denied**, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice. The notice of initial concurrent denial will:
 - identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
 - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal review;
 - give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
 - reference the specific Plan provision(s) on which the determination is based;

- describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
 - provide an explanation of the Plan's internal appeal procedure review processes along with time limits and information regarding how to initiate an appeal and information on any external review processes and time limits such as for the HDHP plan;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
 - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
 - disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.
7. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
- SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-879-8500.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-879-8500.
8. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.
9. **If you disagree with a denial of a concurrent claim**, you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A CONCURRENT CARE CLAIM

1. You may request an appeal review of a concurrent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator (Utilization Management Company or Prescription Drug Program), whose contact information is listed on the Quick Reference Chart in this document.
2. You will be provided with:
 - upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
 - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
 - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
 - free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable time to respond prior to that date;
 - a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

- in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Plan Administrator will:
 - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
 - provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.
3. A determination will be made on the appeal (without the opportunity for extension) as soon as possible before the benefit is reduced or treatment is terminated.
 4. The notice of appeal review for the concurrent claim may be provided orally (for urgent care claims), with written (or electronic, as appropriate) notice. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
 - information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
 - the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level appeal review;
 - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
 - reference the specific Plan provision(s) on which the determination is based;
 - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
 - an explanation of the Plan's 2nd level appeal review process, along with any time limits and information regarding how to initiate the next level of review, and information on any external review processes and time limits such as for the HDHP plan, as well as a statement of the voluntary Plan appeal procedures, if any;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
 - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
 - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and
 - disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.
 5. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
 - SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-879-8500.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-879-8500.
 6. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

7. This concludes the concurrent claim appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

HOW TO FILE A PRE-SERVICE CLAIM FOR BENEFITS UNDER THIS PLAN

1. A claim for pre-service (as defined in this chapter) must be made by a claimant or the claimant's authorized representative (as described in this chapter) in accordance with this Plan's claims procedures outlined in this chapter.
2. A pre-service claim (claim which requires precertification) must be submitted (orally or in writing) in a timely fashion (as discussed in the Utilization Management chapter and Drug row of the Schedule of Medical Benefits of this document) to the Appropriate Claims Administrator (as defined in this chapter).
3. The pre-service claim will be reviewed no later than 15 calendar days from the date the pre-service claim is received by the Appropriate Claims Administrator. If you do not follow the pre-service claim filing process, you will be notified as soon as possible or within 5 calendar days from your request.
4. The 15 calendar day review period may be extended one time for up to 15 additional calendar days if it is determined that an extension is necessary due to matters beyond the control of the Appropriate Claims Administrator, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 15-day period by using a written Notice of Extension.
5. If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.
6. The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.
7. In either case noted above, you will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
8. A claim determination will be made no later than 15 calendar days from the earlier of the date the additional information is received or the date displayed in the Notice of Extension on which a decision will be made if no additional information is received.
9. The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable time to respond prior to that date.
10. **If the pre-service claim is approved** you will be notified orally and in writing (or electronic, as applicable).
11. **If the pre-service claim is denied in whole or in part**, a notice of this initial denial will be provided to you orally and in writing (or electronic, as applicable). This notice of initial denial will:
 - identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
 - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal review;
 - give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
 - reference the specific Plan provision(s) on which the determination is based;
 - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;

- provide an explanation of the Plan’s internal appeal procedure review processes along with time limits and information regarding how to initiate an appeal and information on any external review processes and time limits such as for the HDHP plan;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
 - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
 - disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.
12. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
- SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-879-8500.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-879-8500.
13. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.
14. **If you disagree with a denial of a pre-service claim**, you or your authorized representative may ask for a pre-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A PRE-SERVICE CLAIM

1. This Plan maintains a 2 level appeals process. Appeals must be submitted in writing to the Appropriate Claims Administrator for the first level of appeal review and to the Board of Trustees (in care of the Claims Administrator) for the second level appeal review, both of whom have their contact information listed on the Quick Reference Chart in this document. You will be provided with:
- upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
 - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
 - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
 - free of charge and automatically, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you time to respond prior to that date;
 - a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
 - in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Plan Administrator will:

- consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
 - provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.
2. Under this Plan's 2 level appeal process, the Plan routes the first level of review to the Appropriate Claim Administrator who will make the first level determination on the pre-service appeal no later than 15 calendar days from receipt of the appeal.
 3. There is **no extension permitted** to the Plan in the first or second level of the appeal review process. You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.
 4. If still dissatisfied with the initial appeal level determination you will have 180 calendar days under this Plan from receipt of the first level review determination to request a second level appeal review by writing to the Plan Administrator whose contact information is listed on the Quick Reference Chart in this document.
 5. A second level determination will be made no later than 15 calendar days from receipt of the second level appeal.
 6. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.
 7. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
 8. You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:
 - information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
 - the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal review;
 - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
 - reference the specific Plan provision(s) on which the determination is based;
 - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
 - an explanation of the Plan's 2nd level appeal process, along with any time limits and information regarding how to initiate the next level of review, and information on any external review processes and time limits such as for the HDHP plan, as well as a statement of the voluntary Plan appeal procedures, if any;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
 - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
 - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency" and
 - disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

9. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
 - SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-879-8500.
 - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-879-8500.
10. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.
11. This concludes the preservice appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

OUTLINE OF THE TIMEFRAMES FOR THE CLAIM FILING AND CLAIM APPEAL PROCESS

Overview of Claims and Appeals Timeframes					
	Urgent	Concurrent	Pre-service	Post-service	Disability
Plan must make Initial Claim Benefit Determination as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days	30 days	45 days
Extension permitted during initial benefit determination?	No ¹	No	Yes, one 15-day extension.	Yes, one 15-day extension.	Yes, up to 2 extensions each 30 days in duration.
First (initial) Appeal Review must be submitted to the Plan within:	180 days	180 days	180 days	180 days	180 days
Plan must make Appeal Claim Benefit Determination as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days for each appeal level	30 days for each appeal level	45 days
Second Appeal Review must be submitted to the Plan within:	NA	NA	180 days	180 days	180 days
Extension permitted during appeal review?	No	No	No	No	Yes

¹ no formal extension for urgent care claims but regulation does allow that if a claimant files insufficient information the claimant will be allowed up to 48 hours to provide the information.

EXTERNAL REVIEW OF CLAIMS FOR THE HDHP PLAN ONLY

This External Review process **for the HDHP Plan only**, is intended to comply with the Affordable Care Act (ACA) external review requirements. For purposes of this section, references to “you” or “your” include you, your covered dependent(s), and you and your covered dependent(s)’ authorized representatives; and references to “Plan” include the Plan and its designee(s).

You may seek further external review, by an Independent Review Organization (“IRO”), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim, is denied and it fits within the following parameters:

- The denial involves medical judgment, including but not limited to, those based on the Plan’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, an adverse determination related to coverage of routine costs in a clinical trial, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and/or
- The denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, this **external review process does not pertain** to

- disability benefits;
- the Premier Plan or Basic Plus Plans that are still grandfathered medical plan options;
- the dental plan or vision plans that are excepted/limited scope plans.

The Plan assumes responsibility for fees associated with External Review. Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on appeal.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

1. **External Review of Standard (Non-Urgent) Claims.**

Your request for external review of a standard (not urgent) claim must be made, in writing, **within four (4) months of the date that you receive notice** of an Initial Claim Appeal Benefit Determination (first level of appeal) or adverse Claim Appeal Benefit Determination (second level of appeal). For convenience, these Determinations are referred to below as an “Adverse Determination,” unless it is necessary to address them separately.

An external review request on a standard claim should be made to the following appropriate **Plan designee**:

- The Medical Plan Claims Administrator, with respect to a denied medical plan claim not involving retail or mail order prescription drug expenses or behavioral health expenses;
- The Prescription Drug Program provider, with respect to a denied claim involving retail or mail order prescription drug expenses;
- The Utilization Management Program provider, with respect to a denied Pre-service or concurrent review determination not involving prescription drug expenses or behavioral health expenses;

Contact information for the Medical Plan Claims Administrator, the Prescription Drug Program provider, and the Utilization Management Program provider is identified in the Quick Reference Chart, as amended from time to time.

A. **Preliminary Review of Standard Claims.**

1. Within five (5) business days of the Plan’s or appropriate Plan designee’s receipt of your request for an external review of a standard claim, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether:
 - (a) You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
 - (b) The Adverse Determination satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation of coverage;
 - (c) You have exhausted the Plan’s internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and
 - (d) You have provided all of the information and forms required to process an external review.
2. Within one (1) business day of completing its preliminary review, the Plan or appropriate Plan designee will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:
 - (a) If your request is complete and eligible for external review; or

- (b) If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

B. Review of Standard Claims by an Independent Review Organization (IRO).

1. If the request is complete and eligible for an external review, the Plan or appropriate Plan designee will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:
 - a. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days).
 - b. Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.
 - c. If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
 - d. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

- e. The assigned IRO will provide written notice of its final external review decision to you and the Plan or appropriate Plan designee **within 45 days** after the IRO receives the request for the external review.
 - 1) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
- f. The assigned IRO's decision notice will contain:
 - 1.) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

- 2.) The date that the IRO received the request to conduct the external review and the date of the IRO decision;
- 3.) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;
- 4.) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
- 5.) A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);
- 6.) A statement that judicial review may be available to you; and
- 7.) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

2. External Review of Expedited Urgent Care Claims.

A. You may request an expedited external review if:

1. you receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
2. you receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Your request for an expedited external review of a non-standard claim should be made to the following appropriate **Plan designee**:

- The Utilization Management Program provider, with respect to a denied Urgent, Pre-service or Concurrent review determination not involving retail or mail order prescription drug expenses or behavioral health expenses;
- The Prescription Drug Program provider, with respect to a denied claim involving retail or mail order prescription drug expenses;

Contact information for the Utilization Management Program provider and the Prescription Drug Program provider, is identified in the Quick Reference Chart, as amended from time to time.

B. Preliminary Review for an Expedited Claim.

Immediately upon receipt of the request for expedited external review, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The Plan or appropriate Plan designee will immediately notify you (e.g. telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

C. Review of Expedited Claim by an Independent Review Organization (IRO).

Following the preliminary review that a request is eligible for expedited external review, the Plan or appropriate Plan designee will assign an IRO (following the process described under Standard Review above). The Plan or appropriate Plan designee will expeditiously (e.g. meaning via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of their final expedited external review decision, in accordance with the requirements, set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than **seventy-two (72) hours** after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

1. If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
2. If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim.

3. Overview of the Timeframes During the Federal External Review Process.

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
Claimant requests an external review (<i>generally after internal claim appeals procedures have been exhausted</i>)	Within 4 months after receipt of an Adverse Claim Benefit Determination (benefits denial notice)	After receipt of an Adverse Claim Benefit Determination (benefits denial notice)
Plan or appropriate Plan designee performs preliminary review	Within 5 business days following the Plan's or appropriate Plan designee's receipt of an external review request	Immediately
<ul style="list-style-type: none"> • Plan's or appropriate Plan designee's notice to claimant regarding the results of the preliminary review 	Within 1 business day after Plan's or appropriate Plan designee's completion of the preliminary review	Immediately
<ul style="list-style-type: none"> • When appropriate, claimant's timeframe for perfecting an incomplete external review request 	Remainder of the 4 month filing period or if later, 48 hours following receipt of the notice that the external review is incomplete	Expeditiously
Plan or appropriate Plan designee assigns case to IRO	In a timely manner	Expeditiously
Notice by IRO to claimant that case has been accepted for review along with the timeframe for submission of any additional information	In a timely manner	Expeditiously
Time period for the Plan or appropriate Plan designee to provide the IRO documents and information the Plan considered in making its benefit determination	Within 5 business days of assigning the IRO to the case	Expeditiously
Claimant's submission of additional information to the IRO	Within 10 business days following the claimant's receipt of a notice from the IRO that additional information is needed (IRO may accept information after 10 business days)	Expeditiously

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
IRO forwards to the Plan any additional information submitted by the claimant	Within 1 business day of the IRO's receipt of the information	Expediently
If (on account of the new information) the Plan reverses its denial and provides coverage, a Notice is provided to claimant and IRO	Within 1 business day of the Plan's decision	Expediently
External Review decision by IRO to claimant and Plan	Within 45 calendar days of the IRO's receipt of the request for external review	As expeditiously as the claimant's medical condition or circumstances require but in no event more than 72 hours after the IRO's receipt of the request for expedited external review. (If notice is not in writing, within 48 hours of the date of providing such non-written notice, IRO must provide written notice to claimant and Plan.)
Upon Notice from the IRO that it has reversed the Plan's Adverse Benefit Determination	Plan must immediately provide coverage or payment for the claim	Plan must immediately provide coverage or payment for the claim

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You or any other claimant may not start a lawsuit to obtain Plan benefits, including proceedings before administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal review procedures described in this document) **for every issue deemed relevant by the claimant**, or until after you have completed the Plan's claim appeal review procedures (described in this document) or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. No lawsuit may be started more than three (3) years after the end of the year in which services were provided.

DISCRETIONARY AUTHORITY OF THE PLAN ADMINISTRATOR AND ITS DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

FACILITY OF PAYMENT

If the Plan Administrator or its designee determines that you cannot submit a claim or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, Claims Administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

ELIMINATION OF CONFLICT OF INTEREST

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

ARTICLE 14: COORDINATION OF BENEFITS (COB)

Coordination of Benefits (COB) occurs when you have healthcare coverage under more than one Plan.

This Plan does not coordinate benefits with itself, meaning that medical plan options do not coordinate with other medical plan options offered under this Plan and dental plan options do not coordinate with other dental plan options offered under this Plan.

HOW DUPLICATE COVERAGE OCCURS

This chapter describes the circumstances when you or your covered dependents may be entitled to medical and/or dental benefits under this Plan and may also be entitled to recover all or part of your medical and/or dental expenses from some other source. It also describes the rules that apply when this happens.

There are several circumstances that may result in you and/or your covered dependents being reimbursed for your medical and/or dental expenses not only from this Plan but also from some other source. This can occur if you or a covered dependent is also covered by:

1. Another group health care plan; or
2. Medicare or some other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, or any coverage either provided by a federal, state or local government or agency, or any coverage required by federal, state or local law, including, but not limited to, any motor vehicle no-fault coverage for medical expenses or loss of earnings that is required by law; or
3. Workers' compensation.

Duplicate recovery of medical and/or dental expenses can also occur if a third party is financially responsible for your medical and/or dental expenses because that third party caused the injury or illness giving rise to those expenses by negligent or intentionally wrongful action.

This Plan operates under rules that prevent it from paying benefits that, together with the benefits from any other source described above, would allow you to recover more than 100% of medical and/or dental expenses you incur. In many instances, you may recover less than 100% of those medical and/or dental expenses from the duplicate sources of coverage or recovery.

In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when you or your covered dependent actually recover some or all of your losses from a third party.

COORDINATION OF BENEFITS (COB)

Coordination of Benefits or COB applies to members who are covered by more than one health care plan (meaning they have duplicate coverage). Coordinating benefits helps ensure that these members will receive the benefits they are entitled to while avoiding overpayment by either plan.

When a member is covered by more than one health plan (for example, when a spouse is covered under this group plan as well as under the spouse's own employer sponsored health plan), one plan is considered to be the primary payer and the other is considered to be the secondary payer. The primary payer covers the major portion of the bill according to that Plan's allowances, and the secondary payer covers some or all of the remaining allowable expenses.

Other types of duplicate coverage include but are not limited to Medicare, Medicaid, motor vehicle insurance, or third party liability insurance.

Members who are covered by more than one medical, dental or vision plan must let this Plan's Claims Administrators know about all the additional medical, dental and vision coverages they have. Please contact the Medical Plan Claims Administrator (contact information is on the Quick Reference Chart in the front of this document).

The COB provisions of each plan determine which plan is primary. Benefits are then coordinated among all of the health plans, and payments do not typically exceed 100% of charges for the covered services. In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when a member actually recovers some or all of their losses from a third party (see also the Third Party Liability provisions in this chapter).

For the purposes of this Coordination of Benefits chapter, the word “plan” refers to any group medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical or dental services incurred by the covered person or that provides medical or dental services to the covered person. A “group plan” provides its benefits or services to employees, retirees or members of a group who are eligible for and have elected coverage.

Many families that have more than one family member working outside the home are covered by more than one medical or dental plan. If this is the case with your family, you must let this Plan (or its insurer) know about **all** your coverages when you submit a claim.

Coordination of benefits operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental expenses incurred.** Sometimes, the combined benefits that are paid will be less than the total expenses.

WHICH PLAN PAYS FIRST

The Overriding Rules

This Plan **does not coordinate benefits with an individual plan**, including a plan purchased through the Health Insurance Marketplace.

- A. Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform set of order of benefit determination rules that are applied in the specific sequence outlined below. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules always pays its benefits first.**
- B. When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent/Dependent

The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the plan that covers the same person as a dependent pays second. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

- secondary to the plan covering the person as a dependent; and
- primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee);

then the order of benefits is reversed, so that the plan covering the person as a dependent pays first; and the plan covering the person other than as a dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

The plan that covers the parent whose birthday falls earlier in the year pays first; and the plan that covers the parent whose birthday falls later in the year pays second, if:

- the parents are married;
- the parents are not separated (whether or not they ever have been married); or
- a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second. The word “birthday” refers only to the month and day in a year; not the year in which the person was born.

If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does **not** apply in any year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

If the parents are not married, or are legally separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

- the plan of the custodial parent pays first;
- the plan of the spouse of the custodial parent pays second; and
- the plan of the non-custodial parent pays third; and
- the plan of the spouse of the non-custodial parent pays last.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as described in Rule 5 (the longer/shorter length of coverage) and if length of coverage is the same, then the birthday rule (Rule 2) applies between the dependent child's parents coverage and the dependent's self or spouse coverage. For example, if a married dependent child on this Plan is also covered as a dependent on the group plan of their spouse, this Plan looks to Rule 5 first and if the two plans have the same length of coverage, then the Plan looks to whose birthday is earlier in the year: the employee-parent covering the dependent or the employee-spouse covering the dependent.

Rule 3: Active/Laid-Off or Retired Employee

The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second. 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. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

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. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this Rule.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended. The start of a new plan does not include a change:

- in the amount or scope of a plan's benefits;
- in the entity that pays, provides or administers the plan; or
- from one type of plan to another (such as from a single employer plan to a multiple employer plan).

The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Rule 6: When No Rule Determines the Primary Plan

If none of the previous rules determines which plan pays first, each plan will pay an equal share of the expenses incurred by the covered person.

HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY

Secondary Liability of this Plan: When this Plan pays second, it will pay, 100% of “Allowable Expenses” less whatever payments were actually made by the Plan (or plans) that paid first. It will reduce its benefits so that the total benefits paid or provided by all coordinating plans, for each claim as it is processed, is not more than 100% of total allowable expenses and in no case will this Plan pay more in benefits than it would have paid had it been the Plan that paid first.

For this determination, allowable expense will mean the allowed charge for any necessary, item of expense, a part of which is covered under one of the plans of the individual for whom the claim is made. If a Preferred Provider Organization (PPO) discount is made by the primary carrier, this Plan, as secondary, will only allow payments up to the contracted PPO allowance.

ADMINISTRATION OF COB

To administer COB, the Plan reserves the right to:

- exchange information with other plans involved in paying claims;
- require that you or your health care provider furnish any necessary information;
- reimburse any plan that made payments this Plan should have made; or
- recover any overpayment from your hospital, Physician, dentist, other health care provider, other insurance company, you or your dependent.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount the Plan Administrator or designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the medical and/or dental expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB. If this Plan is secondary, this Plan will pay secondary medical benefits only when the coordinating primary plan pays medical benefits, and it will pay secondary dental benefits only when the primary plan pays dental benefits. This Plan will not pay secondary medical benefits when the coordinating primary plan pays dental benefits, nor will this Plan pay secondary dental benefits when the coordinating primary plan pays medical benefits.

If this Plan is secondary, and if the coordinating primary plan provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan only to the extent they would have been payable if this Plan were the primary plan.

COORDINATION WITH MEDICARE

A. Entitlement to Medicare Coverage:

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage usually after a waiting period.

B. Medicare Participants May Retain or Cancel Coverage Under This Plan:

If you, your covered Spouse or Dependent Child becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, you may either retain or cancel your coverage under this Plan. If you and/or any of your Dependents are covered by both this Plan and by Medicare, as long as you remain actively

employed, your Medical Expense Coverage will continue to provide the same Benefits and your contributions for that coverage will remain the same. In that case, this Plan pays first and Medicare pays second.

If you are covered by Medicare and you cancel your coverage under this Plan, coverage of your Spouse and/or your Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage if there has been a COBRA Qualifying Event. See the chapter on When Coverage Ends (COBRA) for further information about COBRA Continuation Coverage.

If any of your Dependents are covered by Medicare and you **cancel** that Dependent’s coverage under this Plan (such as at open enrollment time), that Dependent will **not** be entitled to COBRA Continuation Coverage since being dropped at open enrollment time is not a COBRA qualifying event.

The choice of retaining or canceling coverage under this Plan of a Medicare participant is yours, and yours alone. Neither this Plan nor a participating employer of the Trust will provide any consideration, incentive or benefits to encourage you to cancel coverage under this Plan.

C. Coverage Under Medicare and This Plan When You Are Totally Disabled:

If an employee becomes Totally Disabled and entitled to Medicare because of their disability, the employee will no longer be considered to remain actively employed. As a result, once the employee becomes entitled to Medicare because of their disability, Medicare pays first and this Plan pays second. Generally, if an eligible dependent under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, this Plan pays first for that dependent and Medicare pays second. This Medicare secondary payer rule applies to employers with 100 or more employees.

D. Coverage Under Medicare and This Plan When You Have End-Stage Renal Disease:

If, while you are actively employed, you or any of your covered Dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the **earlier** of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

E. Summary Chart on COB with Medicare:

If you are covered by Medicare and also have other group health plan coverage, the coordination of benefits (COB) rules are set by the Centers for Medicare & Medicaid Services (CMS). These COB rules are outlined below:

Summary of the Coordination of Benefits between Medicare and the Group Health Plan			
If you:	Condition	Pays First	Pays Second
Are covered by both Medicare and Medicaid	Entitled to Medicare and Medicaid	Medicare	Medicaid but only after other coverage such as a group health plan has paid
Are age 65 and older and covered by a group health plan because you are working or are covered by a group health plan of a working Spouse of any age	The employer has less than 20 employees	Medicare	Group health plan
	The employer has 20 or more employees	Group health plan	Medicare
Have an employer group health plan after you retire and are age 65 or older	Entitled to Medicare	Medicare	Group health plan (e.g. a retiree plan coverage)
Are disabled and covered by a large group health plan from your work or from a family member who is working	The employer has less than 100 employees	Medicare	Group health plan
	You are entitled to Medicare or the Employer has 100 or more employees	Group health plan	Medicare

Summary of the Coordination of Benefits between Medicare and the Group Health Plan			
If you:	Condition	Pays First	Pays Second
Have End-Stage Renal Disease (ESRD is permanent kidney failure) requiring dialysis or a kidney transplant and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group health plan	Medicare
	After 30 months	Medicare	Group health plan
Are covered under worker's compensation because of a job-related injury or illness	Entitled to Medicare	Workers' compensation for worker's compensation-related claims	Medicare
Have black lung disease and are covered under the Federal Black Lung Benefits Program	Entitled to Medicare and the Federal Black Lung Benefits Program	Federal Black Lung Benefits Program for black lung-related claims	Medicare
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or Liability insurance, for the accident-related claims	Medicare
Are a Veteran and have Veterans' benefits	Entitled to Medicare and Veterans' benefits	Medicare pays for Medicare-covered services Veterans' Affairs pays for VA authorized services. Generally, Medicare and VA cannot pay for the same service.	Usually does not apply
Are covered under TRICARE	Entitled to Medicare and TRICARE	Medicare pays for Medicare-covered services. TRICARE pays for services from a military hospital or any other federal provider.	TRICARE may pay second
Are age 65 or over <u>OR</u> , are disabled and covered by both Medicare and COBRA	Entitled to Medicare	Medicare	COBRA
Have End-Stage Renal Disease (ESRD) and COBRA	First 30 months of eligibility or entitlement to Medicare	COBRA	Medicare
	After 30 months	Medicare	COBRA
See also : http://www.medicare.gov/Publications/Pubs/pdf/02179.pdf or 1-800-Medicare for more information			

F. How Much This Plan Pays When It Is Secondary to Medicare:

- 1. When the Plan Participant Is Covered by this Plan and by Medicare Parts A and B:** When the plan participant is covered by Medicare Parts A and B and also by this plan, this plan is secondary to Medicare and this Plan pays the same benefits provided for active employees less any amounts paid by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the Usual and Customary Charges of the Health Care Provider.
- 2. When the Plan Participant Is Covered by this Plan and by Medicare Advantage (formerly called Medicare + Choice or Part C):** This Plan provides benefits that supplement the benefits you receive from Medicare Part A and B coverage. If a Plan Participant is covered by this Plan and also by a Medicare Advantage Plan and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services In-Network when the Medicare Advantage program requires it, this Plan will reimburse all applicable copayments and will pay the same benefits provided for active employees less any amounts paid by the Medicare Advantage program. However, if the Plan Participant doesn't comply with the rules of the Medicare Advantage program, including without

limitation, approved referral, preauthorization, or case management requirements, this Plan will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the Plan Participant receives.

3. **When the Plan Participant Is Not Covered by Medicare:** If the Plan Participant is eligible for, but is not enrolled in, Medicare, this Plan pays the same benefits provided for active employees less the amounts that would have been paid by Medicare had the Plan Participant been covered by Medicare Parts A and B and not on the Usual and Customary Charges of the Health Care Provider.
4. **When the Plan Participant Enters Into a Medicare Private Contract:** Under the law, a Medicare participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare participant enters into such a contract and is also an eligible person under this Plan, this Plan will pay benefits for health care services and/or supplies the Medicare participant receives pursuant to it, but those benefits will be subject to all of the Plan's terms and provisions, including those relating to exclusions, Medical Necessity, Allowed Charges, and Utilization Management.
5. **When Covered by this Plan and also by a Medicare Part D Plan such as a Prescription Drug Plan:** If you have dual coverage under both this Plan and Medicare Part D, the following explains how this Plan and Medicare will coordinate that dual coverage:
 - For Medicare eligible Active Employees and non-Medicare eligible Retirees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage is secondary.

For more information on Medicare Part D refer to www.medicare.gov or contact your Human Resource Department.

MEDICAID: If you are covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second.

TRICARE: If you are covered by both this Plan and TRICARE, this Plan pays first and TRICARE pays second.

SERVICES RECEIVED IN A U.S. DEPARTMENT OF VETERANS AFFAIRS FACILITY: If you receive services in a U.S. Department of Veterans Affairs hospital or facility on account of a military service-related illness or injury, benefits are not payable by this Plan. If you receive services in a U.S. Department of Veterans Affairs hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by this Plan to the extent those services are medically necessary and the charges are reimbursed in accordance with the out-of-network provisions of this Plan.

MOTOR VEHICLE NO-FAULT COVERAGE REQUIRED BY LAW: If you are covered for medical and/or dental benefits by both this Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this Plan pays second. If you are covered for loss of earnings by both this Plan and any motor vehicle no-fault coverage that is required by law, the benefits payable by this Plan on account of disability (College and County employees only) will be reduced by the benefits available to you for loss of earnings related to the motor vehicle no-fault coverage.

INDIAN HEALTH SERVICES (IHS): If an individual is covered by both this Plan and Indian Health Services, this Plan pays first and Indian Health Services pays second.

OTHER COVERAGE PROVIDED BY STATE OR FEDERAL LAW: If you are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

WORKERS' COMPENSATION: This Plan does **not** provide benefits if the medical or dental expenses are covered by workers' compensation or occupational disease law. If the participating employer of the Trust contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, you and/or your covered dependent must execute a reimbursement agreement acceptable to the Plan Administrator or its designee.

THIRD PARTY LIABILITY

“Advance” Payment Prior to Determination of Responsibility of a Third Party

The Plan does not cover expenses for services or supplies for which a third party pays or is liable to pay due to any recovery whether by settlement, judgment or otherwise. See the General Exclusions section of the Medical Exclusions chapter. However, subject to the terms and conditions of this chapter, the Plan will advance payment on account of Plan benefits (an “Advance”) subject to its right to be reimbursed to the full extent of any Advance payment from the covered Employee (and/or a representative, guardian, conservator, or trustee of the Covered Individual) and/or Dependent(s) if and when there is any recovery from any third party.

The right of reimbursement will apply:

1. even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical or dental expenses for which the Advance was made; and
2. even if the recovery is not sufficient to make the ill or injured employee and/or dependent(s) whole pursuant to state law or otherwise (sometimes referred to as the “make-whole” rule); and
3. without any reduction for legal or other expenses incurred by the employee and/or dependent(s) in connection with the recovery against the third party or that third party’s insurer pursuant to state law or otherwise (sometimes referred to as the “common fund” rule); and
4. regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the “collateral source” rule);
5. even if the recovery was reduced due to the negligence of the covered Employee or covered Dependent (sometimes referred to as “contributory negligence”) or any other common law defense.

Reimbursement Agreement

Every covered individual on whose behalf an Advance on account of Plan benefits is made must sign/execute and deliver any and all reimbursement agreements, instruments and papers requested by or on behalf of the Plan, and must do whatever is necessary to protect all of the Plan’s reimbursement rights. As a condition precedent to the advance on account of Plan benefits by the Plan, all covered individuals will, upon written request, execute a reimbursement agreement in a form provided by or on behalf of the Plan.

If the covered individual is a minor or is otherwise incompetent to execute a reimbursement agreement, that person’s parent (in the case of a minor) or spouse or legal representative (in the case of an incompetent adult) will execute the agreement on request by or on behalf of the Plan.

If any covered individual, or that individual’s parent, spouse or legal representative, does not execute any such reimbursement agreement for any reason, that failure to execute the agreement will **not** waive, compromise, diminish, release, or otherwise prejudice any of the Plan’s reimbursement rights if the Plan, at its discretion, makes an advance on account of Plan Benefits in the absence of a reimbursement agreement.

Cooperation with the Plan by All Covered Individuals

By accepting an Advance, regardless of whether or not an Agreement has been executed, every covered individual agrees:

1. to reimburse the Plan for all amounts paid or payable to the covered Employee and/or covered Dependent(s) or that third party’s insurer for the entire amount Advanced; and
2. that the Plan has the first right of reimbursement from any judgment or settlement including priority over any claim for non-medical charges, attorneys’ fees or other costs and expenses; and
3. to do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan’s reimbursement rights; and
4. to not assign the right of recovery to any third party without the specific consent of the Plan;
5. to inform the Plan in writing if a covered Employee and/or covered Dependent(s) were injured by a third party and, within seven (7) days of such injury, provide information to the Plan Administrator;
6. to notify and consult with the Plan Administrator or designee before starting/initiating any legal action or administrative proceeding against a third party alleged to be responsible for the injury or illness that resulted in

the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts; and

7. to inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

Application to any Fund

The Plan's right to reimbursement shall apply to any fund, account or other asset created:

1. pursuant to the judgment of any court awarding damages against any third party in favor of the ill or injured Employee and/or Dependent(s) payable by any third party on account of an illness or injury alleged to have been caused by that third party; or
2. as a result of any settlement paid by any third party on account of any claim by or on behalf of the ill or injured Employee and/or Dependent(s).

Lien and Segregation of Recovery

By accepting the Advance the covered Employee and/or covered Dependent agrees to the following:

1. The Plan will automatically have an equitable lien, to the extent of the Advance, upon any recovery, whether by settlement, judgment or otherwise, by the covered Employee and/or covered Dependent. The Plan's lien extends to any recovery from the third party, the third party's insurer, and the third party's guarantor and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health insurance or other policy. The Plan's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.
2. The Plan holds in a constructive trust that portion of the recovery that is the extent of the Advance. The covered Employee, covered Dependent, and those acting on their behalf, shall place and maintain such portion of any recovery in a separate segregated account until the reimbursement obligation to the plan is satisfied. The location of the account and the account number must be provided to the Plan.
3. Should the covered Employee, covered Dependent or those acting on their behalf, fail to maintain this segregated account or comply with any of the Plan's reimbursement requirements, they stipulate to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Plan receives all amounts that must be reimbursed. Such remedy shall be in addition to any other available remedies under the terms of the Health Plan and applicable law.

Remedies Available to the Plan

In addition to the remedies discussed above, if the covered Employee or covered Dependent(s) does not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

1. apply any future Plan benefits that may become payable on behalf of the covered Employee and/or covered Dependent(s) to the amount not reimbursed; or
2. garnish or attach the wages or earnings of the covered Employee and/or covered Dependent(s); or
3. institute legal action to obtain a judgment against the covered Employee and/or covered Dependent(s) for the amount Advanced and not reimbursed. In such event, the covered Employee and/or covered Dependent(s) shall be liable for the amount Advanced as well as all of the Plan's costs of collection, including reasonable attorney fees and costs.

The Plan has six (6) years to seek reimbursement for all or part of an Advance received by a covered Employee and/or covered Dependent(s) because of any injury caused by a third party, and for which a covered Employee and/or Dependent or their counsel was awarded or received a monetary settlement from such injury from a court judgment, arbitration award, settlement or any other arrangement. The six year timeframe begins from the date the Plan discovers that a covered Employee, covered Dependent(s) or their legal counsel was awarded or received such monetary recovery.

ARTICLE 15: COBRA CONTINUATION OF COVERAGE

EXTENSION AND CONTINUATION OF COVERAGE IN GENERAL

Your Plan does **not** provide Plan benefits for any health care coverage (medical, dental or vision) expenses) incurred **after** coverage ends. However, under certain circumstances, your health care coverage may be continued for a limited, temporary period of time.

This chapter explains when and how this temporary continuation of coverage occurs. Contact your Human Resource Department for more information.

Continuation of coverage applies only to the type of health care coverage you had in effect on the date you lost such coverage and does **not** apply to life insurance, accidental death and dismemberment insurance, short term disability benefits (College, County and City employees only), long term disability benefits or other income replacement coverages.

CONTINUATION OF COVERAGE (COBRA)

Entitlement to COBRA Continuation Coverage: In compliance with a federal law commonly called COBRA, this Plan offers its eligible employees, and their covered Dependents (called “Qualified Beneficiaries” by the law) the opportunity to elect a temporary continuation of the group health coverage (“COBRA Continuation Coverage”) sponsored by the Trust, including medical, dental and/or vision coverages, (the “Plan”), when that coverage would otherwise end because of certain events (called “Qualifying Events” by the law).

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense. Initial election of COBRA coverage is extended only for those health care coverages in effect for the individual on the date coverage ended under the group health plan.

Alternatives to COBRA:

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov.

Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

COBRA Administrator: The name, address and telephone number of the COBRA Administrator responsible for the administration of COBRA, and to whom you can direct questions about COBRA, is shown in the Quick Reference Chart in the front of this document.

IMPORTANT:

This chapter serves as a notice to summarize your rights and obligations under the COBRA continuation coverage law. It is provided to all covered employees and their covered spouses and is intended to inform them (and their covered dependents, if any) in a summary fashion of their rights and obligations under the continuation provisions of the federal law. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that you and your spouse take the time to read this notice carefully and be familiar with its contents.

Who Is Entitled to COBRA Continuation Coverage, When and For How Long

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event, that person’s health care coverage ends, either as of the date of the Qualifying Event or as of some later date. A parent or legal guardian may elect COBRA for a minor child.

A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment.

1. **“Qualified Beneficiary”:** Under the law, a Qualified Beneficiary is any Employee or the Spouse or Dependent Child of an employee who was covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered employee during a period of COBRA Continuation Coverage is also a Qualified Beneficiary. A person who becomes the new spouse of an existing COBRA participant during a period of COBRA Continuation Coverage is not a Qualified Beneficiary.
2. **“Qualifying Event”:** Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan.** If a covered individual has a qualifying event but does not lose their health care coverage under this Plan, (e. g. employee continues working even though entitled to Medicare) then COBRA is not yet offered.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries ¹		
	Employee	Spouse	Dependent Child(ren)
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for health care coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months

1: When a covered employee’s qualifying event (i.e. termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the employee’s covered spouse and dependent children who are Qualified Beneficiaries (but not the employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.

Special Enrollment Rights

You have special enrollment rights under federal law that allows you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of the qualifying events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date of the loss of Plan coverage. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (described in another section of this chapter on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on “Early Termination of COBRA Continuation Coverage” that appears later in this chapter.

Medicare Entitlement

A person becomes entitled to Medicare on the first day of the month in which he or she attains age 65, but only if he or she submits the required application for Social Security retirement benefits within the timeperiod prescribed by law. A person may also become entitled to Medicare on the first day of the 30th month after the date on which he or she was determined by the Social Security Administration to be totally and permanently disabled so as to be entitled to Social Security disability income benefits.

Procedure on When the Plan Must Be Notified of a Qualifying Event (Very Important Information)

In order to have the chance to elect COBRA Continuation Coverage after loss of coverage due to these events: after a divorce, legal separation, or a child ceasing to be a “dependent child” under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that event occurs.**

That notice should be sent to the COBRA Administrator whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail or be hand-delivered and is to include your name, the qualifying event, the date of the event, and appropriate documentation in support of the qualifying event, such as divorce documents.

NOTE: If such a notice is not received by the COBRA Administrator within the 60-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.

Officials of the employee’s own employer should notify the COBRA Administrator of an employee’s death, termination of employment, reduction in hours, or entitlement to Medicare. However, **you or your family should also promptly notify the COBRA Administrator in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Notices Related to COBRA Continuation Coverage

When:

- a. **your employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to coverage under the Plan, you died, have become entitled to Medicare, or
- b. **you notify the COBRA Administrator** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

then the COBRA Administrator will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. Failure to notify the Plan in a timely fashion may jeopardize an individual’s rights to COBRA coverage. Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice, to elect COBRA Continuation Coverage.

NOTE: If you and/or your covered dependents do not choose COBRA coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.

The COBRA Continuation Coverage That Will Be Provided

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on Paying for COBRA Continuation Coverage that appears later in this chapter for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

When COBRA continuation coverage of your participation in the health care flexible spending account is available, it will be on the same terms outlined above for group health coverage, but since the person who elects COBRA will no longer be employed by a participating employer of the Trust, it will not be possible to make contributions to the health care flexible spending account on a before-tax basis.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

By law, any person who elects COBRA Continuation Coverage will have to pay the full cost of the COBRA Continuation Coverage. The Trust is permitted to charge the full cost of coverage for similarly situated active employees and families (including both the Trust’s and employee’s share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50%

applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

IMPORTANT

You are responsible for making sure that timely COBRA premium payments are made to the COBRA Administrator.

Health Coverage Tax Credit (HCTC)

The Trade Act of 2002 created a tax credit (called the Health Coverage Tax Credit or HCTC) for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance including COBRA. While the HCTC expired on January 1, 2014, it was reinstated to be effective for coverage periods through 2019. For more information, visit, www.irs.gov/HCTC.

Grace Periods

The initial payment for the COBRA Continuation Coverage is due to the COBRA Administrator **45 days** after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect.

After the initial COBRA payment, **subsequent payments** are due on the first day of each month, but there will be a **30-day grace period** to make those payments. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

For Monthly Payments, What If The Full COBRA Premium Payment Is Not Made When Due?

If the COBRA Administrator receives a COBRA premium payment that is not for the full amount due, the COBRA Administrator will determine if the COBRA premium payment is short by an amount that is significant or not. A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall exceeds the lesser of \$50 or 10% of the required COBRA premium payment.

If there is a **significant shortfall** then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made.

If there is not a significant shortfall, the COBRA Administrator will notify the Qualified Beneficiary of the deficiency amount and allow a reasonable period of 30 days to pay the shortfall.

- If the shortfall is paid in the 30-day time period then COBRA continuation coverage will continue for the month in which the shortfall occurred.
- If the shortfall is not paid in the 30-day time period then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made (which may result in a mid-month termination of COBRA coverage).

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage and you, your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** you, your Spouse or Dependent Child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will

terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Addition of Newly Acquired Dependents

If, while you (the employee) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the COBRA Administrator to add a dependent.

Loss of Other Group Health Plan Coverage

If, while you (the employee) are enrolled for COBRA Continuation Coverage your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the spouse or dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a qualifying event but the COBRA Administrator determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

A spouse and dependent children who already have COBRA coverage, and then experience a second qualifying event, may be entitled to extend COBRA, from 18 or 29 months, to a total of 36 months of COBRA coverage. Second qualifying events may include the death of the covered employee, divorce or legal separation from the covered employee, the covered employee becoming entitled* to Medicare benefits (under Part A, Part B or both), or a dependent child ceasing to be eligible for coverage as a dependent under the group health plan.

Medicare entitlement is not a qualifying event under the Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for spouses and dependents who are qualified beneficiaries.

Notifying the Plan: To extend COBRA when a second qualifying event occurs, you must notify the COBRA Administrator in writing within 60 days of a second qualifying event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail or be hand-delivered and is to include your name, the second qualifying event, the date of the second qualifying event, and appropriate documentation in support of the second qualifying event, such as divorce documents.

This extended period of COBRA Continuation Coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. This extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the 18-month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period

of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

Extended COBRA Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period

If, at any time during or before the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child become totally and permanently disabled so as to be entitled to Social Security Disability Income benefits (SSDI), the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

1. This extension is available only if:
 - the Social Security Administration determines that the individual's disability began no later than 60 days after the termination of employment or reduction in hours; **and**
 - the disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.

Notifying the Plan: you or another family member follow this procedure (to notify the Plan) by sending a written notification to the COBRA Administrator of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail or be hand-delivered and is to include your name, the name of the disabled person, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the COBRA Administrator before the end of the 18-month COBRA Continuation period.

2. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage will be higher (50% higher) than the cost for that coverage during the 18-month period.
3. The COBRA Administrator must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

Early Termination of COBRA Continuation Coverage

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

1. The date on which employee's employer no longer provides group health coverage to any of its employees;
2. The first day of the time period for which the amount due for the COBRA Continuation Coverage is not paid in full and on time;
3. The date, after the date of the COBRA election, on which the covered person first becomes entitled to Medicare;
4. The date, after the date of the COBRA election, on which the covered person first becomes covered under another group health plan. **IMPORTANT:** The Qualified Beneficiary must notify this Plan as soon as possible once they become aware that they will become covered under another group health plan, by contacting the COBRA Administrator;
5. The date the Plan has determined that the covered person must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan);
6. During an extension of the maximum coverage period to 29 months due to the disability of the covered person, the disabled person is determined by the Social Security Administration to no longer be disabled.

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a qualified beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the qualifying event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the qualified beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the COBRA Administrator determines that COBRA coverage will terminate early. Once COBRA coverage terminates early it cannot be reinstated.

No Entitlement to Convert to an Individual Health Plan after COBRA Ends

There is no opportunity to convert to an individual health plan after COBRA ends under this Plan.

COBRA Questions or To Give Notice of Changes in Your Circumstances

If you have any questions about your COBRA rights, please contact the COBRA Administrator whose address is listed on the Quick Reference Chart in the front of this document. **Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you must notify the COBRA Administrator:**

- within 31 days of a **change in marital status (e.g. marry, divorce)**; or have a **new dependent child**; or
- within 60 days of the date you or a covered dependent spouse or child has been determined to be **totally and permanently disabled** by the Social Security Administration; or
- within 60 days if a covered child **ceases to be a “dependent child”** as that term is defined by the Plan; or
- promptly if an individual has **changed their address, becomes entitled to Medicare, or is no longer disabled**.

Brief Outline on How Certain Laws Interact with COBRA

FMLA and COBRA

Taking a leave under the Family & Medical Leave Act (FMLA) is not a COBRA qualifying event. A qualifying event can occur **after** the FMLA period expires, **if** the employee does not return to work and thus loses coverage under their group health plan. Then, the COBRA period is measured from the date of the qualifying event—in most cases, the last day of the FMLA leave. Note that if the employee notifies the employer that they are not returning to employment prior to the expiration of the maximum FMLA 12-week period, a loss of coverage could occur earlier.

Leave of Absence (LOA) and COBRA

If an employee is offered alternative health care coverage while on LOA, and this alternate coverage is **not identical** in cost (increase in premium), or benefits to the coverage in effect on the day before the LOA, then such alternate coverage does not meet the COBRA requirement, and is considered to be a loss in coverage requiring COBRA to be offered.

If a qualified beneficiary rejects the COBRA coverage, the alternative plan is considered to be a different group health plan and, as such, after expiration of the LOA, no COBRA offering is required. If the alternative coverage is identical in cost and benefits but the coverage period is **less than** the COBRA maximum period (18, 29, 36 months), the lesser time period can be credited toward covering the 18, 29, or 36 month COBRA period. For example, if an employee is allowed to maintain the same coverage and premium for six months while on an LOA, the six months can be credited toward the COBRA maximum period.

Appealing an Adverse Determination Related to COBRA

If an individual receives an adverse determination (denial) related to a request for eligibility for COBRA (such as with a Notice of Unavailability of COBRA), a request for extension of COBRA for a disability, a request for extension of COBRA for a second qualifying event, or a notice of early termination of COBRA, the individual is permitted to appeal to the Plan. To request an appeal, follow this process:

- a) Send a written request for an appeal to the COBRA Administrator within 60 days of the date you received the adverse determination letter.

- b) Explain why you disagree with the adverse determination.
- c) Provide any additional information you want considered during the appeal process.
- d) Include the most current name and address of each individual affected by the adverse determination.

The COBRA Administrator will respond in writing to this appeal within 60 days of the Plan's receipt of the request for appeal. The appeal response will be sent to the address provided by the individual. This concludes the COBRA appeal process.

Note that a claim for reimbursement of health expenses would follow the claim appeal processes outlined in the Claim Filing and Appeals Information chapter of this document.

ARTICLE 16: OTHER INFORMATION

PLAN AMENDMENTS OR TERMINATION

Yavapai Combined Trust reserves the right to amend or terminate this Plan, or any part of it, at any time. Amendments may be made in writing by the Board of Trustees and become effective on the written approval of the Board of Trustees, or on such other date as may be specified in the document amending the Plan. The Plan or any coverage under it may be terminated by its Board of Trustees and new coverages may be added by its Board of Trustees.

DISCRETIONARY AUTHORITY OF THE PLAN ADMINISTRATOR AND ITS DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, will have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

NO LIABILITY FOR PRACTICE OF MEDICINE

The Plan, Plan Administrator or any of their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

INFORMATION YOU OR YOUR DEPENDENTS MUST FURNISH TO THE PLAN

In addition to information you must furnish in support of any claim for Plan benefits under this Plan, you or your covered dependents must furnish, **preferably within 31 days but no later than 60 days after the event**, any information you or they may have that may affect eligibility for coverage under the Plan. This includes, but is not limited to:

1. Change of name and/or address.
2. Proof of marriage, divorce, or death of you or any covered spouse or dependent child.
3. Any information regarding the status of a dependent child, including, but not limited to the dependent child reaching the Plan's limiting age; or the existence of or resolution of any physical or mental Disability.
4. Medicare enrollment or disenrollment.
5. The existence of other medical or dental coverage.

YOUR CONTRIBUTIONS FOR COVERAGE

If you are eligible for and wish to be covered by this Plan, you may be required to make a contribution for each of the benefits you choose to be covered under. These coverages include medical, dental, vision and prescription drugs. The decision regarding how much contribution is required is made by your participating employer, not by the Trust.

HEADINGS DO NOT MODIFY PLAN PROVISIONS

The headings of chapters and any subheadings (appearing in **BOLD** text with solid capital letters), sections, paragraphs and subparagraphs (appearing in **Bold** text with upper and lower case letters) are included for the sole purpose of generally identifying the subject matter of the substantive text so that a table of contents can be constructed for the convenience of the reader. The headings are **not** part of the substantive text of any provision, and they should not be construed to modify the text of any substantive provision in any way.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 14, 2003, a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like the Yavapai Combined Trust (YCT) (hereafter referred to in this section as the “Plan”), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term “**Protected Health Information**” (**PHI**) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- **PHI does not include** health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical leave (FMLA), etc.

A complete description of your rights under HIPAA can be found in the Plan’s Notice of Privacy Practices, which was previously distributed to you upon enrollment in the Plan and is available from your Human Resource Department. Information about HIPAA in this document is not intended and cannot be construed as the Plan’s Notice of Privacy Practices.

The Plan, and the Plan Sponsor (the Board of Trustees of the Yavapai Combined Trust), will not use or further disclose information that is protected by HIPAA (“protected health information or PHI”) except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.**

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim or for other reasons related to the administration of the Plan.

A. **The Plan’s Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

- **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.
- **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:
 - a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual’s claim), and establishing employee contributions for coverage;
 - b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing;
 - c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization review, including precertification, concurrent review and/or retrospective review.
- **Health Care Operations** includes, but is not limited to:
 - a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;
 - b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions,

- c. Underwriting, (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,
 - d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
 - e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.
- B. When an Authorization Form is Needed:** Generally the Plan will require that you sign a valid authorization form (available from your Human Resource Department) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.
- C. The Plan will disclose PHI to the Plan Sponsor only** upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:
- 1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law,
 - 2. Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.
 - 3. Not use or disclose the information for employment-related actions and decisions,
 - 4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices).
 - 5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
 - 6. Make PHI available to the individual in accordance with the access requirements of HIPAA,
 - 7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
 - 8. Make available the information required to provide an accounting of PHI disclosures,
 - 9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA, and
 - 10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction if feasible.
 - 11. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.
- D. In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained** in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:
- 1. Benefits staff designated by the Plan Administrator;
 - 2. Business Associates under contract to the Plan including but not limited to the medical claims administrator, medical preferred provider network, prescription drug program, and utilization management program.

The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer(s) whose address and phone number are listed on the Quick Reference Chart in the front of this document.

- E. **Effective April 21, 2005 in compliance with HIPAA Security regulations**, the Plan Sponsor will:
1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
 2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
 3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
 4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.
- F. **Hybrid Entity:** For purposes of complying with the HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions. The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the self-funded medical plan options, self-funded dental plan options, self-funded vision plan options, COBRA administration and Health Flexible Spending Account (FSA) administration.

ARTICLE 17: DEFINITIONS

The following are definitions of specific terms and words used in this document. These definitions do not, and should not be interpreted to, extend coverage under the Plan. Certain definitions pertaining to claims administration and claim appeals are found in Article 13 in this document.

Abutment: A tooth or root that retains or supports a fixed or removable bridge.

Accident: A sudden and unforeseen event as a result of an external or extrinsic source, that is not work related.

Active Course of Orthodontia Treatment: The period beginning when the first orthodontic appliance is installed and ending when the last active appliance is removed.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, taking drugs or medicines that can be self-administered.

Allowed Charge/Allowed Expense/Allowable Charge/Expense: means the amount this Plan allows as payment for eligible covered medically necessary services or supplies. The allowed charge amount is determined by the Plan Administrator or its designee to be the **lowest** of:

1. **With respect to a network provider** (PPO network Health Care or Dental Care provider/facility), the fee set forth in the agreement between the PPO network Health Care or Dental Care Provider/facility and the PPO network or the Plan; **or**
2. **With respect to an out-of-network provider**, allowed charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible medically necessary services or supplies performed by out-of-network providers. The Plan's allowed charge amount list is **not** based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR) or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. See also the definition of Balance Billing in this chapter; **or**
3. For an In-Network health care provider/facility whose network contract stipulates that they do not have to accept the network discount for **claims involving a third party payer**, including but not limited to auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the allowed charge amount under this Plan is the discounted fee that would have been payable by the Plan had the claim been processed as an In-Network claim; **or**
4. The Health Care or Dental Care Provider's/facility's actual billed charge.

The Plan will not always pay benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the "allowed charge" amount for health care services or supplies.

Any amount in excess of the "allowed charge" amount does not count toward the Plan's annual Out-of-Pocket limit. Participants are responsible for amounts that exceed "allowed charge" amounts by this Plan.

- In the case where the PPO allowed charge amount on an eligible claim exceeds the actual billed charges, the participant will pay their coinsurance on the lesser amount, the billed charges, and the Plan will pay their coinsurance on the PPO allowed charge amount, plus, the Plan will pay the participant's additional coinsurance responsibility on the difference in the PPO allowed charge amount versus the actual billed charges.

For the HDHP Plan, in accordance with federal law, with respect to emergency services performed in an Out-of-Network Emergency Room (ER), the Plan's allowance for ER visit facility fees is to pay the **greater** of:

- the negotiated amount for In-Network providers (the median amount if more than 1 amount to In-Network providers), or
 - 100% of the Plan's usual payment (Allowed Charge) formula (reduced for cost-sharing) or
 - (when such database is available), the amount that Medicare Parts A or B would pay (reduced for cost-sharing).
- See the definition of **emergency services** in this chapter.

Allowable Expense: A health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering a Plan participant, except as otherwise provided by the terms

of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by this Plan is not an allowable expense.

Ambulance: A legally licensed vehicle, helicopter, or airplane certified for emergency patient transportation.

Ambulatory Surgical Facility: A public or private surgical facility, either freestanding or hospital-based, licensed and operated according to law, that does not provide services for a patient to stay overnight, and that admits and discharges patients from the facility on the same day. The facility must have an organized medical staff of Physicians; and maintain permanent facilities equipped and operated primarily for performing ambulatory surgical procedures; and provide registered professional nursing services whenever a patient is in the facility.

Amendment (Amend): A formal document signed by the representatives of the Yavapai Combined Trust. The amendment adds, deletes or changes the provisions of the Plan and applies to all covered persons, including those persons covered before the amendment becomes effective, unless otherwise specified.

Ancillary Services: Services provided by a hospital or other specialized health care facility other than room and board; including, but not limited to, use of the operating room, recovery room, intensive care unit, etc.; and laboratory and x-ray services, drugs and medicines; and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (general anesthesia) or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Appliance (Dental): A device to provide or restore function or provide therapeutic (healing) effect. **Fixed Appliance:** A device that is cemented to the teeth or attached by adhesive materials. **Prosthetic Appliance:** A removable device that replaces a missing tooth or teeth.

Applied Behavioral Analysis (ABA) Therapy: is the design, implementation, and evaluation of environmental modifications to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior. ABA strives to improve speech and social interaction skills and reduce disruptive behavior and includes instruction in a range of skills including speech, motor and socialization. Applied Behavior Analysis Therapy is not a covered benefit.

Balance Billing: A bill from a Health Care Provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the provider actually charged (the billed charges). Amounts associated with balance billing **are not covered** by this Plan, even if the Plan's annual Out-of-Pocket Limit is reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Allowed Charge. Remember, amounts exceeding the Allowed Charge do not count toward the Plan's annual Out-of-Pocket Limit and may result in balance billing to you. **Out-of-Network Health Care Providers commonly engage in balance billing.** Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the plan's payment for a covered service. Generally, you can avoid balance billing by using In-Network providers for covered services. Typically, In-Network providers do not balance bill except in situations of third party liability claims. **Generally, you can avoid balance billing by using In-Network providers.**

Behavioral Health Disorders: Behavioral Health is an umbrella term that refers to mental health and/or substance use/abuse. Disorders, conditions and diseases as defined within the mental disorders section of the current edition of the Diagnostic and Statistical Manual (DSM), which includes, among other things, depression, schizophrenia, and substance abuse. Certain behavioral health disorders, conditions and diseases are specifically excluded from coverage in the Medical Exclusions chapter of this document. See also the definition of Substance Abuse.

Behavioral Health Practitioners: A psychiatrist, psychologist, certified mental health or substance abuse counselor, social worker, or anyone else who is legally licensed and/or legally authorized to practice or provide service, care or treatment of behavioral health disorders and/or substance abuse disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Behavioral Health Treatment Facility: A public or private facility, licensed and operated according to law, that provides a program for diagnosis, evaluation, and effective treatment of behavioral health disorders. The facility

must have at least one Physician on staff or on call; and provide skilled nursing care by licensed nurses under the direction of a full-time registered nurse (RN); and prepare and maintain a written plan of treatment for each patient, which plan must be based on the medical, psychological and social needs of the patient.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the PPO allowable fee schedule or Allowed Charge (for non-PPO providers or dental services), after calculation of all deductibles, coinsurance and copayments, and after determination of the Plan's exclusions, limitations and maximums.

Birthing Center: A public or private facility, licensed and operating according to law, other than private offices or clinics of Physicians, that meets the freestanding birthing center requirements of the Department of Health in the state where the covered person receives the services. The birthing center must provide:

1. a facility that has been established, equipped and operated for the purpose of providing prenatal care, delivery, immediate postpartum care, and care of a child born at the center; and
2. supervision by at least one Physician who is a specialist in obstetrics and gynecology; and
3. a Physician or certified nurse midwife at all births and immediate postpartum period; and
4. extended staff privileges to Physicians who practice obstetrics and gynecology in an area hospital; and
5. at least two beds or two birthing rooms; and
6. full-time nursing services directed by a registered nurse or a certified nurse midwife; and
7. arrangements for diagnostic x-rays and laboratory services; and
8. the capacity to administer local anesthesia and to perform minor surgery.

In addition, the facility must accept only patients with low-risk pregnancies; and have a written agreement with a hospital for emergency transfers; and maintain medical records on each patient and child.

Bitewing X-Rays: Dental x-rays showing the coronal (crown) halves of the upper and lower teeth when the mouth is closed.

Bridge, Bridgework: Fixed: A prosthesis that replaces one or more teeth and is cemented in place to existing abutment teeth. It consists of one or more pontics and one or more retainers (crowns or inlays). The patient cannot remove the prosthesis. **Removable:** A prosthesis that replaces one or more teeth and which is held in place by clasps. The patient can remove the prosthesis. See also definition of Partial Denture.

Buccolingual: A dental term referring to the surfaces of a tooth facing the cheek or mouth (buccal) and the tongue (lingual).

Bone Density test: A Bone density test is often used to screen for and detect the early stages of osteoporosis, a condition defined by a decreased density of normal bone that puts you at risk for fractures. Currently, the most commonly used techniques for determining bone density is an xray of the spine and hip called single-energy x-ray densitometry and dual-energy X-ray densitometry (SXA or DEXA). The bone density test compares a person's bone density to what is expected in someone of a similar age, sex and size.

Case Management: A process, administered by the Utilization Management Company, in which its medical professionals work with the patient, family, caregivers, health care providers, Claims Administrator and the Trust to coordinate a timely and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential health care providers.

Chemical Dependency: See the definitions of Behavioral Health Disorders and Substance Abuse.

Child(ren): See the definition of Dependent Child(ren).

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Claims Administrator: A person or company retained by the Plan to administer the claim payment responsibilities of the Plan.

Coinsurance: That portion of eligible health care expenses for which the covered employee has financial responsibility. In most instances, you are responsible for paying a percentage of covered medical or dental expenses

in excess of the Plan's deductible, but in some instances, you are responsible for paying a higher percentage of those expenses, and in other instances, no coinsurance applies.

Concurrent Review: A managed care program designed to assure that hospitalization and specialized health care facility admissions and length of stay, surgery and other health care services are medically necessary by having the Utilization Management Company conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or specialized health care facility.

Convalescent Care Facility: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan benefits are payable when a person is covered by this Plan and another employer-sponsored health care plan or Medicare or worker's compensation, etc. See the Coordination of Benefits chapter that sets forth the Plan's COB rules and procedures.

Copayment, Copay: The set dollar amount you are responsible for paying when you incur an eligible medical expense for certain services. See the Schedule of Medical Benefits.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (orthotic) or replace a missing body part (prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function, as distinguished from medically necessary surgery or treatment to correct defects resulting from trauma, infection, or other diseases or the consequences of treatment of trauma, infection, or other diseases, or to correct a congenital disease or anomaly of a covered dependent child that causes a functional defect.

Cost-sharing: A term to mean the amount of money a plan participant is to pay toward a service or item, versus the amount of money the Plan is to pay. Plans typically have three different types of cost-sharing provisions: Deductibles, Copayments/Copays and Coinsurance, although not all plans feature each of these types of cost-sharing. It is common to have a Plan change the amount of its cost-sharing provisions at least once each 12 months (more often if necessary).

Course of Treatment: The planned program of one or more services or supplies, provided by one or more dentists to treat a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment begins when a dentist first renders a service to correct or treat the diagnosed dental condition.

Covered Individual: Any employee (or eligible retiree) and that person's spouse or dependent child who is enrolled for coverage under the Plan and is actually covered by the Plan.

Covered Medical and/or Dental Expenses: See the definition of Eligible Medical and/or Dental Expenses.

Crown: The portion of a tooth covered by enamel.

Custodial Care: Care and services (including room and board needed to provide that care or services) given mainly for personal hygiene or to perform the activities of daily living. Custodial care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Some examples of custodial care are training or helping patients to get in and out of bed, as well as help with bathing, dressing, feeding or eating, use of the toilet, ambulating, or taking drugs or medicines that can be self-administered. These services are custodial care regardless of where the care is given or who recommends, provides, or directs the care.

Deductible: The amount of eligible medical or dental expenses you are responsible for paying before the Plan begins to pay benefits. **Individual Deductible:** The amount one covered person must pay before the Plan begins to pay benefits for that person. **Family Deductible:** The amount that all covered family members must pay before the Plan begins to pay benefits for the family members.

Dental: Dental services and supplies are **not** covered under the medical expense coverage of the Plan unless the Plan specifically indicates otherwise. As used in this document, dental refers to any services performed by or under the supervision of a dentist, or supplies, including dental prosthetics, but not including prescription drugs prescribed

by a dentist, even if the services or supplies are necessary because of symptoms, illness or injury affecting another part of the body.

Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: The teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection.

Dental Care Provider: A dentist, or dental hygienist or other health care practitioner or nurse as those terms are specifically defined in this chapter of the document, who is legally licensed and who is a dentist or performs services under the direction of a licensed dentist; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Subspecialty Areas

Subspecialty Area	Services Related to the Diagnosis, Treatment or Prevention of Diseases Related To:
Endodontics	The dental pulp and its surrounding tissues.
Implantology	Attachment of permanent artificial replacement of teeth directly to the jaw using artificial root structures.
Oral Surgery	Extractions and surgical procedures of the mouth.
Orthodontics	Abnormally positioned or aligned teeth.
Pedodontics	Treatment of dental problems of children.
Periodontics	Structures that support the teeth (gingivae, alveolar bone, periodontal membrane or ligament, cementum).
Prosthodontics	Construction of artificial appliances for the mouth (bridges, dentures, crowns).

Dental Hygienist: A person who is trained and legally licensed and authorized to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed dentist, and who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dentist: A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Denture: A device replacing missing teeth.

Dependent Child(ren):

A. For the purposes of this Plan, a Dependent Child is any of the employee’s or retiree’s children listed below who are under the age of 26 for the medical plan or under age 23 for the dental and vision plan (whether married or unmarried) including a:

- **natural child**, (proof of relationship and age may be required) or
- **stepchild**, (proof of relationship and age may be required) or
- **legally adopted child**, or child placed for adoption with the employee (proof of adoption or placement for adoption and age may be requested), or
- **foster child** who has been lawfully-placed with the employee, for whom health coverage is not provided by the State (proof of foster child placement from a qualified state agency may be requested), or
- child named in a **qualified medical child support order (QMCSO)** is also an eligible dependent under this Plan. See the Eligibility chapter for details on QMCSOs; or
- child for whom the employee has **legal guardianship** under a court order (copy of the court-appointed guardianship documents and the child’s birth certificate required), provided:
 1. The child has not reached his or her 26th birthday for the medical Plan or 23rd birthday for the dental and vision plan; **OR**
 2. The child has reached his or her 26th birthday for the medical Plan or 23rd birthday for the dental and vision plan and is **mentally or physically Disabled** (as that term is defined in this Plan); the child is

unmarried, the child is incapable of self-sustaining employment as a result of that disability and the child's disability occurred prior to their 26th birthday for the medical Plan or 23rd birthday for the dental and vision plan. This Plan may require initial and periodic proof of disability.

B. The following individuals are not eligible under the Plan: a spouse of a Dependent Child (e.g. employee's son-in-law or daughter-in-law) or a child of a Dependent Child (e.g. employee's grandchild) unless the employee is the legal guardian, a Domestic Partner, or a child of a Domestic Partner.

No individual may be covered under this Plan both as an employee or retiree and as a Dependent, nor may any Dependent Child be covered as the Dependent of more than one employee or retiree. No individual may be covered under this Plan as both an employee and a retiree.

C. It is the employee's obligation to inform the Plan if any of the requirements set out in this definition of a Dependent child are NOT met with respect to any child for whom coverage is sought or is being provided.

D. Coverage of a Dependent Child ends at the end of the month in which that child:

1. reaches his or her 26th birthday for the medical Plan or 23rd birthday for the dental and vision plan (unless the child is disabled); or
2. no longer meets the eligibility requirements of the Plan.

Disabled: (Physically or Mentally): The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise totally disabled, provided the condition was diagnosed by a Physician, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition. See the definition of Total Disability.

Double Abutment: Tying two teeth together to help support a bridge. If there is bone loss due to periodontal disease (pyorrhea), this will be considered a form of periodontal splinting. See the definition of Periodontal Splinting.

Durable Medical Equipment (DME): Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and is not disposable or nondurable. Durable medical equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds (with safety rails), electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device).

Elective Hospital Admission, Service or Procedure: Any non-emergency hospital admission, service or procedure that can be scheduled or performed at the patient's or Physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Dependent: Your lawful spouse and your dependent child(ren). An eligible dependent may be enrolled for coverage under the Plan by following the procedures required by the Plan. See the Eligibility chapter. Once an eligible dependent is duly enrolled for coverage under the Plan, coverage begins in accordance with the terms and provisions of the Plan, and that person is a covered dependent and remains a covered dependent until his or her coverage ends in accordance with the terms and provisions of the Plan.

Eligible Medical and/or Dental Expenses: Expenses for medical and/or dental services or supplies, but only to the extent that they are medically necessary, as defined in this Definitions chapter of the document; and the charges for them are within the Plan's allowances; and coverage for the services or supplies is not excluded, as provided in the Medical Exclusions, Dental Exclusions, and Short Term Disability Benefits Coverage chapters of this document; and the maximum Plan benefits for those services or supplies has not been reached.

Emergency (Dental): A sudden unexpected onset of a dental condition that manifests itself by such acute symptoms of sufficient severity that urgent and immediate dental attention is required to provide relief from pain and prevent serious impairment of dental functions or lead to serious and/or permanent impairment or dysfunction of another body organ or part, or because the patient's life may be threatened.

Emergency (Medical): The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Emergency Care. Emergency care means medical or dental care and treatment provided after the sudden unexpected onset of a medical or dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average

knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or in the case of a pregnant woman, the health of her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency Services (as related to enrollees in the HDHP Plan): means with respect to an Emergency Medical Condition (defined below), a medical screening examination **within the emergency department of a hospital** including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

- The term “to stabilize” means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).
- The term “**Emergency Medical Condition**” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.
- The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

Emergency Hospitalization or Confinement: A hospital admission that takes place within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

Employee: Unless specifically indicated otherwise, when used in this document, employee refers to a person employed by a participating employer of the Yavapai Combined Trust who is eligible to enroll for coverage under the Plan. See the definition of Employer.

Employer: An individual or company that employs a person in exchange for financial compensation. See the definition of Participating Employer.

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the Medical Exclusions, Dental Exclusions and Short Term Disability Benefits Coverage chapters of this document, for which the Plan does not provide Plan benefits.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Experimental and/or Investigational: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as experimental and/or investigational. A service or supply will be deemed to be experimental and/or investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for precertification under the Plan’s Utilization Management Program, **any** of the following conditions were present with respect to one or more essential provisions of the service or supply:

1. The service or supply is described as an alternative to more conventional therapies in the protocols or consent document of the health care provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its designee, there is a preponderance of authoritative medical, dental or scientific literature published in the United States; and written by experts in the field that shows that recognized medical, dental or scientific experts classify the service or supply as experimental and/or

investigational or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.

4. With respect to services or supplies regulated by the Food and Drug Administration (FDA):
 - FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or
 - A current investigational new drug or new device application has been submitted and filed with the FDA.However, a drug will not be considered experimental and/or investigational if it is:
 - approved by the FDA as an “investigational new drug for treatment use”; or
 - classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a “life threatening disease” as that term is defined in FDA regulations; or
 - approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.
5. The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; or Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

Note that under the HDHP medical plan only, experimental, investigational or unproven does not include **routine costs associated with a certain “approved clinical trial” related to cancer or other life-threatening illnesses**. For individuals who will participate in a clinical trial, precertification is required in order to determine if the participant is enrolled in an “approved clinical trial” and notify the Plan’s claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial. The routine costs that are covered by this Plan are discussed below:

- a. **“Routine costs”** means services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered for a participant or beneficiary who is not enrolled in a clinical trial. However, the plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient’s particular diagnosis.
- b. An **“approved clinical trial”** means a phase I, II, III, or IV clinical trial (including a clinical trial titled as a pilot study) conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial’s study or investigation must be (1) federally-funded; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. “Federally funded” clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHCRO), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRO, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- c. A participant or beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual’s referring physician is a participating health care provider in the plan who has determined that the individual’s participation in the approved clinical trial is medically appropriate, or the individual provides the plan with medical and scientific information establishing that participation in the trial would be medically appropriate.
- d. The plan may require that an eligible individual use an in-network provider as long as the provider will accept the patient. This plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient’s state of residence.
- e. The plan may rely on its Utilization Management Company or other medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to

help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process. See Article 13 for information on the appeal process of the Plan. Additionally, external review is available for an adverse determination related to coverage of routine costs in a clinical trial. See the Utilization Management chapter for information on precertification requirements.

In determining if a service or supply is or should be classified as experimental and/or investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided, or considered for precertification under the Plan's Utilization Management Program:

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia"; and "American Hospital Formulary Service";
5. The published opinions of:
 - the American Medical Association (AMA); or specialty organizations recognized by the AMA; or
 - the National Institutes of Health (NIH); or
 - the Center for Disease Control (CDC); or
 - the Office of Technology Assessment; or
 - published clinical policy bulletins or major insurance companies in the US such as Aetna, CIGNA or United Healthcare or MCG/Milliman Care Guidelines;
 - the American Dental Association (ADA), with respect to dental services or supplies.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
7. The latest edition of The Medicare National Coverage Determinations Manual.

To determine how to obtain a Precertification of any procedure that might be deemed to be experimental and/or investigational, see the section on Precertification Review in the Utilization Management Program chapter of this document.

Fluoride: A solution applied to the surface of teeth to prevent dental decay.

Genetic Counseling: Counseling services provided before Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman to allow the patient to make an informed decision.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Gnathologic Recording: A measurement of force exerted in the closing of the jaws.

Habilitative/Habilitation: Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal functional

abilities. Examples of habilitative services includes physician-prescribed therapy for a child who is not walking or talking at the expected age.

HDHP: refers to the High Deductible Health Plan, a medical plan option that is paired with a Health Savings Account or HSA.

Health Care Practitioner: A Physician, Behavioral Health Practitioner, Chiropractor, Dental Hygienist, Dentist, Nurse, Nurse Practitioner, Physician Assistant, Podiatrist, Pharmacist, Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Naturopath, or Nurse Midwife as those terms are defined in this chapter, or any other Provider who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Health Care Provider: A Health Care Practitioner as defined above, or a Hospital, Ambulatory Surgical Facility, Behavioral Health Treatment Facility, Birthing Center, Home Health Care Agency, Hospice, Skilled Nursing Facility, or Subacute Care Facility, as those terms are defined in this Definitions chapter.

Home Health Care: Intermittent skilled nursing care services provided by a licensed home health care agency as defined below.

Home Health Care Agency: An agency licensed or certified and operating according to law that meets all of the following requirements:

1. It primarily provides skilled nursing and other therapeutic services under the supervision of Physicians or registered nurses; and
2. It is run according to rules established by a group of professional medical providers including Physicians and registered nurses; and
3. It maintains clinical records on all patients; and
4. It is licensed by the jurisdiction where it is located if licensure is required, and operates according to the laws of that jurisdiction pertaining to agencies providing home health care; and
5. It is certified by Medicare.

Hospice: A facility or organization licensed and operating according to law and certified by Medicare that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home or in a home-like setting, with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family.

Hospital: A public or private facility or institution, other than one owned by the U.S. Government, licensed and operating according to law, that is accredited by The Joint Commission (TJC) and that provides care and treatment by Physicians and nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises. A hospital may include inpatient acute care facilities for mental, nervous and/or substance abuse treatment that are licensed and operated according to law. Any portion of a hospital used as a subacute care facility, skilled nursing facility, or residential treatment facility or place for rest, custodial care, or the aged will **not** be regarded as a hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition. Pregnancy of a covered employee or covered spouse will be considered to be an illness only for the purpose of coverage under this Plan. For females enrolled in the HDHP Plan, prenatal and postnatal visits for a pregnant dependent child will be an illness that is covered by this Plan, but not ultrasounds and other pregnancy-related services of the pregnant dependent child, the delivery and/or newborn expenses. However, infertility is **not** an illness for the purpose of coverage under this Plan.

Immediate Temporary Denture: A temporary denture that is placed immediately after the extraction of teeth.

Implantology: The science of placing artificial root structures on or within the jaw bones that will act to hold and support a dental prosthesis.

Impression: A negative reproduction of the teeth and gums from which models of the jaws are made. These models are used to study certain conditions and to make dental appliances and prostheses.

Infusion Therapy: Infusion therapy involves the administration of medication or nutrition through a needle or catheter. It is prescribed when a patient's condition is so severe that the condition cannot be treated effectively by oral medications or other nutrition routes. Commonly administered infusion therapy includes infusion of antibiotic, antifungal, antiviral, chemotherapy, hydration, pain management, parenteral nutrition, and total parenteral nutrition or TPN. Diseases commonly requiring infusion therapy include infections that are unresponsive to oral/intramuscular antibiotics, cancer and cancer-related pain, dehydration, gastrointestinal diseases or disorders which prevent normal functioning of the gastrointestinal system, etc.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth: An injury to the teeth caused by trauma from an external source. This **does not include** an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for Accidental Injury to Teeth may be payable under Oral services in the Schedule of Medical Benefits.

Inlay: A restoration made to fit a prepared tooth cavity and then cemented into place. See the definition for Restoration.

In-Network Services: Services provided by a health care provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from out-of-network Services that are provided by a health care provider that is **not** a member of the PPO. See also the definition of PPO Contract Fee Schedule.

Inpatient Services: Services provided in a hospital or other specialized health care facility during the period when charges are made for room and board.

Investigational: See the definition of Experimental and/or Investigational.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Mammogram: Mammography is a specific type of imaging that uses a low-dose x-ray system to examine breasts. Screening mammograms are used as a tool to detect early breast cancer or other breast disease in individuals experiencing no symptoms. Diagnostic mammograms are used to help detect and diagnose breast disease in individuals with symptoms or suspicion of a breast disease.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result.

Massage Therapy: The delivery of therapeutic massage (manipulation, methodical pressure, friction and kneading of the body).

Maxillary Disorders: Disorders of the upper jaw.

Maximum Plan Benefits: The maximum amount of benefits payable by the Plan on account of medical expenses incurred by any covered Plan participant under this Plan and any previous medical expense plan provided by the Trust.

- **Limited Overall Maximum Plan Benefits** are the maximum amount of benefits payable on account of certain services as noted in the Schedule of Medical Benefits, during the entire time a Plan participant is covered under this Plan and any previous medical expense plan provided by the Trust.
- **Plan Year Maximum Plan Benefits** are the maximum amount of benefits payable each Plan year on account of certain medical expenses incurred by any covered Plan participant.

Medically Necessary:

- A. A medical or dental service or supply will be determined to be "medically necessary" by the Plan Administrator or its designee if it:
1. is provided by or under the direction of a Physician or other duly licensed health care practitioner who is authorized to provide or prescribe it or dentist if a dental service or supply is involved; and
 2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted medical standards; and
 3. is determined by the Plan Administrator or its designee to meet all of the following requirements:
 - It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
 - It is not provided solely for the convenience of the patient, Physician, hospital, health care provider, or health care facility; and

- It is an “appropriate” service or supply given the patient’s circumstances and condition; and
- It is a “cost-efficient” supply or level of service that can be safely provided to the patient; and
- It is safe and effective for the illness or injury for which it is used; and
- It is not otherwise listed as an exclusion in this Plan.

- B. A medical or dental service or supply will be considered to be “appropriate” if:
- It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient’s overall health condition.
 - It is care or treatment that is as likely to produce a significant positive outcome as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient’s overall health condition.
- C. A medical or dental service or supply will be considered to be “cost-effective” if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.
- D. The fact that your Physician or dentist may provide, order, recommend or approve a service or supply **does not mean** that the service or supply will be considered to be medically necessary for the medical or dental coverage provided by the Plan.
- E. A hospitalization or confinement to a specialized health care facility will **not** be considered to be medically necessary if the patient’s illness or injury could safely and appropriately be diagnosed or treated while not confined.
- F. A medical or dental service or supply that can safely and appropriately be furnished in a Physician’s or dentist’s office or other less costly facility will **not** be considered to be medically necessary if it is furnished in a hospital or specialized health care facility or other more costly facility.
- G. The non-availability of a bed in another specialized health care facility, or the non-availability of a health care practitioner to provide medical services will **not** result in a determination that continued confinement in a hospital or other specialized health care facility is medically necessary.
- H. A medical or dental service or supply will **not** be considered to be medically necessary if it does not require the technical skills of a health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient’s family, any person who cares for the patient, any health care practitioner, or any hospital or specialized health care facility.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Morbidly Obese, Morbid Obesity: As defined by the Plan Administrator or its designee, under this Plan the term means the:

1. Presence of morbid obesity that has persisted for at least 5 years, defined as either:
 - a. body mass index (BMI) (*term defined at the end of this definition*) exceeding 40; or
 - b. BMI greater than 35 in conjunction with ANY of the following severe co-morbidities:
 - coronary heart disease; or type 2 diabetes mellitus; or clinically significant obstructive sleep apnea; or high blood pressure/hypertension (BP > 140 mmHg systolic and/or 90 mmHg diastolic) AND
2. Patient has completed growth (18 years of age or documentation of completion of bone growth); AND
3. Patient has participated in a Physician (or, for the HDHP Health Care Practitioner) supervised nutrition and exercise program (including dietitian consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record. This Physician (or, for the HDHP Health Care Practitioner) supervised nutrition and exercise program must meet ALL of the following criteria:
 - a. Participation in nutrition and exercise program must be supervised and monitored by a Physician (or, for the HDHP Health Care Practitioner) working in cooperation with dietitians and/or nutritionists; AND
 - b. Nutrition and exercise program must be 6 months or longer in duration; AND
 - c. Nutrition and exercise program must occur within the two years prior to surgery; AND

- d. Participation in Physician (or, for the HDHP Health Care Practitioner) supervised nutrition and exercise program must be documented in the medical record by an attending Physician (or, for the HDHP Health Care Practitioner) who does not perform bariatric surgery. Note: A Physician's summary letter is not sufficient documentation.

NOTE: BMI is calculated by dividing the patient's weight (in kilograms) by height (in meters) squared:

$$BMI = \frac{\text{weight in kilograms}}{\text{height in meters} \times \text{height in meters}}$$

or compute using the Obesity Education Initiative website: <http://www.nhlbi.nih.gov/about/org/oei>

To convert pounds to kilograms, multiply pounds by 0.45.

To convert inches to meters, multiply inches by 0.0254.

Naturopath: When the services of naturopaths are payable by this Plan, the naturopath must be properly licensed to practice Naturopathy in the state in which he or she is practicing and must be performing services within the scope of that license; or where licensing is not required, must be a qualified health care practitioner or Physician or hold a degree as a Doctor of Naturopathic Medicine from a school approved by the Council on Naturopathic Medicine. See the definition of Naturopathic Medicine.

Naturopathic Medicine: A therapeutic system based on principles of treating diseases with natural forces such as water or heat, drugless methods, non-surgical methods and devices such as physical, electrical hygienic and sanitary measures or all forms of physiotherapy. See the definition of Naturopath.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, slings, hypodermic syringes, diapers, soap or cleansing solutions, etc. Such items may or may not be covered. Refer to the Schedule of Medical Benefits. See also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device).

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Nurse Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Nurse Midwife: A person legally licensed as a nurse midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient. A nurse midwife generally may **not** independently manage moderate or high-risk mothers, admit to a hospital, or prescribe any type of medications.

Office Visit: A visit to a Physician's or dentist's office that results in a direct personal contact between the Physician or dentist (or nurse practitioner, Physician assistant, dental hygienist or nurse midwife in that office) and the patient for diagnosis or treatment, as evidenced by the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association or the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CPT coding. Neither a telephone discussion with a Physician or other health care provider nor a visit to a health care provider's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is considered to be an office visit for the purposes of this Plan.

Onlay: An inlay restoration that is extended to cover the biting surface of the tooth, but not the entire tooth. It is often used to restore lost and weakened tooth structure.

Open Enrollment Period: The period during which participants in the Plan may add, drop or change dependents on their coverage. The Plan's open enrollment period is determined and communicated separately by each participating employer; or, in the case of a special open enrollment period, as such other period as may be designated in advance by the Plan Administrator or its designee.

Orthodontics: The science of the movement of teeth in order to correct a malocclusion or “crooked teeth.”

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as Prognathism and Retrognathism. See the definitions of Prognathism and Retrognathism.

Orthotic Appliance (or Device): A type of corrective appliance or device, either customized or available “over-the-counter,” designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the medical plan, this definition does **not** include dental orthotics. See also the definitions of Durable Medical Equipment, Nondurable Supplies, and Prosthetic Appliance (or Device).

Out-of-Network Services: Services provided by a health care provider that is **not** a member of the Plan’s Preferred Provider Organization (PPO), as distinguished from in-network services that are provided by a health care provider that is a member of the PPO.

Out-of-Pocket Limit: For the Premier Plan and the Basic Plus Plan, the Out-of-Pocket Limit is the maximum amount of coinsurance each covered person or family is responsible for paying during a plan year before the coinsurance required by the Plan ceases to apply. For the HDHP Plan the out-of-pocket limit is the maximum amount of cost-sharing for deductibles, copayments and coinsurance each covered person or family is responsible for paying during a plan year before the cost-sharing required by the Plan ceases to apply. When the out-of-pocket limit is reached, the Plan will pay 100% of any additional eligible covered expenses for the remainder of the plan year. Note however that certain expenses are NOT ever applied to meet an out-of-pocket limit. These expenses are discussed in the Out-of-Pocket Limit row of each Schedule of Medical Benefits.

Outpatient Services: Services provided either outside of a hospital or specialized health care facility setting or at a hospital or specialized health care facility when room and board charges are **not** incurred.

Partial Denture: A prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures. The denture may be removable or fixed. See also the definition of Bridge.

Partial Hospitalization: means treatment of mental, nervous, or emotional disorders and substance abuse for at least three (3) hours, but not more than twelve (12) hours in a twenty-four (24) hour period and the care does not include an overnight stay in a hospital/facility.

Participating Employer: The City of Prescott, Yavapai County, Yavapai College and the Town of Chino Valley in Arizona.

Periodontal Splinting: Tying two or more teeth together when there is bone loss. This is done to gain additional stability for teeth that can no longer stand alone.

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered and who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Placed for Adoption: A child is “placed for adoption” with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

Plan, This Plan: The program, benefits and provisions described in this document.

Plan Administrator/Plan Sponsor: The Board of Trustees of Yavapai Combined Trust who are the persons or legal entity with the fiduciary responsibility for the overall administration of the Plan.

Plan Benefit: See the definition of Benefit.

Plan Participant: The employee (or retiree) or individual who has enrolled for coverage under the Plan. As used in this document, this term does **not** include the spouse or dependent child(ren) of the Plan participant.

Plan Year: The period of time July 1 through June 30th. All deductibles and maximum Plan benefits are determined during the plan year.

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) and authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Pontic: The part of a fixed bridge that is suspended between two abutments and replaces a missing tooth.

PPO Contract Fee Schedule: The preferred fee allowances as determined by the contracted PPO vendor. These fees normally result in a discount for both the covered person and the Plan. For more information refer to the section on Preferred Provider Organization (PPO) in the Medical Expense Coverage chapter of this document. See also the definition of Allowed Charge.

Practitioner: See the definition of Health Care Practitioner.

Pre-Admission Testing: Laboratory tests and x-rays and other medically necessary tests performed on an outpatient basis prior to a scheduled hospital admission or outpatient surgery.

Precertification: A managed care program designed to assure that hospital and specialized health care facility admissions and lengths of stay, surgery and other health care services are medically necessary by having the Utilization Management Company determine the medical necessity **before** the services are provided.

Preferred Provider Organization (PPO): A group or network of health care providers under contract with the Plan to provide health care services and supplies at agreed-upon discounted rates as payment in full, except with respect to a coinsurance, or in certain defined situations, a copayment, and deductible for which the covered employee or dependent is responsible, and to handle the paperwork required for submission of claims. Refer to the Medical Expense Coverage chapter and the Schedule of Medical Benefits.

Prescription Drugs: For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend Drug:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. **Compound Drug:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law. Some compound drugs are only available at a retail pharmacy location, not mail order.
3. **Brand drug:** means a drug that has been approved by the U.S. Food and Drug Administration (FDA) and that drug has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company who holds the patent has the right to sell that brand drug. A brand drug cannot have competition from a generic drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.
4. **Generic drug:** means a generic version of a brand-name drug (basically a copy of an FDA approved brand-name drug that contains the same active ingredients as the brand-name drug and is the same in terms of dosage, safety, purity, strength, how it is taken, quality, performance and intended use). Generic drugs work in the same way and in the same amount of time as brand-name drugs. The generic drug must be the same (or bio-equivalent) in several respects: the active ingredients (those ingredients that are responsible for the drug's effects), the dosage amount, the way in which the drug is taken must be the same as the brand name drug, the safety must be the same and the amount of time the generic drug takes to be absorbed into the body must be the same as the brand name drug. A generic drug has been approved by the U.S. Food and Drug Administration (FDA). Generic drugs can have different names, shapes, colors and inactive ingredients than the original brand name drug.
5. **Specialty drug:** Generally refers to high-cost, low volume, biotechnology-engineered FDA approved, non-experimental medications used to treat complex, chronic or rare diseases. These medications may also have one or more of the following qualities: are injected, infused, taken oral or inhaled, may need to be administered by a Health Care Practitioner, have side-effects or compliance issues that need monitoring, require substantial patient education/support before administration, and/or have unique manufacturing, handling and distribution issues that make them unable to be purchased from a retail and/or mail order service. Examples of specialty drugs can include medications to treat hemophilia, immunity disorders, multiple sclerosis, rheumatoid arthritis, hepatitis or certain types of cancer. Specialty drugs are managed by a specialty drug pharmacy that is part of the Prescription Drug Program under contract to the Plan. See the Drug row of the Schedule of Medical Benefits for more information.

Pre-service Claim: See the Claim Filing and Appeal Information chapter for the definition.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Prophylaxis: The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth is performed by a dentist or dental hygienist.

Prosthesis (Dental): An artificial replacement of one or more natural teeth and/or associated structures.

Prosthetic Appliance (or Device): A type of corrective appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, eye, or corrective lenses needed after cataract surgery. For the purposes of the medical plan, this definition does **not** include dental prostheses or hair replacements including, but not limited to, wigs, toupees, hair pieces or hair implants. See also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic Appliance (or Device).

Provider: See the definition of Health Care Provider.

Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an employee to provide health care coverage for a dependent child, and requiring that benefits payable on account of that dependent child be paid directly to the health care provider who rendered the services or to the custodial parent of the dependent child.

Reconstructive Surgery: A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy on account of a malignancy.

Rehabilitation Therapy: Cardiac, occupational, physical, pulmonary or speech therapy, that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license.

Rehabilitation does not have the same meaning as Habilitation. Rehabilitation focuses on restoring/regaining functions that have been lost due to injury or illness, while Habilitation focuses on helping individual attain certain functions that they never have acquired.

- **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function. Active Rehabilitation is covered by the Plan, subject to maximum Plan benefits and certain specific benefit maximums such as for speech therapy.
- **Maintenance Rehabilitation** refers to therapy in which a patient actively participates and that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. Maintenance Rehabilitation is not covered by the Plan.
- **Passive Rehabilitation** refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, subject to maximum Plan benefits, but only during a course of hospitalization for acute care and then only until the patient is capable of being discharged from the hospital because hospitalization for the condition requiring acute hospital care is no longer medically necessary. Continued hospitalization for the sole purpose of providing Passive Rehabilitation will not be considered to be medically necessary for the purposes of this Plan.

See also the definition of habilitation.

Residential Treatment Program/Facility/Care: is defined as a 24-hour level of care that operates 7 days a week for people with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders. To be payable by this Plan, a facility must be licensed as a residential treatment facility. Licensure requirements for this residential level of care may vary by state.

Restoration: A broad term applied to any filling, crown, bridge, partial denture or complete denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape and function of part or all of the tooth or teeth.

Retiree: See the Eligibility chapter for a description of any retirees that may be eligible for Plan benefits.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Retrospective Review: Review of health care services **after** they have been provided to determine if those services were medically necessary.

Root Canal (Endodontic) Therapy: Treatment of a tooth having a damaged pulp. The treatment is usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with a sealing material.

Scale: To remove calculus (tartar) and stains from the teeth with special instruments.

Second Opinion: A consultation and/or examination, preferably by a board-certified Physician not affiliated with the primary attending Physician, to evaluate the medical necessity and advisability of undergoing a surgery or receiving a medical service.

Skilled Nursing Care: Services performed by a licensed Nurse if the services are ordered by and provided under the direction of a Physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of skilled nursing care services include, but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility: A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets **all** of the following requirements:

1. It is accredited by The Joint Commission (TJC) as a skilled nursing facility or is recognized by Medicare as a skilled nursing facility; and
2. It maintains on its premises all facilities necessary for medical care and treatment; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed registered nurse, with at least one licensed registered nurse on duty at all times; and
5. It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, or mentally deficient; and
6. It is not a hotel or motel.

Specialized Health Care Facilities: For the purposes of this Plan, Specialized Health Care Facilities include Ambulatory Surgical Facilities, Behavioral Health Treatment Facilities, Birthing Centers, Hospices, Skilled Nursing Facilities, and Subacute Care Facilities, as those terms are defined in this Definitions chapter.

Specialty Care Unit: A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by registered nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Spinal Manipulation: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal manipulation is commonly performed by chiropractors, but it can be performed by any Physician.

Spouse: The employee's lawful spouse as defined consistent with state law. The Plan may require proof of the legal marital relationship. A legally separated spouse or divorced former spouse of an employee is not an eligible Spouse under this Plan.

Subacute Care Facility: A public or private facility, either freestanding, hospital-based or based in a skilled nursing facility, licensed and operated according to law and authorized to provide subacute care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an

acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement, generally not to exceed 60 days, to the patient's home or to a suitable skilled nursing facility, and that meets **all** of the following requirements:

1. It is accredited by The Joint Commission (TJC) as a subacute care facility or is recognized by Medicare as a subacute care facility; and
2. It maintains on its premises all facilities necessary for medical care and treatment; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed registered nurse; and
5. It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, or mentally deficient; and
6. It is not a hotel or motel.

Substance Abuse/Substance Use: Alcohol and/or drug dependency as defined by the current edition of the Diagnostic and Statistical Manual (DSM). See also definitions of Behavioral Health Disorders and Chemical Dependency.

Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits.

When the procedures will be considered to be separate procedures, the following percentages of the Allowed Charge will be allowed as the Plan's benefit:

1. Allowances for multiple surgeries through the same incision or operational field:

Primary procedure	100% of the Allowed Charge
Secondary and additional procedures	50% of the Allowed Charge per procedure

2. Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

First site primary procedure	100% of the Allowed Charge
First site secondary and additional procedures	50% of the Allowed Charge per procedure
Second site primary and additional procedures	50% of the Allowed Charge per procedure

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Syndrome: The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, severe aching pain in and about the TMJ (sometimes made worse by chewing), limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment, often associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly) or ill-fitting dentures.

Therapist: See the definition of Health Care Practitioner.

Third Opinion: A consultation and/or examination, preferably by a board certified Physician not affiliated with the primary attending Physician, to evaluate the medical necessity and advisability of undergoing Surgery or receiving a medical service, provided by the Plan when the second opinion indicates that the recommended surgery or medical service is not medically necessary.

Topical: Painting the surface of teeth as in a fluoride treatment or application of a cream-like anesthetic formula to the surface of the gum.

Tort, Tortfeasor: A civil wrong or injury, typically arising from a negligent or intentional act of an individual, who is called a tortfeasor.

Total Disability, Totally Disabled: The inability of a covered employee to perform all the duties of his or her occupation with his or her employer as a result of a non-occupational illness or injury, or the inability of a covered dependent to perform the normal activities or duties of a person of the same age and sex. See also the definition of Disabled.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissues or cells (such as bone marrow or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted tissue in the recipient.

- **Autologous** refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.
- **Allogenic** refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are always allogenic.
- **Xenographic** refers to transplants of organs, tissues or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Xenographic transplants are **not** covered by this Plan.

See the Schedule of Medical Benefits and the Medical Exclusions chapters of this document for additional information regarding transplants.

Trust: The Yavapai Combined Trust. See also Participating Employer.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate even though health and life is **not** in jeopardy. Examples of medical conditions that may be appropriate for Urgent Care include, but are not limited to, fever, sprains, bone or joint injuries, continuing diarrhea or vomiting, or bladder infections.

Urgent Care Facility: A public or private freestanding facility not located on the premises of a hospital that is licensed or legally operating, that primarily provides minor emergency and episodic medical care in which one or more Physicians, registered nurses, and x-ray technicians are in attendance at all times the facility is open, and that includes x-ray and laboratory equipment and a life support system.

Utilization Management Program: A managed care procedure to determine the medical necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include, but is not limited to, precertification and/or preauthorization; concurrent and/or continued stay review; discharge planning; retrospective review; case management; hospital or other health care provider bill audits; and health care provider fee negotiation.

Utilization Management services (sometimes referred to as UM services, UM program, Utilization Review services, UR services, Utilization Management and Review services, or UMR services) are provided by licensed health care professionals employed by the Utilization Management Company operating under a contract with the Plan.

Utilization Management Company: The independent utilization management company, staffed with licensed health care professionals, operating under a contract with the Plan to administer the Plan's Utilization Management services.

Visit: A personal meeting between the patient and a Physician, dentist or other health care provider regarding the health condition or care of the patient, and which is properly classified or coded in accordance with the Current Procedural Terminology (CPT) manual of the American Medical Association or the American Dental Association codes.

Well Baby Care: Health care services provided to a healthy newborn or child through age 18 months that are determined by the Plan to be medically necessary even though they are not provided as a result of illness, injury or congenital defect. The Plan's coverage of periodic well baby care is described in the Wellness Programs section of the Schedule of Medical Benefits chapter of this document.

You, Your: When used in this document, these words refer to the employee (or retiree) who is covered by the Plan. They do **not** refer to any dependent of the employee.

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