Arizona Metropolitan Trust (AzMT)

Employee Benefit Plan
HDHP Plan Document and Summary Plan Description

Amended and Restated
Effective July 1, 2024

In addition to providing benefit information and descriptions this document includes notices of your rights and responsibilities under various United States laws including without limitation: Consolidated Omnibus Budget Reconciliation Act (COBRA); Health Insurance Portability and Accountability Act (HIPAA); Consolidated Appropriations Act (CAA); Women's Health and Cancer Rights Act; Newborns' and Mothers' Health Protection Act; Patient Protection and Affordable Care Act (PPACA); and Medicaid and Children's Health Insurance Program (CHIP).

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SECTION I—INTRODUCTION

This document is a description of the Arizona Metropolitan Trust (AzMT) Employee Benefit HDHP Plan (the *Plan*). No oral interpretations can change this *Plan*. The *Plan* described is designed to protect *plan participants* against certain catastrophic health expenses. Terms which have special meanings when used in this Plan will be italicized. For a list of these terms and their meanings, please see the **Defined Terms** section of the plan document. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise.

Coverage under the *Plan* will take effect for an eligible *employee* and designated *dependents* when the *employee* and such *dependents* satisfy the waiting period and all the eligibility requirements of the *Plan*.

The *employer* fully intends to maintain this *Plan* indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the *Plan* at any time and for any reason.

Changes in the *Plan* may occur in any or all parts of the *Plan* including benefit coverage, *deductibles*, maximums, exclusions, limitations, defined terms, eligibility, and the like.

This *Plan* is not a 'grandfathered health plan' under the *Patient Protection and Affordable Care Act (PPACA)*, also known as Health Care Reform. Questions regarding the *Plan's* status can be directed to the *Plan Administrator*. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272, or visit **www.dol.gov/ebsa/healthreform**.

Failure to follow the eligibility or enrollment requirements of this *Plan* may result in delay of coverage or no coverage at all. Reimbursement from the *Plan* can be reduced or denied because of certain provisions in the *Plan*, such as coordination of benefits, subrogation, exclusions, timeliness of Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA*)* elections, utilization review or other cost management requirements, lack of *medical necessity*, lack of timely filing of *claims*, or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the *Plan Administrator* at no extra cost.

Read your benefit materials carefully. Before you receive any services you need to understand what is covered and excluded under your benefit *Plan*, your cost sharing obligations, and the steps you can take to minimize your out-of-pocket costs.

Review your *Explanation of Benefits* (EOB) forms, other claim-related information, and available *claims* history. Notify the *Third Party Administrator* of any discrepancies or inconsistencies between amounts shown and amounts you actually paid.

The *Plan* will pay benefits only for the expenses *incurred* while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is *incurred* on the date the service or supply is furnished.

This *Plan* is established pursuant to Arizona Revised Statute Section 11-952.01 et. seq. as a self-funded governmental *employee* benefit pool and, therefore, is exempt from the federal Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA.

No action at law or in equity shall be brought to recover under any section of this *Plan* until the *appeal* rights provided have been exercised and the *Plan* benefits requested in such *appeals* have been denied in whole or in part.

If the *Plan* is terminated, amended, or benefits are eliminated, the rights of *plan participants* are limited to *covered charges incurred* before termination, amendment, or elimination.

A. Quick Reference Chart

When you need information, please check this document first. If you need further help, call the appropriate phone number listed in the following Quick Reference Information chart:

QUICK REFERENCE INFORMATION	
Information Needed	**Whom to Contact**
Plan Administrator • Second-Level *Appeals* of Post-Service *Claims*	Arizona Metropolitan Trust c/o Gallagher Benefit Services 8800 E Raintree Dr., Ste 250 Scottsdale, AZ 85260 1-928-391-2297 TIN# 30-6316739
Medical Claims Administrator/Third Party Administrator • *Claim* Forms (Medical) • Medical *Claims* • First-Level *Appeals* of Post-Service *Claims* • Eligibility for Coverage • Plan Benefit Information	AmeriBen P.O. Box 7186 Boise, ID 83707 1-855-350-8699 **www.MyAmeriBen.com**
Medical Management Administrator *(Pre-Certification)* • *Pre-Certification*, Concurrent Review, and Case Management • First and Second-Level *Appeals* of *Pre-Service Claims*	AmeriBen Medical Management Phone: 1-855-778-9053 Fax: 1-833-730-7961 **www.MyAmeriBen.com**
Provider Network *Names of Physicians & Hospitals* • Network Provider Directory – see website	Blue Cross® and Blue Shield® of Arizona Provider Information: 1-855-350-8699 **www.azblue.com/CHSnetwork**
Prescription Drug Program • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information & Formulary • Preauthorization of Certain Drugs • Reimbursement for non-network retail pharmacy use • Specialty Pharmacy Program	**Retail** Navitus Health Solutions P.O. Box 999 Appleton, WI 54912 1-866-333-2757 **www.navitus.com** **Mail Order** Costco 802 134th ST SW Everett, WA 98204 1-800-607-6861
HSA Vendor • Health Savings Account	HealthEquity 15 W. Scenic Pointe Dr., Ste. 100 Draper, UT 84020 1-866-346-5800 **www.healthequity.com**
COBRA Administrator • Continuation Coverage	AmeriBen P.O. Box 7565 Boise, ID 83707 1-855-350-8699

SECTION II—ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

A. Eligibility

Eligible Employee

All *active employees* and Elected/Appointed Officials, in accordance with the established policy of the employing member entity, are eligible provided they work at least thirty (30) hours per week on a regular basis at their customary place of employment and perform all of the duties of their employment.

Eligibility Requirements for Employee Coverage

All new Arizona Metropolitan Trust (AzMT) *employees* will be covered on the first day of the month following the waiting period established by each participating *employer*. Coverage will be effective provided proper enrollment has been made and any required contributions have been authorized.

Eligible Classes of Dependents

A *dependent* is any of the following persons:

1. a covered *employee's* spouse

   The term spouse shall mean the person to whom a covered *employee* is legally married based upon the laws of the state in which the individuals' marriage was entered into. Common-law spouses are not considered for *dependent* coverage under this *Plan*.

   For participating entities who elect to provide benefits to domestic partners ONLY:

   Check with your Human Resources Department to see if this benefit applies. The term spouse shall also mean the person who is currently registered with the *employer* as the domestic partner (as defined below) of the *employee*.

   Domestic Partner. An individual who is the same or opposite sex as the eligible *employee* and who has shared a long-term committed domestic partnership relationship with the eligible *employee* for a minimum of the last twelve (12) months.

   Children of a Domestic Partner. The children of the domestic partner, including natural children, legally adopted children, children placed for adoption, children under legal guardianship substantiated by a court order, and children who are entitled to coverage under a *Medical Child Support Order*.

   Domestic Partnership. A relationship between an eligible *employee* and his or her domestic partner that meets **all** of the following criteria:

   a. The partners currently reside together in an exclusive mutual commitment similar to marriage and have done so for at least the last twelve (12) consecutive months and each intend to continue the relationship indefinitely.
   b. The partners are jointly responsible for basic living expenses.
   c. Both partners are eighteen (18) years of age or older.
   d. Both partners were mentally competent to consent to contract when the domestic partnership began and remain so for purposes of contracting for coverage for the domestic partner.
   e. The partners are not married to any other individual (statutory or common law) and neither is a member of another domestic partnership.
   f. The *employee* and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside [Code A.R.S. 25-101(A)].
   g. Each partner is the other's sole domestic partner and is responsible for the other's common welfare.
   h. The partners are financially interdependent, jointly responsible for each other's basic living expenses and able to provide documents for at least three (3) of the following situations to demonstrate that interdependence has existed for a minimum of the last twelve (12) consecutive months:
      i. joint mortgage, joint property tax identification, or joint tenancy on a residential lease
      ii. joint bank, investment, and/or credit account
      iii. joint liabilities (e.g., credit cards, automobile loans)

iv. joint ownership of real property or a common leasehold, interest in real property, such as a residence or business or common ownership of an automobile

v. a will which designates the other as the primary beneficiary or a beneficiary designation form currently in effect for a retirement plan or life insurance policy setting forth that one (1) partner is a beneficiary of the other

vi. designation of one (1) partner as holding power of attorney for health care or a general durable power of attorney for the other

vii. written agreement(s) or contracts regarding the domestic partner relationship showing mutual support obligations

To obtain more detailed information or to apply for this benefit, the *employee* must contact their Human Resources Department.

In the event the domestic partnership is terminated, either partner is required to inform the *Plan* through their Human Resources Department of the termination of the partnership.

If two (2) *employees* (spouses or, for those entities who provide domestic partner coverage, domestic partners) are covered under the *Plan* and the *employee* who is covering the *dependent* children terminates coverage, the *dependent* coverage may be continued by the other covered *employee* with no waiting period as long as coverage has been continuous.

2. a covered *employee's* child(ren)

   An *employee's* child and the children of the *employee's* spouse or children of a domestic partner (as defined above). This includes natural child(ren), step-child(ren), *foster child(ren*), adopted child(ren), or child(ren) placed with the *employee* for adoption. An *employee's* child will be an eligible *dependent* until reaching the limiting age of twenty-six (26) without regard to student status, marital status, financial dependency, or residency status with the *employee* or any other person. Please refer to the subsection entitled When Dependent Coverage Terminates, to determine when coverage will end once the child reaches the applicable limiting age.

   The phrase placed for adoption refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term placed means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

3. a covered *employee's* qualified *dependents*

   The term qualified dependents shall include children for whom the *employee* is a *legal guardian* substantiated by a court order.

   To be eligible for *dependent* coverage under the *Plan*, a qualified *dependent* must be under the limiting age of twenty-six (26) years. Please refer to the subsection entitled When Dependent Coverage Terminates, to determine when coverage will end once a qualified *dependent* reaches the applicable limiting age.

   Any child of a *plan participant* who is an *alternate recipient* under a *Qualified Medical Child Support Order (QMCSO)* or National Medical Support Notice shall be considered as having a right to *dependent* coverage under this *Plan*.

   A *participant* of this *Plan* may obtain, without charge, a copy of the procedures governing *QMCSO* determinations from the *Plan Administrator*.

   The *Plan Administrator* may require documentation proving eligibility for *dependent* coverage, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

4. a covered *dependent* child or qualified *dependent* who reaches the limiting age and is *totally disabled*, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered *employee* for support and maintenance, and unmarried

   The *Plan Administrator* may require, at reasonable intervals, continuing proof of the *total disability* and dependency.

   The *Plan Administrator* reserves the right to have such *dependent* examined by a *physician* of the *Plan Administrator's* choice, at the *Plan's* expense, to determine the existence of such incapacity.

Ineligible Dependent(s)

Unless otherwise provided in this plan document, the following are not considered eligible *dependents*:

1. other individuals living in the covered *employee's* home, but who are not eligible as defined
2. the legally separated or divorced former spouse of the *employee*
3. any former domestic partner of the *employee*
4. any person who is on active duty in any military service of any country

   Note: This provision does not apply to dependent children.
5. a person who is covered as an *employee* under the *Plan*
6. any other person not defined above in the subsection entitled Eligible Classes of Dependents

Restrictions on Elections

If a person covered under this *Plan* changes status from *employee* to *dependent* or *dependent* to *employee*, and the person is covered continuously under this *Plan* before, during, and after the change in status, credit will be given for *deductibles* and all amounts will be applied to maximums.

If both spouses are *employee*s, their children will be covered as *dependents* of one (1) of the covered *employees*, but not of both.

If an *employee* works for more than one (1) *participating entity*, he or she can only elect coverage under the policy of one (1) *participating entity*. In addition, his or her *dependents* may only be covered under the same policy as the *employee*.

Accumulators will transfer if a dependent changes from coverage under one parent *employee* to coverage under another parent *employee*.

Eligibility Requirements for Dependent Coverage

Dependent coverage is available only if an eligible *employee* has enrolled for coverage. Eligible *dependents* will have the same effective date as the eligible *employee* if they are included on the application at the time the eligible *employee* first enrolls. If the *employee* and/or *dependents* do not enroll when first eligible, the *employee* and/or *dependents* may only apply for coverage at the group's annual open enrollment period, except as stated in Special Enrollment Provisions subsection or if court-ordered.

At any time, the *Plan* may require proof that a *dependent* qualifies or continues to qualify as a *dependent* as defined by this *Plan*.

B. Enrollment

Enrollment Requirements

An *employee* must enroll for coverage for themselves and their *dependents* by completing the enrollment process along with the appropriate payroll deduction authorization.

Enrollment Requirements for Newborn Children

Newborn children will be covered from the time of birth **only if** timely enrollment is received and required contributions are authorized within thirty-one (31) days of the date of birth.

If the newborn child is not enrolled in this *Plan* on a timely basis, as defined in the subsection Timely Enrollment, there will be no payment from the *Plan* and the parents will be responsible for all costs. You will also have to wait until the next open enrollment period to add the child as a *dependent*.

C. Timely Enrollment

Timely Enrollment

The enrollment will be timely if the completed form is received by the *Plan Administrator* no later than thirty-one (31) days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

Late Enrollment

An enrollment is late if it is not made on a timely basis or during a Special Enrollment Period. *Late enrollees* and their *dependents* who are not eligible to join the *Plan* during the Special Enrollment Period may join only during open enrollment.

The time between the date a *late enrollee* first becomes eligible for enrollment under the *Plan* and the first day of coverage is not treated as a waiting period. Coverage begins July 1.

D. Special Enrollment Rights

Federal law provides special enrollment provisions under some circumstances. If an *employee* is declining enrollment for himself or herself or his or her *dependents* (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this *Plan* if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within thirty-one (31) days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, registration of a domestic partnership, adoption, or placement for adoption, there may be a right to enroll in this *Plan*. However, a request for enrollment must be made as stated in the Qualifying Events Chart.

The special enrollment rules are described in more detail below. To request special enrollment, or obtain more detailed information of these portability provisions, contact your Human Resources Department.

Note: *Employees* and eligible *dependents* fial enrollment event during the *benefit year* may not elect to move to a different plan option once enrolled.

E. Special Enrollment Periods

Individuals that do not enroll in the *Plan* during their initial eligibility period because at the time they have other *creditable coverage*, and then they subsequently lose that coverage as a result of certain events such as termination of spouse's employment, loss of eligibility for coverage, expiration of COBRA coverage, reduction in the number of hours of employment, or employer contributions towards such coverage terminates, may now enroll in this *Plan*. Enrollment in this *Plan* must be completed as stated within the Qualifying Events Chart.

F. Qualifying Events Chart

This chart is only a summary of some of the permitted health plan changes and is not all-inclusive.

If changes are not made within the specified timeline, the eligible *employee*, and/or *dependent* will have to wait until open enrollment to make any change in coverage.

Qualifying Event	Effective Date	Forms and Notification Must be Received Within:	You May Make the Following Changes(s)
Marriage or registration of a domestic partnership	date of event	thirty-one (31) days of marriage	Enroll yourself, if applicable Enroll your new spouse and other eligible *dependents*
Divorce, legal separation, or annulment	first of the month following the date of the event	thirty-one (31) days of the date of final divorce decree or annulment	Coverage will terminate for your spouse Enroll yourself and *dependent* child(ren) if you, or they, were previously enrolled in your spouse's plan
Birth of your child	date of event	thirty-one (31) days of birth	Enroll yourself Enroll the newborn child
Adoption, placement for adoption, *foster child*, or legal guardianship of a child	date of event	thirty-one (31) days of event	Enroll yourself Enroll the newly adopted child
Your *dependent* child reaches maximum age for coverage	first of the month following the date of the event	thirty-one (31) days of loss of eligibility	Coverage will terminate for the child who lost eligibility from your health coverage
Death of your spouse or *dependent* child	date of event	sixty (60) days of spouse's or *dependent's* death	Coverage will terminate for the *dependent* from your health coverage
A *change in employment status* in *employment* classification or work schedule for you, your spouse, or *dependent* child	first of the month following the date of the event	thirty-one (31) days of *change in employment status* classification	Enroll yourself, if your employment change results in you being eligible for a new set of benefits Enroll your spouse and other eligible *dependents* Drop health coverage Drop your spouse and other eligible *dependents* from your health coverage
Change of residence or worksite if change impairs ability to access *network providers*	first of the month following the date of the event	thirty-one (31) days of *change in employment status* classification	Enroll or drop coverage for yourself, your spouse, or covered *dependent* children
Significant change in or cost of your or your spouse's or *dependent's* health coverage due to spouse's or *dependent's* employment, including open enrollment	first of the month following the date of the event	thirty-one (31) days of effective date of change in coverage	Enroll yourself and other eligible *dependents*
Significant change in benefits	first of the month following the date of the event	thirty-one (31) days of effective date of change in coverage	Enroll yourself and other eligible *dependents*
Spouse or covered *dependent* obtains coverage in another group health plan	first of the month following the date of the event	thirty-one (31) days of gain of coverage	Drop coverage for yourself, your spouse, or covered *dependent* children
Loss of other coverage, including COBRA coverage	first of the month following the date of the event	thirty-one (31) days of the date of loss of coverage	Enroll yourself, your spouse and eligible *dependent* children

Spouse's loss of coverage, including COBRA coverage	first of the month following the date of the event	thirty-one (31) days of the date of loss of coverage	Enroll your spouse and eligible *dependent* children Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse's plan
Eligibility for government-sponsored plan, such as *Medicare* (excluding the government-sponsored Marketplace)	first of the month following the date of the event	thirty-one (31) days of eligibility date	Drop coverage for the person who became entitled to *Medicare*, Medicaid, or other eligible coverage
CHIP Special Enrollment – loss of eligibility for coverage under a state Medicaid or CHIP program, or eligibility for state premium assistance under Medicaid or CHIP	first of the month following the date of the event	sixty (60) days of loss of eligibility or eligibility date	Enroll yourself, if applicable Add the person who lost entitlement to CHIP Drop coverage for the person entitled to CHIP coverage
Qualified Medical Support Order affecting a *dependent* child's coverage	first of the month following receipt of the notice	thirty-one (31) days of order	Enroll yourself, if applicable Enroll the eligible child named on *QMCSO*

G. Effective Date

Effective Date of Employee Coverage

An *employee* will be covered under this *Plan* as of the first day of the calendar month following the date that the *employee* satisfies **all** of the following:

1. the eligibility requirement
2. the *active employee* requirement
3. the enrollment requirements of the *Plan*

Active Employee Requirement

An *employee* must be an *active employee* (as defined by this *Plan*) for this coverage to take effect.

Effective Date of Dependent Coverage

A *dependent's* coverage will take effect on the day that the eligibility requirements are met; the *employee* is covered under the *Plan*; and all enrollment requirements are met.

H. Termination of Coverage

Rescission of Coverage

Coverage under the *Plan* may be rescinded (cancelled retroactively) if you or a covered *dependent* perform an act, practice, or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the *Plan*. Coverage may also be rescinded for failure to pay required premiums or contributions as required by the *Plan*. Coverage may be rescinded to your date of divorce if you fail to notify the *Plan* of your divorce and you continue to cover your ex-spouse under the *Plan*. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered *dependent*. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the *Plan* will provide at least thirty (30) days advance written *notice* of such action.

When Employee Coverage Terminates

Employee coverage will terminate on the earliest of these dates, except in certain circumstances, a covered *employee* may be eligible for COBRA continuation coverage.

1. the date the *Plan* is terminated
2. the last day of the calendar month in which the covered *employee* ceases to be in one of the eligible classes

   This includes termination of *active employment* of the covered *employee,* an *employee* on disability, or other *leave of absence*, unless the *Plan* or federal or state law specifically provides for continuation during these periods.

3. The last day of the calendar month of the covered *employee's* death
4. the end of the period for which the required contribution has been paid if the charge for the next period is not paid when due

For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled **Continuation Coverage Rights under COBRA.**

When Dependent Coverage Terminates

A *dependent's* coverage will terminate on the earliest of these dates, except in certain circumstances, a covered *dependent* may be eligible for COBRA continuation coverage.

1. the date the *Plan* or *dependent* coverage under the *Plan* is terminated
2. the date that the *employee's* coverage under the *Plan* terminates for any reason including death
3. on the last day of the calendar month a covered spouse loses coverage due to loss of *dependency* status
4. on the end of the month that a person ceases to be a *dependent* as defined by the *Plan*
5. on the last day of the calendar month that a *dependent* child ceases to be a *dependent* as defined by the *Plan* due to age as listed in the Eligible Classes of Dependents provisions
6. the last date of the month of the covered *dependent's* death
7. the end of the period for which the required contribution has been paid if the charge for the next period is not paid when due

For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled **Continuation Coverage Rights under COBRA**.

When Domestic Partner Coverage Terminates

For Participating Entities who elect to provide benefits to domestic partners ONLY

In addition to the reasons stated above concerning *dependent* spouses and children, a domestic partner and/or the children of the domestic partner also lose eligibility for coverage on the earliest of these dates:

1. on the last day of the calendar month in which the domestic partner who is the eligible *employee* loses coverage under this benefit *Plan*
2. on the last day of the calendar month in which the domestic partnership is terminated or dissolved
3. on the last day of the calendar month in which the group discontinues eligibility for domestic partners and/or eligible children of the domestic partner

I. Continuation during Family and Medical Leave

Regardless of the established leave policies mentioned above, this *Plan* shall at all times comply with the *Family and Medical Leave Act of 1993 (FMLA)* as promulgated in regulations issued by the Department of Labor.

During any leave taken under the *Family and Medical Leave Act*, the *employer* will maintain coverage under this *Plan* on the same conditions as coverage would have been provided if the covered *employee* had been continuously employed during the entire leave period.

If *Plan* coverage terminates during the *FMLA leave*, coverage will be reinstated for the *employee* and his or her covered *dependents* if the *employee* returns to work in accordance with the terms of the *FMLA leave*. Coverage will be reinstated only if the person(s) had coverage under this *Plan* when the *FMLA leave* started, and will be reinstated to the same extent that it was in force when that coverage terminated.

J. Continuation during Periods of Employer-Certified Disability, Leave of Absence, or Layoff

A person *may* remain eligible for a limited time if active, full-time work ceases due to disability, *leave of absence,* or layoff. For information regarding this continuance, please refer to your *participating entity's* employee handbook.

K. Continuation of Coverage for Certain Public Safety Employees

Pursuant to Arizona Revised Statute § 38-961, eligible Public Safety Employees who are injured while on duty, to the extent that they cannot perform the functions of their position, may be eligible to continue their coverage under this *Plan* on the same conditions and with the same coverage as an actively-at-work *employee*. The Public Safety Employee

must be receiving Workers' Compensation benefits and meet established *injury* standards as determined by the *employer*. Continuation of coverage will be offered for a period of six (6) months.

L. Special Eligibility for Surviving Spouses and Surviving Unmarried Dependents of Certain Law Enforcement Officers

Pursuant to Arizona Revised Statute § 38-1103, certain Surviving Spouses and Unmarried Dependents of Law Enforcement Officers, as defined in Arizona Revised Statute § 38-1103(G)(2), who were killed in the line of duty, or who died from *injuries* suffered in the line of duty, and who were enrolled in a Health Insurance Program defined in Arizona Revised Statute § 38-1103(B) at the time the Law Enforcement Officer was killed in the line of duty or died from *injuries* suffered in the line of duty, are eligible to continue obtaining coverage under this *Plan*. Such eligibility ends for a surviving spouse under this section when they remarry, become *Medicare* eligible, or die. Such eligibility ends for a surviving unmarried *dependent* when they turn twenty-six (26) years of age.

The premium payable by the *participating entity employer* of the deceased Law Enforcement Officer is the amount the *employer* of the deceased Law Enforcement Officer would pay for an active Law Enforcement Officer for single or family coverage premium, whichever is applicable.

M. Rehiring a Terminated Employee

A terminated *employee* who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements to the extent permitted by the terms of the *Plan* and applicable law.

N. Open Enrollment

Every year during the annual open enrollment period, covered *employees* and their covered *dependents* will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the open enrollment period will become effective July 1 and remain in effect until the next June 30 unless the *employee* qualifies for a Special Enrollment Period. To the extent previously satisfied coverage waiting periods will be considered satisfied when changing from one benefit option under the *Plan* to another benefit option under the *Plan*.

A *plan participant* who fails to make an election during the *open enrollment period* may lose coverage. Each *employer* determines whether an *open enrollment period* is considered active or passive. Since this can change from year to year, please verify with your *employer* whether you need to make a new election during the *open enrollment period* to avoid losing coverage.

Plan participants will receive detailed information regarding open enrollment from their *employer*.

SECTION III—CONSOLIDATED APPROPRIATIONS ACT OF 2021 AND TRANSPARENCY IN COVERAGE REGULATIONS

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Billing Act. In addition, the Transparency in Coverage (TIC) regulations contain transparency requirements. Portions of the CAA and TIC are described briefly below. Enforcement dates, standards for implementation, coordination with other entities, legal developments, and updates offered by federal and/or state entities directly impact actions and availability of the items described. In addition, some plan types are not subject to the CAA and/or TIC, or certain provisions of either.

A. Surprise Billing Claims

Surprise billing claims are claims that are subject to the No Surprises Billing Act requirements. These are:

1. *emergency services* in an emergency department of a hospital or independent freestanding emergency department provided by *non-network* providers or facility
2. services provided by a *non-network* provider at a *network* facility
3. *non-network* air ambulance services

The section below contains further information about how these *claim* categories apply to your *Plan* and are dependent on covered benefits.

B. No Surprises Billing Act Requirements

Emergency Services

As required by the CAA, *emergency services* are covered under your *Plan*:

1. without the need for *pre-certification*
2. whether the provider is *network* or *non-network*

If the *emergency services* you receive in an emergency department of a hospital or independent freestanding emergency department are provided by a *non-network* provider or facility, covered services will be processed at the *network* benefit level in accordance with the CAA.

Note that if you receive *emergency services* from a *non-network* provider or facility, your out-of-pocket costs will be limited to amounts that would apply if the covered services had been furnished by a *network* provider or facility. However, *non-network cost-sharing amounts* (i.e., *co-payments*, *deductibles*, and/or *co-insurance*) will apply to your *claim* if the treating *non-network* provider or facility determines you are stable and the *non-network* provider satisfies all of the following requirements:

1. determines that you are able to travel to a *network* facility by non-emergency or non-medical transport to an available *network* provider or facility within a reasonable distance based on your condition
2. complies with the *notice* and consent requirement
3. determines that you are in condition to receive the information and provide informed consent

If you continue to receive services from the *non-network* provider after you are stabilized, you will be responsible for the *non-network cost-sharing amounts*, and the *non-network* provider will also be able to charge you any difference between the *maximum allowable amount* and the *non-network* provider's billed charges.

Non-Network Services Provided at a Network Facility

When you receive covered services from a *non-network* provider at a *network* facility, your *claims* will be paid at the *non-network* benefit level if the *non-network* provider gives you proper *notice* of its charges, and you give written consent to such charges. This means you will be responsible for *non-network cost-sharing amounts* for those services and the *non-network* provider can also charge you any difference between the *maximum allowable amount* and the *non-network* provider's billed charges.

This requirement does not apply to ancillary services. Ancillary services are defined as:

1. items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a *physician* or non-physician practitioner
2. items and services provided by assistant surgeons, hospitalists, and intensivists

3. diagnostic services, including radiology and laboratory services
4. items and services provided by a *non-participating provider* if there is no *participating provider* who can furnish such item or service at such facility

This *notice* and consent exception also does not apply if the covered services furnished by a *non-network* provider result from unforeseen and urgent medical needs arising at the time of service.

Non-network providers satisfy the *notice* and consent requirement by one (1) of the following:

1. by obtaining your consent and offering the required notice not later than seventy-two (72) hours prior to the delivery of services
2. the *notice* is given and consent is obtained on the date of the service, if you make an appointment within seventy-two (72) hours of the services being delivered

To help you determine whether a provider is *non-network*, the *network* is required to confirm the list of *network* providers in its provider directory every ninety (90) days. If you can show that you received inaccurate information from the *network* that a provider was *in-network* on a particular *claim*, then you will only be liable for *network cost sharing amounts* (i.e., *co-payments*, *deductibles*, and/or *co-insurance*) for that *claim*. Your *network cost-sharing amount* will be calculated based upon the *maximum allowed amount*. In addition to your *network* cost-share, the *non-network* provider can also charge you for the difference between the *maximum allowed amount* and their billed charges.

C. How Cost-Shares Are Calculated

Your *cost sharing amounts* for emergency services in an emergency department of a hospital or independent freestanding emergency department or for covered services received by a *non-network* provider at a *network* facility will be calculated as defined by the CAA, such as the lesser of billed charges or the median plan *network* contract rate (called the Qualifying Paying Amount or QPA) that we pay *network* providers for the geographic area where the covered service is provided if other calculation criteria does not apply. Any out-of-pocket cost you pay to a *non-network* provider for either these *emergency services* or for covered services provided by a *non-network* provider at a *network* facility will be applied to your *network out-of-pocket limit*. Cost-sharing for air ambulance services is based on the lesser of billed charges or the QPA.

D. Appeals

If you receive *emergency services* in an emergency department of a hospital or independent freestanding emergency department from a *non-network* provider, covered services from a *non-network* provider at a *network* facility, or *non-network* air ambulance services, and believe those services are covered by your *Plan's* benefits and the No Surprise Billing Act, you have the right to appeal that *claim*. If your appeal of a *surprise billing claim* is denied, then you have a right to appeal the adverse decision to an independent review organization as set out in the **Claims and Appeals** section of this summary plan description. A provider can dispute the payment they received from the *Plan* by utilizing a process set up by the CAA, or if applicable, state law. The CAA process includes Open Negotiation, and if unresolved, Independent Dispute Resolution. Importantly, this process does not include the *plan participant*, and you are not required to participate. To learn more about the CAA, you can visit **https://www.cms.gov/nosurprises**.

E. Transparency Requirements

1. Under your *Plan*, the following are provided as required by the CAA and TIC. Depending on how the *Plan* interacts with other entities, these may be provided from the *Third Party Administrator*, the *network*, Pharmacy Benefit Manager, and/or other stakeholders (ex. Customer Care or Member Services), protections with respect to *surprise billing claims* by providers
2. estimates on what *non-network* providers may charge for a particular service
3. information on contacting state and federal agencies in case you believe a provider has violated the No Surprise Billing Act's requirements

When asked, a paper copy of the type of information you request from the above list can be provided.

Through the price comparison/shoppable services tool(s) associated with your *Plan* or through Member Services at the phone number on the back of your ID card, you can received the following:

1. cost sharing information that you would be responsible for, for a service from a specific *network* provider

2. a list of all *network* providers
3. cost sharing information on *non-network* provider services based on what you may pay *non-network* providers for the service

As applicable, under machine readable requirements from the TIC, the *network*, Pharmacy Benefit Manager, *Third Party Administrator, and/or* entities associated with your *Plan* will provide access through separate publicly accessible websites that contain the following information:

1. *network* negotiated rates
2. historical *non-network* allowed amounts
3. drug pricing information

F. Continuity of Care

If a *network* provider leaves the *network* for any reason other than termination for failure to meet applicable quality standards, fraud, or otherwise defined by the CAA, you may be able to continue seeing that provider for a limited period of time and still receive *network* benefits. The CAA permits you to request and decide to continue to have benefits provided under the same terms and conditions as you would have had under the plan document had the provider not moved to *non-network* status. If authorized, continuity of care ends ninety (90) days after you are notified by the *Plan* or its delegate of the right to request continuity of care or the date you are no longer under care of the provider, whichever of these is earlier.

Continuity of care under the CAA is permitted for a *plan participant* who, with respect to a provider, qualifies based on any of the following circumstances:

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility
2. is undergoing a course of institutional or inpatient care from the provider or facility
3. is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility

Under the CAA, the term 'serious and complex condition' means, with respect to a *participant*, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage, one (1) of the following:

1. in the case of an acute *illness*, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm
2. in the case of a chronic *illness* or condition, a condition that satisfies both of the following criteria:
    a. is life-threatening, degenerative, potentially disabling, or congenital
    b. requires specialized medical care over a prolonged period of time

If you wish to continue seeing the same provider/facility and you believe continuity of care under the CAA applies, you or your provider/facility should contact the entity responsible for Member Services on back of your card for how to apply for continuity of care.

SECTION IV—MEDICAL NETWORK INFORMATION

A. Network and Non-Network Services

Network Provider Information

The *Plan* has entered into an agreement with a medical *network* that maintains contractual agreements with certain *hospitals*, *physicians*, and other health care *providers* which are called *network providers*. Because these *network providers* have agreed to charge reduced fees to persons covered under the *Plan*, the *Plan* can afford to reimburse a higher percentage of their fees.

Therefore, when a *plan participant* uses a *network provider*, that *plan participant* will receive better benefits from the *Plan* than when a *non-network provider* is used. It is the *plan participant's* choice as to which *provider* to use. Before receiving scheduled services, verify the *network* status of all *providers* who will be involved in your care, such as assistant surgeons, anesthesiologists, and radiologists, as well as the facility where the services will be performed.

Non-Network Provider Information

*Non-network provider*s have no agreements with the *Plan* or the *Plan's* medical *network* and are generally free to set their own charges for the services or supplies they provide. The *Plan* will reimburse for any *medically necessary* services or supplies, subject to the *Plan's deductibles*, *co-insurance*, limitations, and exclusions. *Plan participants* must submit proof of *claim* before any such reimbursement will be made.

Before you obtain services or supplies from a *non-network provider*, you can find out whether the *Plan* will provide *network* or *non-network* benefits for those services or supplies by contacting the *Third Party Administrator* as outlined in the Quick Reference Information Chart.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations section** for additional provisions pertaining to *non-network* services and billing.

Provider Non-Discrimination

To the extent that an item or service is a *covered charge* under the *Plan*, the terms of the *Plan* shall be applied in a manner that does not discriminate against a health care *provider* who is acting within the scope of the *provider's* license or other required credentials under applicable state law. This provision does not preclude the *Plan* from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided, and does not require the *Plan* to accept all types of *providers* as a *network provider*.

B. Choosing a Physician – Patient Protection Notice

The *Plan* does not require you to select a *primary care provider* (*PCP*) to coordinate your care and you do not have to obtain a referral to see a *specialist*.

You do not need prior authorization from the *Plan* or *Third Party Administrator*, or from any other person (including your *PCP*) 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 *provider*, however, may be required to comply with certain procedures, including obtaining *pre-certification* for certain services, following a pre-approved treatment plan, or procedures for making referrals.

C. Special Reimbursement Provisions

Under the following circumstances, the higher *network* payment will be made for certain *non-network* services:

1. **Medical Emergency**. In a *medical emergency*, a *plan participant* should try to access a *network provider* for treatment. However, if immediate treatment is required and this is not possible, the services of *non-network providers* will be covered until the *plan participant's* condition has stabilized to the extent that they can be safely transferred to a *network provider's* care. At that point, if the transfer does not take place, *non-network* services will be covered at *non-network* benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for notifying the *Third Party Administrator* for a review of any *claim* that meets this definition.
2. **No Choice of Provider**. If, while receiving treatment at a *network* facility, a *plan participant* receives ancillary services or supplies from a *non-network provider* in a situation in which they have no control over *provider* selection (such as in the selection of an emergency room visit, pathology, laboratory, radiology, anesthesia, or assistant surgery services), such *non-network* services or supplies will be covered at *network* benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant*

will be responsible for notifying the *Third Party Administrator* for a review of any *claim* that meets this definition.

3. **Providers Outside of Network Area.** If *non-network* provider specialists are used because the necessary specialty is not in the *network* or is not reasonably accessible to the *plan participant* due to geographic constraints [over fifty (50) miles from home or work], such *non-network* specialist care will be covered at *network* benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for notifying the *Third Party Administrator* for a review of any *claim* that meets this definition.

Additional information about this option, as well as a list of *network providers*, will be given to *plan participants*, at no cost, and updated as needed. This list will include *providers* who specialize in obstetrics or gynecology.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations section** for additional provisions pertaining to *non-network* services and billing.

D. Network Information

You may obtain more information about the *providers* in the *network* by contacting the *network* by phone or by visiting their website.

An Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross® and Blue Shield® of Arizona

Provider Information:

1-855-350-8699

www.azblue.com/CHSnetwork

SECTION V—SCHEDULES OF BENEFITS

Verification of Eligibility: 1-855-350-8699

Call this number to verify eligibility for *Plan* benefits **before** charges are *incurred*. Please note that oral or written communications with the *Third Party Administrator* regarding a *plan participant's* or beneficiary's eligibility or coverage under the *Plan* are not *claims* for benefits, and the information provided by the *Third Party Administrator* or other *Plan* representative in such communications does not constitute a certification of benefits or a guarantee that any particular *claim* will be paid. Benefits are determined by the *Plan* at the time a formal *claim* for benefits is submitted according to the procedures outlined within the **Claims and Appeals** section of this plan document.

A. Schedule of Medical Benefits

All benefits described in this **Schedules of Benefits** section are subject to the exclusions and limitations described more fully herein including, but not limited to, the *Plan Administrator's* determination that: care and treatment is *medically necessary*; that charges are in accordance with the *maximum allowable charge*; and that services, supplies, and care are not *experimental* and/or *investigational*.

This document is intended to describe the benefits provided under the *Plan,* but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all *covered charges* and/or exclusions with specificity. If you have questions about specific supplies, treatments, or procedures, please contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

The *Plan Administrator* retains the right to audit *claims* to identify treatment(s) that are, or were, not *medically necessary*, *experimental*, *investigational*, or in accordance with the *maximum allowable charges*.

Pre-Certification

The following services must be *pre-certified* or reimbursement from the *Plan* will be reduced by $300 for paid *claims*. The *plan participant* will be responsible to pay this additional amount if he or she did not obtain *pre-certification*.

1. *inpatient* pre-admission certification and continued stay reviews (all ages, all diagnoses)
    a. surgical and non-surgical (excluding routine vaginal or cesarean deliveries)
    b. long term acute care facility (LTAC), not *custodial care*
    c. *skilled nursing facility*/rehabilitation facility
    d. *inpatient mental health/substance use disorder* treatment (includes *residential treatment facility* services)

    The attending *physician* does not have to obtain *pre-certification* from the *Plan* for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.
2. *inpatient* and *outpatient surgery* including pain management injections and intra-articular hyaluronic acid injections

    Pre-certification is not required for office *surgeries* and all colonoscopies/sigmoidoscopies (screening and diagnostic).
3. advanced imaging – Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans (excluding services rendered in an emergency room setting)
4. *outpatient* rehabilitation services (physical therapy, occupational therapy, and speech therapy) in excess of twenty (20) visits per *benefit year* per therapy type
5. chemotherapy drugs/infusions and radiation treatments for oncology diagnoses
6. *home health care services* and supplies
7. transplant (other than cornea), including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high-dose chemotherapy
8. orthotics/prosthetics in excess of $3,000 (purchase/rental price)
9. *durable medical equipment* in excess of $3,000 (purchase/rental price)
10. genetic/genomic testing (excluding amniocentesis) in excess of $1,000

11. clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening *disease* or condition

    This *Plan* does not cover clinical trials related to other *diseases* or conditions. Refer to the **Medical Benefits** section of this document for a further description and limitations of this benefit.

12. non-emergent air ambulance
13. intensive *outpatient* program in excess of twenty (20) visits per *benefit year*, for *mental health and substance use disorder* treatment
14. partial hospitalization in excess of twenty (20) visits per *plan participant* per *benefit year*
15. non-invasive pre-natal testing
16. sleep disorders
17. specialty infusion/injectable medications over $3,000 per infusion/injection which are covered under the medical benefits and not obtained through the Prescription Drug Benefits (i.e. provided in an *outpatient* facility, *physician's* office, or home infusion)

    For specialty drugs obtained through the Pharmacy Benefits Manager, please refer to the **Prescription Drug Benefits** section for additional information and requirements for prior authorization.

18. dental services required for medical procedures

Services rendered in an emergency room or urgent care setting do not require *pre-certification*.

Please see the Health Care Management Program section in this document for details.

B. Balance Bill

The balance bill refers to the amount you may be charged for the difference between a *non-network provider's* billed charges and the *allowed charge*.

Network providers will accept the *allowed charge* for *covered charges*. They will not charge you for the difference between their billed charges and the *allowed charge*.

Non-network providers have no obligation to accept the *allowed charge*. You are responsible to pay a *non-network provider's* billed charges, even though reimbursement is based on the *allowed charge*. Depending on what billing arrangements you make with a *non-network provider*, the *provider* may charge you for full billed charges at the time of service or seek to balance bill you for the difference between billed charges and the amount that is reimbursed on a *claim*.

Any amounts paid for balance bills do not count toward *deductible*, *co-insurance*, or the *out-of-pocket limit*.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations section** for additional provisions pertaining to *non-network* services and billing.

C. Co-Insurance

For *covered charges incurred* with a *network provider*, the *Plan* pays a specified percentage of the negotiated rate. This percentage varies, depending on the type of *covered charge*, and is specified in the Schedule of Medical Benefits – HDHP Plan. You are responsible for the difference between the percentage the *Plan* pays and 100% of the negotiated rate.

For *covered charges incurred* with a *non-network provider*, the *Plan* pays a specified percentage of *covered charges* at the *maximum amount*. In those circumstances, you are responsible for the difference between the percentage the *Plan* pays and 100% of the billed amount, unless your *claim* is a *surprise billing claim*.

These amounts for which you are responsible are known as *co-insurance*.

Unless noted otherwise in the Special Comments column of the Schedule of Medical Benefits – HDHP Plan or in the **Medical Benefits** section, your *co-insurance* applies towards satisfaction of the *out-of-pocket limit*.

D. Deductible

Deductibles are dollar amounts that the *plan participant* must pay before the *Plan* pays. Before benefits can be paid in a *benefit year* a *plan participant* must meet the *deductible* shown in the Schedule of Medical Benefits – HDHP Plan.

This amount will accrue toward the 100% maximum *out-of-pocket limit*.

E. Requirements for a Health Savings Account (HSA)

To be eligible for enrollment in a Health Saving Account (HSA), you must meet **all** of the following criteria:

1. be enrolled in a Qualified HDHP
2. not be covered under another group insurance plan
3. not be enrolled in a general purpose health care flexible spending account (and your spouse may not be enrolled in a general purpose flexible spending account)
4. not be enrolled in *Medicare*
5. not be claimed as a dependent on someone else's tax return (except a spouse)

F. How an HSA works

Your taxable wages are reduced by the amount of your contribution to your HSA. Funds you withdraw to pay for qualified medical expenses, as defined by Section 213(d) of the IRS Tax Code, are tax-free. If you use your HSA funds to pay for non-health related expenses, the amount will be taxable as regular income and you will pay an additional 20% tax penalty. The tax penalty does not apply if you are over age sixty-five (65) or enrolled in *Medicare*, but is treated as gross income for tax purposes.

G. Qualified Medical Expenses

A partial list is provided in IRS Publication 502 (available at **www.irs.gov**).

H. Benefit Payment

Each *benefit year*, benefits will be paid for the *covered charges* of a *plan participant* that are in excess of the *deductible,* any *co-payments*, and any amounts paid for the same services. Payment will be made at the rate shown under reimbursement rate in the Schedule of Medical Benefits.

Services rendered may have professional, facility, and other components for which *physicians* and facilities may bill separately.

Specific Benefit Maximum

Some benefits may have a specific *benefit maximum*, either a dollar amount or a visit limitation. Amounts applied to the *benefit maximum* are calculated based on the *allowed charge*. No benefits will be paid over the maximum amount specified in a benefit provision. *Benefit maximums* (when applicable) are shown in the Schedule of Medical Benefits – HDHP Plan or in the **Medical Benefits** or **Transplant Program** sections. The *benefit maximum* only includes those which are paid by the *Plan. Cost sharing amounts* paid by the *plan participant* do not apply toward the *benefit maximum*.

I. Out-of-Pocket Limit

Covered charges are payable at the percentages shown each *benefit year* until the *out-of-pocket limit* shown in the Schedule of Medical Benefits – HDHP Plan is reached. Then, *covered charges incurred* by a *plan participant* will be payable at 100% (except for the charges excluded) for the rest of the *benefit year*.

J. Diagnosis-Related Grouping (DRG)

Diagnosis related grouping (*DRG*) is a method for reimbursing *hospitals* for *inpatient* services. This is when a provider bills for services that go together in a group, or bundle, instead of the individual services that make up the group separately. The provider has agreed to a set *DRG* rate with the *network*. When a service is rendered, regardless of what the provider bills, the *DRG* amount has already been set for that specific group of services. A *DRG* amount can be higher or lower than the actual billed charge because it is based on an average cost for the services rendered.

In the case where the *DRG* amount on an eligible *claim* is higher than the actual billed charges, the following will determine how each party's cost sharing will be determined:

1. the *Plan* will base their portion of the charge on the *network allowed amount*
2. the *plan participant's* portion of the charge will be based on the billed charges
3. the difference in the *network allowed amount* versus the actual billed charges will be the responsibility of the *plan participant*

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

K. Schedule of Medical Benefits – HDHP Plan

Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross and Blue Shield Association, provides *network* access only and does not provide administrative or *claims* payment services and does not assume any financial risk or obligation with respect to *claims*. The *Plan* has assumed all liability for *claims* payment.

This Schedule of Medical Benefits – HDHP Plan outlines some (but not all) of the common benefits of the *Plan*. Refer to the sections entitled **Medical Benefits** and **Health Care Management Program** for more information regarding exclusions, limitations, and services needing *pre-certification*.

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Deductible, per Benefit Year The *network* and *non-network deductible* amounts do not accumulate towards each other. You may not use any portion of a *network deductible* to meet a *non-network deductible* and vice versa. *Co-insurance* does not apply to the *deductible*.		
Per *plan participant*	$3,200	$5,000
Per *family unit*	$6,400	$10,000
Deductible Rules when Enrolled in the HDHP Plan: If you are enrolled in the HDHP Plan, the *Plan* does not pay ANY benefits [except certain preventive/wellness care outlined in the Routine Preventive Care and Wellness Care (not defined by PPACA) rows of the Schedule of Medical Benefits – HDHP Plan] until your *deductible* has been met. *Employees* must meet the *deductible* and *out-of-pocket limit* based on their selected level of coverage. For example, once any single individual reaches the individual (*plan participant) deductible* amount in *covered charges*, the *Plan* will begin to pay for his or her *covered charges*. Any combination of family members can meet the *family unit deductible*.		
Family Unit - Embedded Deductible Limit If you are enrolled in the *family unit* option, your *Plan* contains two (2) components: an individual *deductible* and a *family unit deductible*. Having two (2) components to the *deductible* allows for each member of your *family unit* the opportunity to have your *Plan* cover medical expenses prior to the entire dollar amount of the *family unit deductible* being met. The individual *deductible* is embedded in the family *deductible*. **For example,** if you, your spouse, and child are on a family plan with a $5,800 *family unit* embedded *deductible*, and the individual *deductible* is $2,900, and your child *incurs* $2,900 in medical bills, their *deductible* is met, and your *Plan* will help pay subsequent medical bills for that child during the remainder of the *calendar year*, even though the *family unit deductible* of $5,800 has not been met yet.		
Out-of-Pocket Limit, per Benefit Year The *out-of-pocket limit* includes *deductibles*. The *network* and *non-network out-of-pocket limits* do not accumulate towards each other.		
Per *plan participant*	$3,200	$10,000
Per *family unit*	$6,400	$20,000

Family Unit - Embedded Out-of-Pocket Limit

If you are enrolled in the *family unit* option, your *Plan* contains two (2) components: an individual *out-of-pocket limit* and a *family unit out-of-pocket limit*. Having two (2) components to the *out-of-pocket limit* allows for each member of your *family unit* the opportunity to have his/her *covered charges* be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the *family unit out-of-pocket limit* being met. The individual *out-of-pocket limit* is embedded in the *family unit out-of-pocket limit*.

The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached, at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *benefit year,* unless stated otherwise.

Note: The following charges do not apply toward the out-of-pocket limit and are generally not paid by the Plan:

1. *pre-certification* penalties
2. medical food charges
3. health care this *Plan* doesn't cover
4. *balance billed* charges

Note: The maximums listed below are the total for *network* and *non-network* expenses. For example, if a maximum of sixty (60) days is listed under a service, the *benefit year* maximum is sixty (60) days total which may be split between *network* and *non-network providers*.

Benefits shown as *co-payments* are listed for what the *plan participant* will pay.

Benefits shown as *co-insurance* are listed for the percentage the *Plan* will pay.

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
General Percentage Payment Rule	100% after *deductible*	50% after *deductible*	Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply.
HOSPITAL SERVICES			
Emergency Room	100% after *deductible*		Emergency room treatment is limited to *medical emergencies* having sudden and unexpected onset requiring immediate care to safeguard the life of the *plan participant*.
Intensive Care Unit	100% after *deductible*	50% after *deductible*	***Pre-certification* is required.**
Room and Board	100% after *deductible*	50% after *deductible*	Limited to the semi-private room rate when such semi-private room rate is available. ***Pre-certification* is required.**
Skilled Nursing Facility/ Extended Care	100% after *deductible*	50% after *deductible*	**Benefit year maximum:** Sixty (60) days per *plan participant*. Long-term acute care and rehabilitation hospital services apply toward this maximum. ***Pre-certification* is required.**
PHYSICIAN SERVICES			
Allergy Services			
Allergy Testing & Treatment	100% after *deductible*	50% after *deductible*	
Allergy Serum & Injections	100% after *deductible*	50% after *deductible*	
Ambulance Service	100% after *deductible*		
Ancillary Providers	100% after *deductible*	50% after *deductible*	*Providers* who do not typically contract (e.g. anesthesiologist, pathologists, and assistant surgeons) are to be paid based on the network status of the facility in which the services were rendered.
Bariatric Surgery	100% after *deductible*	Not Available	**Lifetime Maximum:** One (1) procedure per *plan participant*. See also the Covered Medical Charges subsection for additional restrictions and qualifications.
Cardiac Rehabilitation	100% after *deductible*	50% after *deductible*	Outpatient cardiac rehabilitation services are available for an outpatient Phase I and/or II cardiac rehabilitation program when prescribed by a *physician* and rendered by an eligible *provider*.

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES continued			
Cataract Surgery (Glasses)	100% after *deductible*	50% after *deductible*	Following *surgery*, benefits are available for eyeglasses or external contact lenses, up to a $500 maximum per *plan participant*, per twelve (12) month period. Refer to the section entitled **Medical Benefits**, Covered Medical Charges, Cataract Surgery, for further requirements and limitations.
Chiropractic Treatment	100% after *deductible*	50% after *deductible*	**Benefit Year Maximum:** Thirty (30) visits per *plan participant*.
Counseling	100% after *deductible*	Not Available	Refer to the section entitled **Medical Benefits**, Covered Medical Charges, Counseling, for further requirements and limitations.
Dental Injury	100% after *deductible*		Refer to the **Medical Benefits** section, Covered Medical Charges subsection for further requirements and limitations. ***Pre-certification* is required** depending on type of service.
Durable Medical Equipment (DME)	100% after *deductible*	50% after *deductible*	The following items will be considered under the *DME* benefit: a. compression and/or jobst stockings: limited to four (4) units per *benefit year* per *plan participant* b. insulin pump c. continuous blood glucose monitor ***Pre-certification* is required for DME in excess of $3,000 purchase/rental price.**
Genetic/Genomic Testing and Counseling	100% after *deductible*	Not Covered	***Pre-certification* is required for genetic/genomic testing and counseling in excess of $1,000.**
Hearing Aids	100% after *deductible*	50% after *deductible*	**Lifetime Maximum:** $1,000 per *plan participant*. Includes batteries.
Home Health Care	100% after *deductible*	50% after *deductible*	**Benefit Year Maximum:** Sixty (60) visits per *plan participant*.
Hospice Care	100% after *deductible*	50% after *deductible*	**Lifetime Maximum:** Six (6) months per *plan participant*. **Lifetime Maximum:** Bereavement counseling services are limited to $300 per *plan participant*.
Inpatient Physician Visits	100% after *deductible*	50% after *deductible*	
Inpatient Rehabilitation Services – Extended Active Rehabilitation (EAR)	100% after *deductible*	50% after *deductible*	***Pre-certification* is required for inpatient admissions.**

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES continued			
Lab and X-Ray Services			
Hospital	100% after *deductible*	50% after *deductible*	Diagnostic testing, including radiology and laboratory services. Laboratory tests sent to a *non-network* facility for processing shall be paid at the *network* benefit level if the *plan participant* utilized a *network* facility. ***Pre-certification* is required** for advanced imaging.
Free Standing Facility - Lab	100% after *deductible*	50% after *deductible*	
Free Standing Facility – Radiology	100% after *deductible*	50% after *deductible*	
Maternity			
First Visit to Confirm Pregnancy	100% after *deductible*	50% after *deductible*	Dependent child *pregnancy* is not covered. Refer to **Medical Benefits**, Covered Medical Charges, Maternity, for a list of mandated benefits covered under the *Patient Protection and Affordable Care Act* (*PPACA*).
Prenatal/Postnatal Care	100% after *deductible*	50% after *deductible*	
Delivery Charges per Admission	100% after *deductible*	50% after *deductible*	
Medical Foods for Inherited Metabolic Disorders	100% after *deductible*	50% after *deductible*	Payments for medical foods do not count toward the *out-of-pocket limit*.
Office Visit			
Primary Care Physician	100% after *deductible*	50% after *deductible*	Spinal manipulations apply to the chiropractic benefit maximum.
Specialist	100% after *deductible*	50% after *deductible*	
Orthognathic Surgery	100% after *deductible*	50% after *deductible*	**Lifetime Maximum:** $5,000 per *plan participant*. ***Pre-certification* is required.**
Outpatient Observation Stays	100% after *deductible*	50% after *deductible*	After twenty-three (23) observation hours, a confinement will be considered at this benefit level. Prior to twenty-three (23) observation hours, benefits will pay at the applicable benefit level.
Outpatient Surgery	100% after *deductible*	50% after *deductible*	***Pre-certification* is required for certain outpatient surgeries. Refer to Schedules of Medical Benefits, Pre-Certification for details.**
Nuclear Medicine	100% after *deductible*	50% after *deductible*	
Rehabilitation Services			
Physical Therapy Occupational Therapy Speech Therapy	100% after *deductible*	50% after *deductible*	**Benefit Year Maximum:** Combined twenty (20) visits per *plan participant*. ***Pre-certification* is required** for services in excess of the twenty (20) visit limit. Spinal manipulations apply to the chiropractic benefit maximum.
Routine Inpatient Newborn Care Following Delivery	100% after *deductible*	50% after *deductible*	Charges *incurred* for the newborn are subject to his or her own *deductible*.

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES continued			
Telemedince through Teladoc			
Medical or Behavioral Consultation	100% after *deductible*	Not Applicable	Teladoc is a *network* of state licensed, board certified primary care *physicians* providing cross coverage consultations twenty-four (24) hours a day, seven (7) days a week, and three hundred sixty-five (365) days a year. Teladoc *physicians* diagnose routine, non-emergency medical problems via telephone, recommend treatment, and prescribe medication when appropriate. To access this service log onto your Teladoc account or call 1-800-Teladoc (1-800-835-2362). The *Plan* is not liable for services provided by Teladoc.
Dermatology Consultation	100% after *deductible*	Not Applicable	
Nutritional Consultation	100% after *deductible*	Not Applicable	
Temporomandibular Joint Dysfunction (TMJ)	100% after *deductible*	50% after *deductible*	**Benefit Year Maximum:** $500 per *plan participant*.
Urgent Care	100% after *deductible*	50% after *deductible*	
Wig	100% after *deductible*	50% after *deductible*	Includes expenses for a wig in connection with the diagnosis of alopecia (loss of hair resulting from *illness* or *injury*). **Benefit Year Maximum:** $300 per *plan participant*.
MENTAL DISORDERS & SUBSTANCE USE DISORDER			
Inpatient	100% after *deductible*	50% after *deductible*	Services include residential treatment. ***Pre-certification* is required.**
Outpatient	100% after *deductible*	50% after *deductible*	Services include *psychiatric day treatment facilities*. ***Pre-certification* is required for partial hospitalization and intensive outpatient treatment in excess of twenty (20) visits per benefit year.**
TRANSPLANTS			
Organ Transplants	100% after *deductible*	Not Covered	Refer to the **Transplant Program** section for a further description and limitations of this benefit. For the purposes of this benefit *network* means: A Transplant Network, Center of Excellence, or *network provider*. ***Pre-certification* is required.**
Transplant Travel and Lodging	100% after *deductible*	Not Covered	**Lifetime Benefit Maximums:** $200 per day up to $10,000 per *plan participant* per lifetime.

PREVENTIVE CARE

If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, Health Resources and Services Administration (HRSA), the IRS Safe Harbor preventive services list, or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by a *network provider* at a Preventive Care visit. For more information about preventive services please refer to the following websites:

https://www.healthcare.gov/coverage/preventive-care-benefits/
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
www.hrsa.gov

Safe Harbor Services:
https://www.irs.gov/pub/irs-drop/n-04-23.pdf
https://www.irs.gov/pub/irs-drop/n-19-45.pdf

Non-Preventive Care services which are ordered or performed at a Routine Wellness Care visit are not considered under the Preventive Care benefit. Those services will apply to their applicable benefit level or exclusion as appropriate.

The *Plan* does not limit all federally mandated *preventive care* services to age/frequency/gender guidelines as outlined by the USPSTF.

Preventive Care	100%, *deductible* waived	Not Covered	Services include, but not limited to: routine physical exam (male and female), mandated lab and x-ray, gynecological exam, pap smear, 2D mammogram, colorectal cancer screening, blood work, bone density testing, and immunizations based on CDC guidelines. **Benefit Year Maximum:** one (1) visit per adult *plan participant*. Refer to the section entitled **Medical Benefits**, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.
3D Mammograms	**On-Site Wellness Provider** 100%, *deductible* waived **Other Network Provider** Not Covered	Not Covered	
Breastfeeding Pump and Supplies	100% *deductible* waived		Breastfeeding support and supplies. Limited to one (1) per pregnancy. Over-the-counter models are included. Over-the-counter and *non-network* breast pumps are subject to a $250 maximum.
Contraceptive Services	100%, *deductible* waived	Not Covered	Services provided by a *network health care provider* related to FDA approved contraceptive methods, sterilization, and patient education and counseling, not including drugs that induce abortion. Benefits include: a. injections for birth control purposes b. diaphragm or cervical cap c. surgical implantation and removal of a contraceptive device d. Intrauterine Device (IUD) e. surgical sterilization and related services Contraceptive *prescription drugs*, including birth control pills, patches, and vaginal rings are covered under the *pharmacy* program, please refer to the **Prescription Drug Benefits** section. **Benefit limitations:** Services are available to all female *plan participants*.
On-Site Wellness Screenings	100%, *deductible* waived		AzMT L.I.V.E wellness screenings/programs provided on-site.

Refer to the Medical Benefits section, Medical Plan Exclusions subsection for additional information relating to excluded services.

L. Schedule of Prescription Drug Benefits – HDHP Plan

The Prescription Drug Benefits are separate from the Medical Benefits and are administered by Navitus Health Solutions. Refer to the **Prescription Drug Benefits** section for details on the Prescription Drug Benefits.

Prescription drug charges apply to the medical *deductible* and *out-of-pocket maximum*.

<table>
<tr><th colspan="3">PRESCRIPTION DRUG BENEFIT</th></tr>
<tr><th></th><th>NETWORK PHARMACY</th><th>NON-NETWORK PHARMACY*</th></tr>
<tr><td colspan="3">Retail Pharmacy Option (30-Day Supply)</td></tr>
<tr><td>Tier 1: Formulary Generics and Certain Low Cost Brand Name Drugs</td><td rowspan="4">The Plan pays 100% of the cost of the drug, after the deductible is met</td><td rowspan="3">If you purchase your prescription drugs from a non-network pharmacy, you will pay the full cost of the drug minus the network price of the prescription.</td></tr>
<tr><td>Tier 2: Formulary Brand Name Drugs and Certain Higher Cost Generic Drugs</td></tr>
<tr><td>Tier 3: Non-Formulary Drugs and Compound Medications</td></tr>
<tr><td>Specialty Drugs: Only available through the Navitus SpecialtyRx Program Pharmacy</td><td>Not Applicable</td></tr>
<tr><td colspan="3">Mail Order or Retail Pharmacy Option (90-Day Supply)</td></tr>
<tr><td>Tier 1: Formulary Generics and Certain Low Cost Brand Name Drugs</td><td rowspan="3">The Plan pays 100% of the cost of the drug, after the deductible is met</td><td rowspan="3">Not Applicable</td></tr>
<tr><td>Tier 2: Formulary Brand Name Drugs and Certain Higher Cost Generic Drugs</td></tr>
<tr><td>Tier 3: Non-Formulary Drugs and Compound Medications</td></tr>
<tr><td colspan="3">Certain preventive care prescription drugs (including contraceptives) received by a network pharmacy are covered at 100% and the deductible/co-insurance (if applicable) is waived.
Please refer to the following websites for information on the types of payable preventive care prescription drugs: https://www.healthcare.gov/coverage/preventive-care-benefits/ or https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.</td></tr>
</table>

Present your ID card to the *pharmacy* for *claim* processing. In certain cases, you may need to request reimbursement for prescriptions that you have filled and paid for yourself. To submit a *claim*, you must provide specific information about the prescription and the reason you are requesting reimbursement. Complete the appropriate *claim* form and mail it, with the receipt, to:

Navitus Health Solutions
Attn: Manual Claims
P.O. Box 999
Appleton, WI 54912-0999

*****Some pharmacies, **including CVS**, are excluded from coverage under the network. Members who utilize excluded pharmacies will be responsible for the full cost of the medication.

Note: For a complete list of covered drugs and supplies, and applicable limitations and exclusions, please refer to the Navitus Health Solutions Drug Coverage List, which is incorporated by reference and is available by calling Navitus at 1-866-333-2757 or by visiting their website at **www.navitus.com**.

SECTION VI—MEDICAL BENEFITS

Medical benefits apply when *covered charges* are *incurred* by a *plan participant* for care of an *injury* or *sickness* and while the person is covered for these benefits under the *Plan*. Depending on your particular benefit *Plan*, the service you receive and the *provider* you choose, you may have a balance bill, *co-insurance*, *deductible,* or some combination of these payments. Each cost share type is explained below.

A. Covered Medical Charges

Covered charges are the *maximum allowable charges* that are *incurred* for the following items of service and supply. These charges are subject to the *benefit maximums*, limits, exclusions, and other provisions of this *Plan*. A charge is *incurred* on the date that the service or supply is performed or furnished.

1. **3D Mammograms.** Performed for preventive services provided by the on-site wellness clinic only.
2. **Advanced Imaging.** Charges for advanced imaging including: Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans. Charges include the readings of these medical tests/scans. ***Pre-certification* is required.**
3. **Ambulance.** Benefits will be provided for ground ambulance transportation from the site of an emergency, *accident*, or acute *illness* to the nearest facility capable of providing appropriate treatment. Air or water ambulance transportation to the nearest facility capable of providing appropriate treatment when the emergency, *accident*, or acute *illness* occurs in an area inaccessible by ground vehicles or transport by ground ambulance would be harmful to the *plan participant's* medical condition is covered. *Medically necessary* inter-facility ground or air ambulance transfer for admission to the nearest *acute care* facility, extended active rehabilitation facility, or *skilled nursing facility* when the transferring facility is unable to provide the level of service required. Inter-facility transport is also available to a *network hospital* after you have been stabilized at a *non-network hospital*. Services for chartered flights will not be covered by the *Plan*.

   Note: Charges for services requested for an advance life support unit, when the patient is not transported, will not be covered by the *Plan*.
4. **Anesthetics.** Includes anesthetic, intravenous injections, solutions, and administration of these items.
5. **Autism Spectrum Disorder – Behavior Therapy Services.** Behavioral therapy services for the treatment of an *Autism Spectrum Disorder* are available for *plan participants* who have been diagnosed with an *Autism Spectrum Disorder*. Covered behavioral therapy services must be delivered by a *provider* who is licensed or certified, as required by law.
6. **Bariatric Surgery.** Bariatric *surgery* may be considered eligible if the *plan participant* meets **all** of the following criteria and the procedure is performed by *network providers* [The No Choice of Provider provision does not apply to bariatric surgery. All *providers* (surgeons, assistant surgeons, anesthesiologists, etc.) must be *network providers*.] at a *network* facility known to have an effective program for doing such a *surgery* and a follow-up program:
   a. The *plan participant* has been covered under the *participating entity's* coverage for a minimum of twenty-four (24) months immediately preceding the date of the procedure.
   b. The *plan participant* is at least eighteen (18) years of age, is physically mature, and is not older than sixty-five (65) years of age.
   c. Two (2) separate *physicians* confirm, in writing, that the *plan participant* satisfies **all** of the following:
      i. is, and has been for two (2) or more years prior to the procedure, *morbidly obese*
      ii. is an acceptable surgical interventional risk (i.e. he or she must otherwise be a good surgical candidate)
      iii. does not have a specifically correctable cause of obesity, such as a glandular or endocrine problem
   d. The *plan participant* provides evidence of *physician* documented compliance with a structured, medically guided weight reduction program for at least six (6) months prior to the proposed *surgery* and the *plan participant* has failed to maintain weight loss.
   e. A licensed psychologist or psychiatrist, a dietitian, an exercise physiologist, and a surgeon have confirmed, in writing, that the *plan participant* has met with them and the *plan participant* is both

physically and mentally prepared to undergo the proposed bariatric *surgery* and a structured post-operative exercise, diet, and related follow-up program.

f. The *plan participant* provides written documentation, from a licensed psychologist or psychiatrist, confirming the absence of a significant psychopathology that may limit the *plan participant's* understanding of the procedure, ability to comply with medical/surgical recommendations, and post-surgery lifestyle changes necessary for the procedure to be successful.

Benefits will not be provided for subsequent (repeat or revision) procedures to correct further *injury* or *illness* resulting from the *plan participant's* non-compliance with prescribed medical treatment follow-up post-surgery.

Expenses which are *medically necessary*, in connection with services or supplies and *surgical procedures* performed in connection with *morbid obesity*, will receive benefits as described in the Schedule of Medical Benefits – HDHP Plan.

Please see the **Defined Terms** section of this document for a definition of *morbid obesity*.

The benefits payable for bariatric surgery, gastric bypass, or any other type of surgical weight loss procedure are limited that such a *plan participant* is only eligible for such benefits once during their lifetime.

7. **Behavioral and Mental Health Services.** Treatment of *mental disorders* and/or chemical dependency/*substance use disorder*. Coverage for mental health treatments are considered the same as benefits provided for other medical conditions.

    a. **Outpatient Facility and Professional Services.** Non-emergency outpatient behavioral and mental health services are considered a *covered charge*. Those services include *applied behavioral analysis (ABA) therapy*, psychotherapy, partial hospitalization, outpatient therapy services for chemical dependency or *substance use disorder*, diagnostic office visits, certain office visits for monitoring of behavioral health conditions or medications, electroconvulsive therapy (ECT), and counseling for personal and family problems. *Psychiatric day treatment facilities* are covered under this benefit when both of the following criteria are met:

        i. the services meet *medical necessity* criteria for the level of care

        ii. upon utilization review approval and *pre-certification*

    b. **Inpatient. *Pre-certification* is required** for non-emergency *inpatient* behavioral and mental health admissions. *Inpatient* facility, residential treatment, and professional behavioral and mental health services are covered. Benefits are available for *inpatient* behavioral and mental health services that meet **all** of the following criteria:

        i. the *inpatient* program is provided in a facility licensed to provide an *inpatient* level of care

        ii. the facility designated medical director is a psychiatrist or *physician* with behavioral or mental health work experience and this person is in charge of the medical services at the *facility*

        iii. a behavioral or mental health medical practitioner is present at the facility or on-call at all times to admit to the *inpatient* program and respond to the needs of patients

        iv. the facility's license requires 24/7 nursing coverage

        v. the facility has sufficient behavioral or mental health professional staff to provide appropriate treatment

        vi. the services meet *medical necessity* criteria for an *inpatient* level of care

    Refer to the **Federal Notices** section for the statement of rights under the Mental Health Parity and Addiction Equity Act of 2008.

8. **Blood.** Non-replaced blood, blood plasma, blood derivatives, and their administration and processing.

9. **Breastfeeding Support, Supplies, and Counseling.** Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period, and costs for renting or purchasing breastfeeding equipment. Breast pumps are limited to one (1) purchase per pregnancy. Refer to Schedule of Medical Benefits for limitations.

10. **Cardiac and Pulmonary Rehabilitation (Outpatient).** Benefits are available for outpatient phase one (1) and two (2) cardiac rehabilitation programs and pulmonary rehabilitation services.

11. **Cataract Surgery.** Benefits are available for the removal of cataracts. This includes the placement of a single intraocular lens at the time of the cataract removal. Following *surgery*, benefits are available for eyeglasses or

external contact lenses, up to a $500 maximum per *plan participant*, per twelve (12) month period. The eyeglasses or external contact lenses must be prescribed and purchased within twelve (12) months of the *surgery*. The $500 *benefit maximum* will include any and/or all add-on services including but not limited to tinting, coating, oversized lenses, and polish edges. Any procedures associated with cataract *surgery* that are not included in this benefit description, including replacement, piggyback, or secondary intraocular lenses, or any other treatments or devices for refractive correction are not a benefit of the *Plan*.

12. **Chemotherapy/Radiation.** Radiation or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included.

13. **Chiropractic.** Charges for spinal manipulations for the correction of structural imbalance, distortion, misalignment, or subluxation of or in the vertebral column, by manual or mechanical means, and the necessary adjunctive modalities (including hot and cold therapy, etc.). Spinal manipulations rendered by an MD or DO apply to the chiropractic maximum. Spinal manipulation while under anesthesia is not covered. Spinal manipulations apply to the chiropractic benefit level.

14. **Circumcision.** Covered for newborns within eighteen (18) months of birth. If performed during an office visit the office visit benefit applies.

15. **Clinical Trials.** This *Plan* will cover routine patient costs for a *qualified individual* participating in an *approved clinical tria*l that is conducted in connection with the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is federally funded through a variety of entities or departments of the federal government, is conducted in connection with an *investigational* new drug application reviewed by the Food and Drug Administration, or is exempt from *investigational* new drug application requirements. Refer to the Medical Plan Exclusions subsection for a further description and limitations of this benefit. ***Pre-certification* is required.**

16. **Counseling.** Family, marital, and group counseling services are covered when **all** of the following criteria are met:

    a. when performed by a *network provider*

    b. when the counseling is provided for a *covered charge*

    c. when the *plan participant* is present during the family/group counseling session

17. **COVID-19 Services.** Testing and treatment for COVID-19 services.

    Effective May 12, 2023, the *Plan* covers diagnostic testing for COVID-19 only when received from a *network physician*.

18. **Dental Injury.** Injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under this *plan* only if that care is initiated within three (3) months following the injury and is for the following oral surgical procedures:

    a. emergency repair due to injury

    b. surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor, and roof of the mouth

    Note: No charge will be covered under this Plan for dental and oral surgical procedures involving orthodontic care of teeth, periodontal disease and preparing the mouth for fitting of or continued use of dentures.

    ***Pre-certification* is required** depending on type of service.

19. **Dental Services Required for Medical Procedures. *Pre-certification* is required** for non-emergency *inpatient* admissions. Benefits are available for dental services which are required in order to perform the medical services listed in this benefit. These dental services may either be part of the medical procedure or may be performed in conjunction with and made *medically necessary* solely because of the medical procedure.

    Benefits are available for the following:

    a. *diagnostic services* prior to planned organ or stem cell transplantation procedures

    b. removal of teeth required for covered treatment of head and neck cancer or osteomyelitis of the jaw

    c. restoration of teeth made *medically necessary* because of the covered treatment of head and neck cancer or osteomyelitis of the jaw

20. **Diagnostic Testing.**

21. **Dialysis**. If you are diagnosed with a condition requiring dialysis, you may be able to enroll in *Medicare*. Upon beginning dialysis treatments, *Medicare*, if applicable, will coordinate benefits with the *Plan* as the secondary payer for months four (4) through thirty-three (33) of the coordination period while you are receiving dialysis treatments. The *Plan* will not enroll you in *Medicare*; it is your decision and your responsibility to enroll in *Medicare*, if applicable.

22. **Durable Medical Equipment (DME).** To be eligible for coverage, *DME* must meet **all** of the following criteria:

    a. be designed for repeated medical use in the home setting

    b. be specifically designed to improve or support the function of a body part

    c. cannot be primarily useful to a person in the absence of an *illness* or *injury*

    d. is intended to prevent further deterioration of the medical condition for which the equipment has been prescribed

    Benefits are available for *DME* rental, up to the purchase price, of the item and for *DME* repair or replacement due to normal wear and tear caused by use of the item in accordance with the manufacturer's instructions or due to growth of a child. Delivery, set-up, and education charges pertaining to *DME* are not a payable benefit under the *Plan*.

    The following items will be considered under the *DME* benefit:

    a. **Compression and/or Jobst Stockings.** Limited to four (4) units per *benefit year* per *plan participant*.

    b. **Diabetic Supplies.** The following diabetic supplies will be considered under the Durable Medical Equipment (DME) provision of this *Plan*:

        i. continuous blood glucose monitor

        ii. insulin pump

        For all other diabetic supplies coverage, refer to the **Prescription Drugs Benefits** section.

        Refer to the *Preventive Care* provision or visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of diabetic equipment and supplies related *preventive care* benefits.

    c. **Sleep Apnea Oral Devices.** When *medically necessary*.

        ***Pre-certification* is required for DME in excess of $3,000 (purchase/rental price).**

23. **Emergency Room.** Charges for the following:

    a. **Emergency, Professional, and Facility Services.** Benefits are available for services needed to treat an emergency.

    b. **Teletrauma Services.** If a *plan participant* is receiving covered *emergency services*, benefits may be available for teletrauma consultations between *providers* at the facility where the *plan participant* is being treated and *providers* at certain Level 1 trauma centers. In order for teletrauma services to be covered, the *plan participant* must be receiving emergency treatment in a facility that is not equipped to handle that *plan participant's* medical condition and the treating *providers* must need the consultation to appropriately treat or stabilize the *plan participant*. A teletrauma consultation may include telephonic or electronic communications between *providers* and video presentation of the *plan participant's* condition. Both facilities must have certain equipment to facilitate the teletrauma communications.

    For purposes of this benefit, trauma is defined as a physical wound or *injury* that results from a sudden *accident* or violent cause and which, if not immediately treated, is likely to result in death, permanent disability, or severe pain.

24. **Foot Care.** Treatment for the following foot conditions:

    a. bunions, when an open cutting operation is performed when *medically appropriate* for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg

    b. non-routine treatment of corns or calluses when *medically appropriate* for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg

    c. toenails when at least part of the nail root is removed

    d. any *medically necessary surgical procedure* required for a foot condition

25. **Genetic/Genomic Testing and Counseling.** Genetic/Genomic testing and counseling is covered as required by federal law or in the following circumstances:

    a. tests to determine sensitivity to FDA-approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity

    b. the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered *plan participants* if **all** of the following conditions are met:

        i. the testing method is considered scientifically valid for identification of a genetically-linked heritable disease

        ii. the covered individual displays clinical features/symptoms, or is at direct risk (family history or first or second-degree relative) of developing the genetically linked heritable disease/condition in question (pre-symptomatic)

        iii. the results of the test will directly impact clinical decision-making, outcome, or treatment being delivered to the covered individual

    c. diagnostic genetic testing used to identify or rule out a specific genetic or chromosomal condition when a particular condition or diagnosis for a patient is suspected based on physical signs and symptoms

    ***Pre-certification* is required for genetic/genomic testing and counseling in excess of $1,000.**

    Refer to the **Federal Notices** section for the statements of rights under the Genetic Information Nondiscrimination Act of 2008 (GINA).

26. **Hearing Aids.** Charges for services or supplies in connection with hearing aids and implantable hearing devices, including, but not limited to, cochlear implants and exams for their fitting. Over-the-counter hearing aids are covered with a prescription. Benefits are subject to the maximum shown in the **Schedules of Benefits**.

27. **Hearing Exams.** Charges for diagnostic hearing exams.

28. **Home Health Care.** Charges for *home health care services and supplies* are covered only for care and treatment of an *illness* or *injury* when *hospital* or *skilled nursing facility* confinement would otherwise be required. The diagnosis, care, and treatment must be certified by the attending *physician* and be contained in a *home health care plan*.

    Benefit payment for nursing, home health aide, and therapy services is subject to the Home Health Care limit shown in the Schedule of Medical Benefits – HDHP Plan.

29. **Home Infusion - Medication Administration Therapy. *Pre-certification* is required** for services in excess of $1,000 under this benefit. Benefits are available for the following home health and home infusion medication administration therapy services:

    a. **Home Infusion Medication Administration Therapy.**

        i. blood and blood components

        ii. hydration therapy

        iii. intravenous catheter care

        iv. intravenous, intramuscular, or subcutaneous administration of medication

        v. specialty injectable medications

        vi. total parenteral nutrition

    b. **Enteral Nutrition (Tube Feeding) when it is the Sole Source of Nutrition.** Sole source of nutrition is defined as the inability to orally receive more than thirty (30) percent of daily caloric needs. Home health visits will be covered only for the purpose of instructing the *plan participant* or caregiver (not compensated by the *Plan*) to initiate and terminate the feeding, unless the *plan participant* or caregiver cannot perform these tasks. If the *plan participant* or caregiver cannot perform the tasks or no caregiver is available, the *Plan* will continue to cover home health visits up to the *benefit year* maximum.

    c. Home health and home infusion medication administration therapy services must meet **all** of the following criteria:

        i. a licensed *home health care agency* must provide the services

ii. a *physician* or Registered Nurse Practitioner must order the services pursuant to a specific plan of home treatment for recovery from an *illness* or *injury*

iii. services must be provided in the *plan participant's* residence

iv. the *plan participant* or primary caregiver (not compensated by the *Plan*) must agree to participate in the home plan of care by learning the techniques and performing the procedures, for transition of care to the *plan participant* or primary caregiver

v. the *physician* or Registered Nurse Practitioner must regularly review the appropriateness of the services [regularly means at least every thirty (30) days or more frequently if appropriate under the treatment plan]

vi. the services must be for skilled nursing care, which is required to be provided by a Licensed Practical Nurse (L.P.N.) or a Registered Nurse (R.N.) or another eligible *provider*

30. **Hospice Care.** *Hospice care services and supplies* as an alternative to hospitalization for a terminally ill *plan participant*. The *hospice agency* determines the required level of care, which is subject to the *medical necessity* provision of the *Plan*. Once the *plan participant* selects the hospice benefit, the *hospice agency* coordinates **all** of the *plan participant's* health care needs related to the terminal *illness*.

    The *plan participant's physician* must certify that the *plan participant* is in the later stages of a terminal *illness* and prescribe hospice care, which must be provided by a state-licensed *hospice agency* is necessary. The *plan participant* must meet the requirements of the *hospice care plan*. Benefits are provided for the following *hospice care services and supplies*:

    a. **Bereavement Counseling.** Sessions for covered family members following the death of a terminally ill *plan participant* up to a *lifetime maximum* of $300 per *plan participant*.

    b. **Continuous Home Care.** Twenty-four (24) hour skilled care provided by a *physician* during a period of crisis, as determined by the *hospice agency*, in order to maintain the *plan participant* at home, if the *plan participant* is receiving services in his or her home.

    c. **Inpatient Acute Care.** *Inpatient* admission for pain control or symptom management, which cannot be provided in the home setting.

    d. **Respite Care.** Admission of the *plan participant* to an approved facility to provide rest to the *plan participant's* family or primary caregiver.

    e. **Routine Care.** Intermittent visits provided by a member of the hospice team.

31. **Hospital Care.** The medical services and supplies furnished by a *hospital* or *ambulatory surgical center* or a *birthing center*. *Covered charges* for *room and board* will be payable as shown in the Schedule of Medical Benefits – HDHP Plan. Some *inpatient* facilities provide different levels of care within the same facility (i.e.: acute *inpatient*, rehabilitation, skilled nursing, and hospice). If you move or transfer between different levels of *inpatient* care, even within the same facility, your *cost sharing amounts* will change to match your level of care. If you are moving to a level of care that requires *pre-certification*, you will also need to obtain a new *pre-certification* for the different level of care. ***Pre-certification* is required prior to all elective or scheduled inpatient admissions**. *Covered charges* include:

    a. *room and board* in a semi-private room, unless the *hospital* only has private rooms

       If the *hospital* only has private rooms, only standard private rooms are covered (not deluxe).

    b. blood transfusions, whole blood, blood components, and blood derivatives

    c. charges for an *intensive care unit* stay and other special care units

    d. diagnostic testing, including *laboratory, pathology services, x-rays, and radiology services*

    e. general, spinal, and caudal anesthetic provided in connection with a *covered charge*

    f. medications, biologicals, and solutions

    g. operating, recovery, and treatment rooms and equipment for *covered charges*

    h. radiation therapy or chemotherapy, except in conjunction with a non-covered transplant

    i. facility and professional anesthesiologist

    j. charges to perform dental services under anesthesia in an *inpatient* or outpatient facility due to one (1) or more of the following concurrent or co-morbid conditions:

i. children five (5) years or younger who, in the opinion of the treating dental *provider*, cannot be safely treated in the dental office

ii. mental retardation

iii. malignant hypertension

iv. senility or dementia

v. unstable cardiovascular condition

vi. uncontrolled seizure disorder

32. **Injection and Infusion Therapy.**

33. **Inpatient Detoxification.** Benefits are available for medical observation and intervention to stabilize a *plan participant* who has developed substance intoxication due to the ingestion, inhalation, or exposure to one (1) or more substances. ***Pre-certification*** **is required for non-emergency admissions.**

34. **Inpatient Rehabilitation Services – Extended Active Rehabilitation (EAR).** An intense therapy program provided in a facility licensed to provide extended active rehabilitation. This care is for patients who require twenty-four (24) hour rehabilitation nursing and have the ability to achieve rehabilitation goals in a reasonable period of time. ***Pre-certification*** **is required**.

35. **Intensive Care Unit.** Charges for an *intensive care unit* stay. ***Pre-certification*** **is required for inpatient admissions.**

36. **Long-Term Acute Care (Inpatient).** Specialized acute, medically complex care for patients provided in a facility licensed to provide long term *acute care*. This care is for patients who require hospitalization on an extended basis in a facility offering specialized treatment programs and aggressive clinical and therapeutic interventions. ***Pre-certification*** **is required**.

37. **Mastectomy Bras and Camisoles.** Mastectomy bra and camisole purchases will be limited to two (2) total items per *plan participant* per *benefit year*.

38. **Maternity.** Maternity benefits are available for *covered charges* related to *pregnancy*. This includes certain screening tests such as prenatal ultrasounds, alpha-fetoprotein (AFP), rubella immunity, Hepatitis B and HIV exposure, blood type, anemia, urinary tract disease or infections, sexually transmitted diseases, and others as determined by the *Plan*. Certain tests, including some genetic screenings, may not be covered. Please call the *Third Party Administrator* to confirm what tests are covered prior to undergoing such testing. Charges for a planned home birth will not be considered a covered benefit.

    For the purpose of this benefit, the following definition applies:

    Global Charge. A fee charged by the delivering *provider* that may include certain prenatal, delivery, and postnatal services.

    Note: Breastfeeding maintenance, breast milk storage supplies, pump parts, and other supplies are also available as outlined in the applicable Schedule of Medical Benefits. Lactation counseling will be paid as other preventive services. Breast pumps will be available without cost sharing for over-the-counter and *non-network* purchases up to a maximum of $250. Breast pumps are limited to one (1) per pregnancy.

    The care and treatment of *pregnancy* for a *dependent* child is limited to certain *preventive care* services. *Pregnancy* tests are not considered *preventive care* even when performed in conjunction with covered birth control services. Visit **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**.

    Delivery and hospitalization stay may be subject to *pre-certification* if over the standards set forth in the Newborns' and Mothers' Health Protection Act. Refer to the **Federal Notices** section for the statement of rights under the Newborns' and Mothers' Health Protection Act for certain protections mothers and newborns have regarding *hospital* stays.

39. **Medical Foods for Inherited Metabolic Disorders.** Benefits are available for medical foods to treat Inherited Metabolic Disorders. These charges do not apply to the *out-of-pocket limit*.

    For the purpose of this benefit, the following definitions apply:

    a. Inherited Metabolic Disorder means a *disease* caused by an inherited abnormality of body chemistry that meets **all** of the following requirements:

i. the disorder is one of the *diseases* tested under the newborn screening program required under Arizona law (A.R.S. § 36-694)

ii. the disorder is such that an afflicted individual will need to consume medical foods throughout life in order to avoid serious mental or physical impairment

iii. the disorder must involve amino acid, carbohydrate, or fat metabolism and have medically standard methods of diagnosis, treatment, and monitoring, including quantification of metabolites in blood, urine, or spinal fluid or enzyme or DNA confirmation in tissues as determined by the *Plan*

b. Medical foods means modified low protein foods and metabolic formulas that are **all** of the following:

i. administered for the medical and nutritional management of a *plan participant* who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation

ii. essential to the *plan participant's* optimal growth, health, and metabolic homeostasis

iii. formulated to be consumed or administered through the gastrointestinal tract under the supervision of an M.D., or D.O., *physician*, or a Registered Nurse Practitioner (R.N.P.)

iv. processed or formulated to be deficient in one (1) or more of the nutrients present in typical foodstuffs (metabolic formula only)

v. processed or formulated to contain less than one (1) gram of protein per unit of serving (modified low protein foods only)

40. **Medical Supplies.** Benefits are available for the following medical supplies:

a. any device or supply required by applicable federal law

b. blood glucose monitors

c. diabetic injection aids and drawing-up devices

d. diabetic syringes and lancets

e. ostomy and urinary catheter supplies

f. peak flow meters

g. supplies associated with oxygen or respiratory equipment

h. test strips for glucose monitors and urine test strips

i. volume nebulizers

Visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of medical supplies related *preventive care* benefits.

41. **Midwife Services.** Benefits for midwife services performed by a Certified Nurse Midwife (C.N.M.) who is certified or licensed as such and acting within the scope of his or her license. This *Plan* will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries. Please see Maternity benefit for home birth limitation.

42. **National/Public Health Emergency.** In the event of a declared National Health Emergency (or Public Health Emergency), the *Plan* will offer coverage as mandated for the condition(s) as outlined in the National Health Emergency, as required by federal regulation. The *Plan* will also cover medications authorized for emergency use by the appropriate federal agencies in the event of a public health emergency. This provision shall override any potentially conflicting, specific exclusions, defined terms, or other *Plan* provisions as necessary to provide, and limited to, any mandated services as outlined in the national and/or public health emergency, and corresponding regulation(s). Such coverage shall remain in effect until the national and/or public health emergency, as declared by the governing federal agency, has ended.

43. **Non-Invasive Pre-Natal Testing (NIPT).** Testing in pregnant woman using the measurement of cell-free fetal nucleic acids in maternal blood for fetal autosomal aneuploidy. Coverage under the *Plan* is limited to testing for fetal aneuploidy [Trisomy twenty-one (21), eighteen (18), and thirteen (13) only] with or without fetal sex determination. ***Pre-certification* is required**.

44. **Nutritional Counseling and Training.** Intensive behavioral dietary counseling for adult *plan participants* with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic *disease*. Intensive

counseling can be delivered by *Primary Care Providers (PCP)* or by referral to other *specialists*, such as nutritionists or dietitians.

45. **Orthognathic Surgery/LeFort Procedures.** Orthognathic *surgery* which corrects jaw and oral relations is a *covered charge*. Refer to the Schedule of Medical Benefits – HDHP Plan for specific limits regarding this benefit. ***Pre-certification* is required.**

46. **Outpatient Laboratory Services.** Benefits are available for the following outpatient services:

    a. blood transfusions, whole blood, blood components, and blood derivatives

    b. diagnostic testing, including laboratory, and radiology services

    c. outpatient *surgery*, which is defined as operative procedures and other invasive procedures such as epidural injections for pain management and various scope procedures, such as arthroscopies and colonoscopies

    d. pre-operative testing

    e. radiation therapy or chemotherapy, unless performed in conjunction with a non-covered transplant

47. **Oxygen.** Oxygen and its administration.

48. **Physician Services.** Benefits are available for the following:

    a. general *surgical procedures* (including assistance at *surgery*) provided outside a *physician's* office

    b. office, home, or *walk-in clinic* visits (urgent care facilities are not walk-in clinics)

    c. *inpatient* medical visits

    d. multiple *surgical procedures* that may be performed during a single operative session

       In general, covered secondary procedures are reimbursed at reduced levels. *Non-network providers* may balance bill you for secondary, incidental, or mutually exclusive procedures in addition to the primary *surgical procedure*.

       Charges for multiple *surgical procedures* will be a *covered charge* subject to the following provisions:

       i. If bilateral or multiple *surgical procedures* are performed by one (1) surgeon, benefits will be determined based on the *maximum allowable charge* that is allowed for the primary procedures; 50% of the *maximum allowable charge* will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered incidental and no benefits will be provided for such procedures.

       ii. If multiple unrelated *surgical procedures* are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the *maximum allowable charge* for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the *maximum amount* allowed for that procedure.

       iii. If an assistant surgeon is required, the assistant surgeon's *covered charge* will not exceed 20% of the surgeon's *maximum allowance*.

       iv. If a co-surgeon is required, meaning skills of both surgeons are necessary to perform distinct parts of a specific operative procedure, payment is based for each physician on the *maximum allowable charge*, dividing the payment equally between the two (2) surgeons. *Surgeries* performed by co-surgeons that have the same specialty are not covered under the *Plan,* unless *medically necessary*.

Note: You may receive services in a *physician's* office that incorporate services or supplies from a *provider* other than your *physician*. If those services or supplies are rendered and billed by a *provider* other than your *physician*, you will pay the *cost sharing amount* applicable to the billing *provider*, in addition to the *cost share amount* for your office visit. Examples of services or supplies from another *provider* include *durable medical equipment* from a medical supply company, specialty injectable medications provided by a *pharmacy*, an x-ray reading by a radiologist, or tissue sample analysis by a pathologist.

49. **Pre-Admission Testing.** Pre-admission testing includes diagnostic lab, x-rays, and EKG's that you obtain on an outpatient basis prior to your scheduled admission to the *hospital*. Ensure the *hospital* will accept the results of these tests and not simply repeat them.

50. **Pregnancy (Termination).** Benefits are available for abortions when the treating *provider* certifies, in writing, that the abortion is *medically necessary* in order to save the life of the mother or to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion.

51. **Prenatal Testing.** Services for prenatal diagnosis or congenital disorders of the fetus by means of screening and diagnostic procedures will be provided the same as for any other condition during your covered *pregnancy*. Such services must be *medically necessary*.

52. **Preventive Care.** Charges *incurred* by *plan participants* for wellness care such as routine physicals, routine laboratory tests and x-rays, routine gynecological exams, routine mammograms, routine well child care, required routine childhood immunizations, cancer screenings, bone density scans, flu shots, and the like are limited under this section to those services eligible as a preventive service as defined by the U.S. Preventive Service Task Force. The *Plan* covers these items as stated in the Schedule of Medical Benefits – HDHP Plan:

    a. **Evidence-based Preventive Services.** Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Task Force (the Task Force), except that for breast cancer screening, mammography, and prevention of breast cancer, the recommendations of the Task Force issued in 2002 will be considered the current recommendations until further guidance is issued by the Task Force or the Health Resources and Services Administration.

    b. **Routine Vaccines.** Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

    c. **Prevention for Children.** For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

    d. **Prevention for Women.** For women, such additional *preventive care* and screenings, not otherwise addressed by the Task Force, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. These services include coverage for family planning, counseling, and contraceptives.

        Preventive pap smears will be limited to one (1) per *benefit year* for women.

    e. **Contraceptive Coverage.** Contraceptive services provided by a health care *provider* related to voluntary female sterilization or contraception. Benefits include:

        i. injections for birth control purposes

        ii. diaphragm or cervical cap

        iii. surgical implantation and removal of a contraceptive device

        iv. Intrauterine Device (IUD)

        v. surgical sterilization and related services

        For contraceptive prescription medications and drugs, including birth control pills, patches, and vaginal rings see **Prescription Drugs Benefits** section.

    f. **Tobacco Cessation.** Education, counseling, and behavioral intervention services provided by a *physician* for smoking/vaping cessation.

    In administering this benefit, as technology changes medical policy or medical guidelines for these services may be modified as appropriate.

    The *Plan* will automatically be updated to reflect new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

    For a detailed listing of preventive services, visit the following websites:

    a. **https://www.healthcare.gov/coverage/preventive-care-benefits/**

    b. **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations https://www.irs.gov/pub/irs-drop/n-19-45.pdf**

    c. **https://www.irs.gov/pub/irs-drop/n-04-23.pdf**

53. **Prosthetic Appliances and Orthotics.** Benefits are available for the following:

    a. external or internal breast prostheses when needed as a result of a *medically necessary mastectomy*

b. prosthetic appliances to replace all or part of the function of an inoperative or malfunctioning body organ or to replace an eye or limb lost as a result of trauma or *disease*

c. orthotics (such as foot orthotics, cranial helmets, collars, braces, or molds) to protect, restore, or improve impaired bodily function

d. orthopedic shoes that are:

   i. attached to a brace

   ii. therapeutic shoes (depth inlay or custom-molded) along with inserts, for individuals with diabetes

   iii. in accordance with *medical necessity* criteria

Note: Benefits are limited to the *allowed charge* for the prosthetic appliance or orthotic base model. The *Medical Management Administrator* will determine what is covered as the base model. Deluxe or upgraded prosthetic appliances or orthotics may be eligible for coverage based upon *medical necessity* criteria.

***Pre-certification* is required for orthotics and prosthetics in excess of $3,000 (purchase/rental price).**

54. **Reconstructive Surgery and Services.** Benefits are available for reconstructive *surgery*, which is *surgery* performed to improve or restore the impaired function of a body part or organ resulting from one (1) of the following:

    a. **Congenital Defects.**

    b. **Illness and Disease.**

    c. **Injury and Trauma.**

    d. **Surgery.**

    e. **Therapeutic Intervention.**

    f. **Post-Mastectomy Services.** Benefits are available, to the extent required by applicable state and federal law, for breast reconstruction following a *medically necessary mastectomy*. Benefits include:

       i. all stages of reconstruction of the breast on which the *mastectomy* was performed

       ii. *surgery* and reconstruction of the other breast to produce a symmetrical appearance

       iii. post-operative implanted or external prostheses and treatment of physical complications for all stages of the *mastectomy*, including lymphedema

    Refer to the **Federal Notices** section for the statement of rights to *surgery* and prostheses following a covered *mastectomy* under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

55. **Rehabilitation Therapies.** Benefits are available for physical therapy, occupational therapy, and speech therapy services. Aquatic therapy is covered when *medically necessary*. Refer to the Schedule of Medical Benefits – HDHP Plan for specific limits regarding this benefit. ***Pre-certification* is required** for services in excess of the visit limit. Wound debridement services do not apply toward the Rehabilitation Therapy maximum and do not require *pre-certification*

56. **Respiratory Therapy.**

57. **Routine Well Newborn Care.** Routine well newborn care is care while the newborn is hospital-confined after birth and includes *room and board* and other normal care for which a *hospital* makes a charge.

    The newborn must be enrolled in a timely manner as an eligible *dependent* under this *Plan*. (Refer to **Eligibility, Effective Date, and Termination Provisions**, Enrollment).

58. **Schools**. Services performed in a school setting. This does not include services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school are also not covered.

59. **Second Surgical Opinion**. Benefits are available for a second surgical opinion the *plan participant* voluntarily obtains before recommended *surgery*. Second opinions provide more information so that the *plan participant* can make an informed decision about whether to have *surgery* or follow another course of treatment.

60. **Skilled Nursing Facility (SNF).** Benefits are available for *inpatient skilled nursing facility* services provided in a facility licensed to offer skilled nursing services and those services meet the definition of skilled nursing care. Skilled nursing services are provided by and under the supervision of qualified and licensed professionals, such

as a Licensed Practical Nurse (L.P.N.) or Registered Nurse (R.N.) and provided at a level of complexity and sophistication requiring assessment, observation, monitoring, and/or teaching or training to achieve the medically desired outcome. ***Pre-certification* is required**.

61. **Sleep Disorders.** *Medically necessary* care and treatment for sleep disorders, including sleep studies performed in the home. ***Pre-certification* is required.**

62. **Sterilization**. Services for vasectomy or other voluntary sterilization procedures for male *plan participants*. Female sterilization and family planning counseling is covered under the Preventive Care provision of this *Plan*. The *Plan* does not cover the reversal of voluntary sterilization procedures, including related follow-up care.

63. **Surgery**. Benefits for the treatment of *illnesses* and *injuries* including fractures and dislocations are covered for the surgeon, assistant surgeon, anesthesiologist, and surgical supplies. ***Pre-certification* is required for certain outpatient surgeries**. **Refer to Schedules of Medical Benefits, Pre-Certification for details.**

64. **Teladoc Services**. Teladoc services are available, including:

    a. Prescriptions may be provided through a Teladoc consultation. When you go to your *pharmacy* of choice to pick up your prescription, you may use your health/prescription insurance card to help pay for the medication. You will be responsible for the *co-payment*/*co-insurance* based on the type of medication and your *Plan* benefits.

    b. Teladoc provides medical care related to routine medical issues only as defined by the Teladoc service. Psychiatric and dental care needs are not provided through this service.

65. **Temporomandibular Joint Disorders (TMJ).** Benefits for medical services for treatment of *temporomandibular joint* disorders. Refer to the Schedule of Medical Benefits – HDHP Plan for specific limits regarding this benefit.

66. **Transplants**. Services and supplies that are *incurred* for care and treatment due to an organ, tissue, or bone marrow transplants and stem cell procedures are subject to the limits located in the **Transplant Program** section. ***Pre-certification* is required**.

67. **Urgent Care**. Urgent care means treatment for conditions that require prompt medical attention, but are not emergencies. No matter what the circumstances, if you obtain urgent care services at a *hospital* or a *hospital's* on-site urgent care department, you will be responsible for the applicable emergency room *co-pay*.

68. **Virtual Visits.** Services rendered telephonically or electronically, performed by providers other than the *Plan's* telemedicine vendor, when performed for otherwise covered services.

69. **X-Rays**. Diagnostic x-rays.

B. Medical Plan Exclusions

The following list is intended to give you a general description of expenses for services and supplies not covered by the *Plan*. Items that are not listed as excluded may be considered based on *medical necessity*, standard of care, and medical appropriateness. This list is not exhaustive.

Note: All exclusions related to prescription drugs are shown in the Prescription Drug Benefits section.

1. **Abortion.** Non-spontaneous, medically-induced abortions (by surgical or non-surgical means), except as stated in this *Plan*.
2. **Activity Therapy.** Activity therapy and milieu therapy, including community immersion, integration, home independence, and work re-entry therapy; and any care intended to assist an individual in the activities of daily living; and any care for comfort and convenience, except for limited hospice benefits.
3. **Acupuncture.**
4. **Adoptive Cell Therapy.**
5. **Alcohol.** Services, supplies, care, or treatment to a *plan participant* for an *injury* or *illness* from taking part in any activity made illegal due to the use of alcohol. Expenses will be covered for *injured plan participants* other than the person partaking in any activity made illegal due to the use of alcohol and expenses may be covered for *substance use disorder* treatment as specified in this *Plan*.
6. **Alternative Medicine.** Includes non-traditional and alternative medical therapies; interventions; services, and procedures not commonly accepted as part of allopathic curriculum and practices; naturopathic and homeopathic medicine; diet therapies; massage therapy, and aromatherapy.
7. **Armed Forces.** Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any *plan participant* in the armed forces of a government.
8. **Athletic Training.**
9. **Before or After Eligibility.** Services, supplies, or accommodations provided prior to the *plan participant's* effective date or after the termination of coverage.
10. **Behavioral Services.** The following services or supplies are excluded under this *Plan*:
    a. development of a learning plan and treatment and education for learning disabilities (such as reading and arithmetic disorders)
    b. services related to *developmental delay*
    c. IQ testing
    d. lifestyle education and management services, except as required by law
    e. neurofeedback
    f. neuropsychological, psychological, and cognitive testing
    g. *inpatient* and outpatient facility charges for services provided by the following: group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters, or foster homes
11. **Biofeedback and Hypnotherapy.**
12. **Body Art, Piercing, and Tattooing.** Services related to body piercing, *cosmetic* implants, body art, tattooing, and any related complications. This exclusion does not apply to breast reconstruction following a *medically necessary mastectomy* or needed for radiation treatment.
13. **Bone Marrow.** Benefits in connection with harvesting and reinfusion of bone marrow for the treatment of an *illness*, except as otherwise specifically provided herein.
14. **Cardiac Rehabilitation.** Cardiac rehabilitation phase three (3) and phase four (4).
15. **Certain Types of Facility Charges.** *Inpatient* and outpatient facility charges for treatment provided by the following facilities: group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters, or foster homes.
16. **Chartered Flights.**
17. **Chelation Therapy.** Except for lead poisoning.

18. **Clinical Trials.** The following items are excluded from *approved clinical trial* coverage under this *Plan*:
    a. the *investigational* item, device, or service, itself
    b. items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the patient
    c. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

    If one (1) or more participating providers do participate in the *approved clinical trial,* the qualified *plan participant* must participate in the *approved clinical trial* through a participating, *network* provider, if the provider will accept the *plan participant* into the trial.

    The *Plan* does not cover routine patient care services that are provided outside of this *Plan's* health care provider *network* unless *non-network* benefits are otherwise provided under this *Plan*.
19. **Cognitive and Vocational Therapy.** Services related to improving cognitive functioning (i.e., higher brain functions), reinforcing or re-establishing previously learned thought processes, compensatory training, sensory integrative activities, and services related to employability.
20. **Complications from a Non-Covered Service.** Complications and consequences, whether immediate or delayed, arising from any condition or service not covered under this *Plan*.
21. **Computer Speech Training, Therapy Programs, and Devices.**
22. **Cord Blood.** Harvesting and storage of umbilical cord blood.
23. **Cosmetic Services and Related Complications.** *Surgery* and any related complications, procedures, treatment, office visits, consultations, and other services for *cosmetic* purposes. This exclusion does not apply to breast reconstruction following a *medically necessary mastectomy*.
24. **Counseling.** Counseling and behavioral modification services, except as stated in this *Plan*.
25. **Court-Ordered Services.** Court-ordered testing, treatment, and therapy, unless such services are otherwise covered under this *Plan*. This exclusion does not apply to *mental health or substance use disorder holds*.
26. **COVID-19 Services.** Effective May 12, 2023, over-the-counter (OTC) home tests for COVID-19 are not covered.
27. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, or *custodial care*.
28. **Dental Care.** Normal dental care benefits, including:
    a. dental and orthodontic services
    b. placement or replacement of crowns, bridges, or implants
    c. any fixed dental reconstruction of the teeth
    d. orthodontics
    e. extractions of teeth
    f. dentures and procedures associated with the fitting of dentures
    g. vestibuloplasty
    h. surgical orthodontics
29. **Dietary and Nutritional Supplements**. All dietary, caloric, and nutritional supplements, such as specialized formulas for infants, children, or adults or other special foods or diets, even if prescribed, except as stated in this *Plan***.**
30. **Durable Medical Equipment.** Delivery, set-up, and education charges pertaining to *DME*.
31. **Error.** Any charge for care, supplies, treatment, and/or services that are required to treat *injuries* that are sustained or an *illness* that is contracted, including infections and complications, while the *plan participant* was under, and due to, the care of a *provider* wherein such *illness*, *injury*, infection, or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the *Plan Administrator*, in its sole discretion, unreasonably gave rise to the expense.
32. **Excess Charges.** Any charge for care, supplies, treatment, and/or services that are not payable under the *Plan* due to application of any *Plan* maximum charges which are in excess of the *maximum amount*, or services not deemed to be *reasonable* or *medically necessary*, based upon the *Plan Administrator's* determination as set

forth by and within the terms of this document. The part of an expense for care and treatment of an *injury* or *illness* that is in excess of the *maximum amount*.

33. **Exercise Programs.** Exercise programs or gym memberships for treatment of any condition, except for *physician*-supervised cardiac rehabilitation, pulmonary rehabilitation, occupational, or physical therapy if covered by this *Plan*.
34. **Experimental/Investigational.** Care and treatment that is *experimental/investigational*. This exclusion shall not apply if the charge is for routine patient care for costs *incurred* by a qualified individual who is a participant in an approved clinical trial.
35. **Eye Care.** Unless stated otherwise in the *Plan* the following are excluded:
    a. orthoptics (eye muscle exercises), orthoptic therapy, vision training, or subnormal vision aids
    b. all types of refractive keratoplasties
    c. any other procedures, treatments, and devices for refractive correction, even when performed in conjunction with a medical diagnosis
    d. eyeglasses, contact lenses, and other eyewear
    e. specialty lenses such as polarized lenses, transition lenses, coatings, tints, or add-ons
    f. vision examinations for fitting of eyeglasses and contact lenses, except as stated in this *Plan*

    This provision only applies to the extent such services are not covered as a benefit under the Routine Preventive Care provisions found in the Schedule of Medical Benefits – HDHP Plan.
36. **Family History Diagnosis.** Any testing performed on a *plan participant* who does not have a specific diagnosis, acute signs, or symptoms of a condition, or *disease* for which the test is being performed but has only a family history for the *disease* or condition. This exclusion does not apply to the exams permitted under the Routine Preventive Care provision found in the Schedule of Medical Benefits – HDHP Plan.
37. **Fees.** Fees other than for medically appropriate, in-person, direct member services, except as stated in this *Plan*. Fees for concierge medicine services are also excluded under this *Plan*.
38. **Fertility and Infertility Services**. Services to improve or achieve fertility (ability to conceive) or to diagnose and treat *infertility* (inability to conceive).
39. **Foods and Formulas.** The following food and formula service or supplies are excluded under this *Plan*:
    a. foods and beverages that are naturally low in protein or galactose
    b. foods and formulas available for purchase without a prescription or order from an M.D. or D.O. physician or Registered Nurse Practitioner (R.N.P.)
    c. foods and formulas that do not require supervision by an M.D., D.O., physician, or a R.N.P.
    d. medical food benefits are not available for any condition not included in the newborn screening program, such as lactose intolerance without a diagnosis of Galactosemia
    e. spices and flavorings
40. **Foot Care.** Services for routine, palliative, or cosmetic foot care, including trimming of nails or treatment of corns and calluses, except when *medically necessary* for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg. Services for treatment of flat feet, weak feet, and fallen arches. Arch supports may be covered when *medically necessary* for diabetes, neurological involvement, or peripheral vascular *disease* of the foot or lower leg.
41. **Foreign Travel.** Expenses for planned and/or routine services received or supplies purchased outside the United States, including services rendered on a cruise ship, even if travel outside the United States is for the purpose of treatment, except services provided in a *medical emergency*.
42. **Gene Therapy.** Therapy that seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use.
43. **Genetic and Chromosomal Testing and Screening.** Genetic and chromosomal testing of an individual who is asymptomatic, unaffected, or not displaying signs or symptoms of a disorder for which the test or screening is performed, except amniocentesis and as required under applicable federal law or as specified herein. The *Plan* specifically excludes genetic testing for pre-parental genetic testing, pre-implantation genetic diagnosis, home genetic test kits, and services that are not *medically necessary*.

44. **Government Coverage.** Care, treatment, or supplies furnished by a program or agency funded by any government, except as stated herein. This exclusion does not apply to Medicaid, a Veteran's Administration facility, or when otherwise prohibited by applicable law. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of any other condition that is not a military service-related *illness* or *injury*, benefits are covered by the *Plan* to the extent those services are *medically necessary* and the charges are within this *Plan's maximum allowable charge*.

45. **Growth Hormones.** Refer to **Prescription Drug Benefits** section.

46. **Habilitation Services.**

47. **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a *physician*, except for wigs for *plan participants* diagnosed with alopecia resulting from *illness* or *injury*. This exclusion does not apply to hair loss services attributed to a covered medical condition.

48. **Health Records.** Charges associated with the preparation, copying, or production of health records.

49. **Hearing Services.** Routine hearing exams, except for hearing screenings included in a physical exam covered under the Routine Preventive Care benefit. Aural therapy services in connection with implantable hearing devices. Diagnostic hearing tests related to a medical condition identified by a *physician* are covered as any other service.

50. **Home Visits.** When a provider visits the home for covered services, commonly known as a 'house call.' This is separate from home health care and therapy done in the home.

51. **Hospice Care**. Services including pastoral or spiritual counseling; services performed by a family member or volunteer workers; homemaker or housekeeping services; food services (such as Meals on Wheels); legal and financial counseling services; and services or supplies not included in the *hospice care plan* or not specifically set forth as a hospice benefit.

52. **Hospital Employees.** Professional services billed by a *physician* or nurse who is an employee of a *hospital* or *skilled nursing facility* and paid by the *hospital* or facility for the service.

53. **Hospital Services**. *Hospital* services when hospitalization is primarily for diagnostic studies or physical therapy when such procedures could have been done adequately and safely on an outpatient basis.

54. **Illegal Acts.** Any charges for care, supplies, treatment, and/or services received for any *injury* or *illness* which is *incurred* while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act.

55. **Illegal Drugs or Medications.** Services, supplies, care, or treatment to a *plan participant* for *injury* or *illness* resulting from that *plan participant's* voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a *physician*. Expenses will be covered for *injured plan participants* other than the person using the controlled substance.

56. **Impotence**. Care, treatment, services, supplies, or medication in connection with treatment for impotence.

57. **Lodging and Meals.** Lodging and meals, except as stated in this *Plan*.

58. **Maintenance Services.** Services rendered after a *plan participant* has met functional goals; services rendered when no objectively measurable improvement is reasonably anticipated, services to prevent regression to a lower level of function, services to prevent future *injury* and services to improve or maintain posture.

59. **Manipulation of the Spine Under Anesthesia.**

60. **Medicare.** Any charge for benefits that are provided, or which would have been provided had the *plan participant* enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (*Medicare*), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled **Coordination of Benefits** and **Medicare**.

61. **Medications Dispensed in Certain Settings.** Prescription medications given to the *plan participant*, for the *plan participant's* future use, by any person or entity that is not a licensed *pharmacy*, *home health care agency*, specialty *pharmacy,* or *hospital* emergency room.

62. **Milieu Therapy.** A treatment program based on manipulation of the *plan participant's* environment for their benefit. Activity therapy, milieu therapy, and any care primarily intended to assist the *plan participant* in the activities of daily living are excluded under this *Plan*.

63. **Negligence.** Care and treatment of an *injury* or *illness* that results from activity where the *plan participant* is found by a court of competent jurisdiction and/or a jury of his or her peers to have been negligent in his or her actions, as negligence is defined by the jurisdiction where the activity occurred.

64. **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

65. **No Legal Obligation.** Any charge for care, supplies, treatment, and/or services that are provided to a *plan participant* for which the *provider* of a service customarily makes no direct charge, or for which the *plan participant* is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the *plan participant* or this benefit *Plan*, may be liable for necessitating the fees, care, supplies, or services.

66. **No Physician Recommendation.** Care, treatment, services, or supplies not recommended and approved by a *physician* or treatment, services, or supplies when the *plan participant* is not under the regular care of a *physician*. Regular care means ongoing medical supervision or treatment which is appropriate care for the *injury* or *illness*.

67. **Non-Compliance.** Any additional *inpatient* charges in connection with treatments or medications which were directly caused by and attributed to the patient's non-compliance with or discharge from an *inpatient hospital* or *skilled nursing facility* against medical advice. This exclusion does not apply to any subsequent emergency room visits or *outpatient* services.

68. **Non-Emergency Hospital Admissions.** Care and treatment billed by a *hospital* for non-medical emergency admissions on a Friday or a Saturday. This does not apply if *surgery* is performed within twenty-four (24) hours of admission.

69. **Non-Medical Expenses.** Expenses such as those for preparing medical reports or itemized bills, completion of claim forms or medical records unless otherwise required by law, calling a patient to provide their test results, sales tax, shipping and handling, services for telephone consultations (except as outlined in the Emergency Room, Teletrauma benefit or the Teladoc Services benefit), expenses for failure to keep a scheduled visit or appointment, *physician* or *hospital* stand-by services, holiday or overtime rates, membership or access fees, educational brochures, or reports prepared in connection with litigation.

70. **Non-Prescription Medication**. Drugs and supplies not FDA approved, *experimental* drugs, including those labeled "Caution: Federal law prohibits dispensing without prescription" and prescription medications related to health care services which are not covered under this *Plan*. Services and supplies that are required by this *Plan* to have a prescription and are not prescribed by a *physician* or other *provider* licensed to prescribe.

71. **Not Actually Rendered.** Any charge for care, supplies, treatment, and/or services that are not actually rendered.

72. **Not Medically Necessary.** Any charge for care, supplies, treatment, and/or services that are not *medically necessary*, unless specifically stated as covered herein.

73. **Occupational or Workers' Compensation**. Charges for care, supplies, treatment, and/or services for any condition, *illness*, *injury*, or complication thereof arising out of or in the course of employment including self-employment, or an activity for wage or profit. If you are covered as a *dependent* under this *Plan* and you are self-employed or employed by an employer that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases Workers' Compensation insurance will cover your costs, but if you do not have such coverage, fail to file, or receive a denial for failure to file timely, you may end up with no coverage at all.

74. **Over-the-Counter Items.** Medications, devices, equipment, and supplies that are lawfully obtainable without a prescription, except as stated in this *Plan*.

75. **Personal Comfort Items.** Services intended primarily for assistance in daily living, socialization, personal comfort, convenience, and other non-medical reasons.

76. **Personal Injury Insurance.** Expenses in connection with an automobile *accident* for which benefits payable hereunder are or would be otherwise covered by mandatory *no-fault auto insurance* or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the *plan participant* actually had such mandatory coverage. This exclusion does not apply if the *injured* person is a passenger in a non-family owned vehicle or a pedestrian.

77. **Physical Examinations, Tests for Employment, Sports, and Administrative Purposes.** Expenses for physical examinations and testing required for employment, government or regulatory purposes, insurance, or by any

third party. This exclusion does not apply to the exams permitted under the Routine Preventive Care provision in the Schedule of Medical Benefits – HDHP Plan, or under applicable law.

78. **Prescription Drugs.** Prescription drugs charges covered under the Prescription Drug Benefits, other than those covered in a *physician's* office or *inpatient* admission.
79. **Private Duty Nursing.** Charges in connection with care, treatment, or services of a private duty nurse.
80. **Prohibited by Law.** Any charge for care, supplies, treatment, and/or services to the extent that payment under this *Plan* is prohibited by law.
81. **Repair or Replacement of Durable Medical Equipment (DME).** The following services or charges:
    a. charges for continued rental of a *DME* item after the purchase price is reached
    b. repair costs that exceed the replacement cost of the *DME* item
    c. repair or replacement of *DME* items lost or damaged due to neglect or use that is not in accordance with the manufacturer's instructions or specifications
82. **Residential Accommodations.** Residential accommodations to treat medical or behavioral health conditions, except when provided in a *hospital*, *hospice unit*, *skilled nursing facility*, *inpatient rehabilitation hospital*, or *residential treatment facility* licensed and regulated by a state or federal agency and is acting within the scope of their license.
83. **Self-Inflicted.** Any loss due to an intentionally self-inflicted *injury*. This exclusion does not apply to a victim injured as a result of an act of domestic violence or an *injury* resulting from a medical (including both physical and mental health) condition.
84. **Services for Idiopathic Environmental Intolerance.** Services associated with environmental intolerance from unknown causes (idiopathic), multiple chemical sensitivity, the diagnosis or treatment of environmental *illness* (clinical ecology) such as chemical sensitivity, or toxicity from exposure to atmospheric or environmental contaminants, pesticides, or herbicides
85. **Services from a Family Member.** Services delivered by an eligible *provider* who is a member of your immediate family. Immediate family members are: parents, siblings, children, step-parents, step-children, spouses, grandparents, grandchildren, and any of the preceding individuals related to the member by marriage. When a *provider* is also the *plan participant*, services rendered by that *provider* for himself or herself are also excluded from coverage.
86. **Sexual Dysfunction.** Services for sexual dysfunction, regardless of the cause.
87. **Sleep Disorders.** Care and treatment for sleep disorders unless deemed *medically necessary*. Sleep studies ordered by a dentist.
88. **Spinal Decompression or Vertebral Axial Decompression Therapy.**
89. **Strength Training.** Services primarily designed to improve or increase fitness, strength, or athletic performance, including strength training, cardiovascular endurance training, fitness programs, and strengthening programs, except as stated in this *Plan*.
90. **Subrogation, Reimbursement, and/or Third-Party Responsibility.** Any charges for care, supplies, treatment, and/or services of an *injury* or *illness* not payable by virtue of the *Plan's* **Reimbursement, Subrogation, and Recovery Provisions**.
91. **Surgical Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.
92. **Surrogate Pregnancy.** Charges for services related to surrogate *pregnancy*.
93. **Transplants.** Transplants and related services not *pre-certified*. Also see the **Transplant Program** section.
94. **Transsexual Treatment.** Surgery, medications, and all related services.
95. **Travel or Accommodations.** Charges for travel, transportation, or accommodations, whether or not recommended by a *physician*, except for ambulance charges as defined as a *covered charge* and the limited travel benefits described in the **Transplant Program**.
96. **War.** Any loss that is due to a declared or undeclared act of war.
97. **Weight Loss and/or Obesity.** Expenses for care, treatment, supplies, instruction, or activities for weight reduction, weight control, weight loss programs, or physical fitness, even if such services are performed or prescribed by a *physician*; weight control drugs, supplies, supplements, or substances; or *surgery*. This

exclusion only applies to the extent such services are not covered under the Routine Preventive Care provision, or as stated in this *Plan* under the Bariatric Surgery benefit.

SECTION VII—TRANSPLANT PROGRAM

A. Transplant Program

The transplant program provides access to a *network* of transplant centers that perform many transplants each year and historically have high success rates. They are often affiliated with renowned teaching and research facilities with access to experienced surgeons and advanced medical techniques. Using a *hospital* with transplant experience can result in shorter *hospital* stays, fewer complications, and fewer repeat transplants.

Transplants are eligible for coverage if they meet the requirements outlined in the Transplant Requirements subsection below.

For the purpose of this benefit, please specifically review the definitions of Bone Marrow Transplant and Caregiver located in the Defined Terms section of this document.

B. Program Benefits

Benefits are available for the following services in connection with or in preparation for a covered transplant:

1. *inpatient* and outpatient facility and professional services
2. air and ground transportation of a medical team to and from the site in the contiguous states of the United States, to obtain tissue that is subsequently transplanted into a *plan participant*
3. bone marrow search and procurement of a suitable bone marrow donor when a *plan participant* is the recipient of a covered allogeneic transplant and in accordance with customary transplant center protocol as identified by that specific transplant center
4. chemotherapy or radiation therapy associated with transplant procedures
5. harvest and reinfusion of stem cells or bone marrow
6. medical expenses incurred by a donor when the recipient is covered by this *Plan*

   Covered donor expenses include complications and *medically necessary* follow-up care related to the donation for up to six (6) months post-transplant, as long as the recipient's *Plan* coverage remains in effect.
7. pre-transplant testing and services

Note: When transplant services are provided through the Mayo Clinic of Arizona, post-transplant services may continue under this facility for a maximum of twelve (12) months post-transplant (as long as the recipient's *Plan* coverage remains in effect).

C. Transplant Requirements

Transplant benefits under the *Plan* are only available when a *plan participant* fully utilizes a Transplant Network, Center of Excellence, or *network provider* and meets **all** of the following requirements:

2. ***pre-certification* must be obtained** as outlined in the **Health Care Management Program** section
3. all transplant services must be rendered at a transplant center facility

If these requirements are not met, transplant benefits are not available under the Plan.

D. Transplant Exclusions

The following transplant-related expenses are not covered by the *Plan*:

1. when the organ or tissue is sold rather than donated to the recipient
2. expenses related to donation of an organ when the recipient is not an eligible *plan participant*
3. expenses covered or funded by governmental, foundation, or charitable grants or programs
4. any artificial or mechanical organ

   This exclusion does not apply to cardiac assist devices such as LVADs.
5. any of the following or similar items associated with travel:

a. entertainment items; alcoholic beverages; cigarettes; toys; books; theatre tickets; movies; items from in-room mini-bars or refrigerators; laundry, cleaning, or valet services; telephone or internet service charges; spa services; gym facilities; or other hotel or motel amenities

b. all travel and lodging expenses in excess of **$200** per day per covered *plan participant*

c. all travel and lodging expenses in excess of the **$10,000** lifetime maximum per covered *plan participant*

d. convenience items such as toiletries, paper products, maid service, laundry/dry cleaning, kennel fees, baby sitter/childcare, valet parking, faxing, cell phones, phone calls, newspapers

e. mortgage, rent, security deposit, furniture, utility bills, appliances, utensils, vacation/apartment rentals

f. ambulance transportation (ground or air)

g. *caregiver* salary, stipend, and compensation for services

h. taxes

i. expenses for travel or lodging incurred in connection with non-covered transplant services or any follow-up care, including treatment of complications

j. expenses for travel or lodging related to evaluation, consultation, or medical testing to determine if a *plan participant* is a candidate for transplantation

k. food preparation services

l. furniture or supplies for a rental apartment

m. home modifications

n. security deposits

o. travel and lodging expenses for transplants other than a covered solid organ, bone marrow, or stem cell transplant, even if such a transplant is a *covered charge*

p. travel and lodging expenses for *plan participants*, donors, or *caregivers* when the *plan participant*, donor or *caregiver* does not travel more than seventy-five (75) miles for an authorized transplant or transplant related services, including follow-up care and treatment of complications

q. vehicle maintenance or services (such as tires, brakes, or oil changes), automobile mileage, taxi fares, parking, moving trucks/vehicles, mileage within the medical transplant facility city

E. Transplant Travel and Lodging

Coverage is available for reimbursement of travel and lodging expenses, as listed below, that are *incurred* by a *plan participant* receiving a covered transplant, a donor donating for a covered transplant, and a *caregiver* for the donor or recipient *plan participant*. Total reimbursement will not exceed actual expenses, up to a maximum of **$200** per day and **$10,000** per lifetime. The daily maximum is an aggregate amount, not a per person amount, for the *plan participant* receiving a covered transplant, donor, and *caregiver*.

To qualify for reimbursement, **all** of the following criteria must be met:

1. *Pre-certification* of the transplant procedure is obtained as outlined in the **Health Care Management Program** section.
2. The distance from the *plan participant*, donor, or *caregiver's* residence must be more than seventy-five (75) miles from the transplant facility.
3. The *plan participant* is receiving a covered solid organ, bone marrow, or stem cell transplant.
4. The *plan participant* or donor must be receiving *medically necessary* pre- and post-operative treatments, including without limitation, treatment of complications related to the covered transplant or routine follow-up care for a covered transplant or a transplant that occurred while the *plan participant* was covered by another insurance plan.
5. The expenses are for any of the following:
    a. meal expenses

b. mileage for travel in a personal vehicle (at the rate set by the Internal Revenue Service for medical purposes in effect at the time of travel), car rental charges, bus, train, or air fare

c. room charges from hotels, motels, and hostels or apartment rental

Travel and lodging benefits will be reimbursed upon the submission to the *Plan* of dated receipts showing the service provided, the cost of the service, and the name, address, and phone number of the service provider. Refer to the **Claims and Appeals** section for instructions on how to submit a claim for reimbursement.

SECTION VIII—HEALTH CARE MANAGEMENT PROGRAM

The Health Care Management Program consists of several components to assist *plan participants* in staying well: optimal management of chronic conditions, and provisions of support and service coordination during times of acute or new onset of a medical condition.

The scope of the Health Care Management Program consists of the following components (each of which will be further discussed in the section):

1. Utilization Review
2. Concurrent Review and Discharge Planning
3. Case Management

A. Utilization Review

Utilization Review is a program designed to help insure that all *plan participants* receive necessary and appropriate health care while avoiding unnecessary expenses.

The purpose of the program is to determine what services are *medically necessary* and eligible for payment by the *Plan*. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending *physician* or other health care provider.

If a particular course of treatment or medical service is not *pre-certified*, it means that either the *Plan* will not pay for the charges, or the *Plan* will not consider that course of treatment as *medically necessary* and appropriate for the maximum reimbursement under the *Plan*. The patient is urged to review why there is a discrepancy between what was requested and what was certified before *incurring* charges.

The attending *physician* does not have to obtain *pre-certification* from the *Plan* for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.

Your *employer* has contracted with AmeriBen Medical Management in order to assist you in determining whether or not proposed services are appropriate for reimbursement under the *Plan*. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility.

Elements of the Utilization Review Program

The program consists of:

1. **Pre-Certification.** Review of the *medical necessity* for non-emergency services before medical and/or surgical services are provided.
2. **Retrospective Review.** Review of the *medical necessity* of the health care services provided on an emergency basis.
3. **Concurrent Review.** Ongoing assessment of the health care as it is being provided, especially, but not limited to, *inpatient* confinement in a *hospital* or covered *medical care facility* (based on the admitting diagnosis, of the listed services requested by the attending *physician)*.
4. **Discharge Planning.** Certification of services and planning for discharge from a *medical care facility* or cessation of medical treatment.

Note: If there is an **emergency** admission to the *medical care facility* the *plan participant*, *participant's* family member, *medical care facility,* or attending *physician* must contact the *Medical Management Administrator* within **forty-eight (48) hours** of the first business day after the admission.

What Services Must Be Pre-Certified (Approved Before they are Provided)

The provider, patient, or family member must call the *Medical Management Administrator* to receive certification of certain health care management services. This call must be made at least forty-eight (48) hours in advance of services being rendered or within forty-eight (48) hours after an *emergency*.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

The following services must be *pre-certified* before the services are provided:

1. *inpatient* pre-admission certification and continued stay reviews (all ages, all diagnoses)

a. surgical and non-surgical (excluding routine vaginal or cesarean deliveries)

b. long term acute care facility (LTAC), not *custodial care*

c. *skilled nursing facility*/rehabilitation facility

d. *inpatient mental health/substance use disorder* treatment (includes *residential treatment facility* services)

The attending *physician* does not have to obtain *pre-certification* from the *Plan* for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.

2. *inpatient* and *outpatient surgery* including pain management injections and intra-articular hyaluronic acid injections

   Pre-certification is not required for office *surgeries* and all colonoscopies/sigmoidoscopies (screening and diagnostic).

3. advanced imaging – Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans (excluding services rendered in an emergency room setting)

4. *outpatient* rehabilitation services (physical therapy, occupational therapy, and speech therapy) in excess of twenty (20) visits per *benefit year* per therapy type

5. chemotherapy drugs/infusions and radiation treatments for oncology diagnoses

6. *home health care services* and supplies

7. transplant (other than cornea), including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high-dose chemotherapy

8. orthotics/prosthetics in excess of $3,000 (purchase/rental price)

9. *durable medical equipment* (DME) in excess of $3,000 (purchase/rental price)

10. genetic/genomic testing (excluding amniocentesis) in excess of $1,000

11. clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening *disease* or condition

    This *Plan* does not cover clinical trials related to other *diseases* or conditions. Refer to the **Medical Benefits** section of this document for a further description and limitations of this benefit.

12. non-emergent air ambulance

13. intensive *outpatient* program in excess of twenty (20) visits per *benefit year*, for *mental health and substance use disorder* treatment

14. partial hospitalization in excess of twenty (20) visits per *plan participant* per *benefit year*

15. non-invasive pre-natal testing

16. sleep disorders

17. specialty infusion/injectable medications over $3,000 per infusion/injection which are covered under the medical benefits and not obtained through the Prescription Drug Benefits (i.e. provided in an *outpatient* facility, *physician's* office, or home infusion)

    For specialty drugs obtained through the Pharmacy Benefits Manager, please refer to the **Prescription Drug Benefits** section for additional information and requirements for prior authorization.

18. dental services required for medical procedures

Services rendered in an emergency room or urgent care setting do not require *pre-certification*.

In order to maximize Plan reimbursements, please read the following provisions carefully.

How to Request Pre-Certification

Before a *plan participant* enters a *medical care facility* on a non-emergency basis or receives other listed medical services, the *Medical Management Administrator* will, in conjunction with the attending *physician*, certify the care as *medically necessary* for *Plan* reimbursement. A non-emergency stay in a *medical care facility* is one that can be scheduled in advance.

The Utilization Review program is set in motion by a telephone call from, or on behalf of, the *plan participant*. Contact the *Medical Management Administrator*, AmeriBen Medical Management, at 1-855-778-9053 **at least forty-eight (48) hours before** services are scheduled to be rendered with the following information:

1. the name of the *plan participant* and relationship to the covered *employee*
2. the name, employee identification number, and address of the covered *employee*
3. the name of the *employer*
4. the name and telephone number of the attending *physician*
5. the name of the *medical care facility*, proposed date of admission, and proposed length of stay
6. the proposed medical services

If there is an **emergency** admission to the *medical care facility* the *plan participant*, *participant's* family member, *medical care facility,* or attending *physician* must contact AmeriBen Medical Management within **forty-eight (48) hours** of the first business day after the admission.

The *Medical Management Administrator* will determine the number of days of *medical care facility* confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure will reduce reimbursement received from the Plan.**

Warning: Obtaining *pre-certification* of particular services does not guarantee that they will be reimbursed by the *Plan*. Benefits are determined by the *Plan* at the time a formal *claim* for benefits is submitted according to the procedures outlined within the **Claims** and **Appeals** section of this plan document.

If your admission or service is determined to **not** be *medically necessary*, you may pursue an *appeal* by following the provisions described in the **Claims and Appeals** section (First Level Appeal of a Pre-Service Claim subsection) of this document. The *plan participant* and provider will be informed of any denial or non-certification in writing.

Penalty for Failure to Pre-Certify (Very Important Information)

If a *plan participant* does not follow the *pre-certification* requirements outlined above, **benefits will be reduced by $300 per paid claim**. This penalty will be applied to the facility charge only. In instances where there is no facility claim, the penalty will be applied to the services rendered. Amounts assessed under this penalty will not go towards satisfaction of your *deductible* or *out-of-pocket limit*. Penalty will still apply if services rendered are deemed medically necessary under retroactive review.

B. Concurrent Review and Discharge Planning

How Concurrent Review Works

Concurrent review of a course of treatment and discharge planning from a *medical care facility* are parts of the Utilization Review program. The *Medical Management Administrator* will monitor the *plan participant's medical care facility* stay or use of other medical services. The *Medical Management Administrator* (along with the attending *physician*, *medical care facilities*, and *plan participant*) will coordinate one of the following:

1. the scheduled release
2. an extension of the *medical care facility* stay
3. extension or cessation of the use of other medical services

If the attending *physician* feels that it is *medically necessary* for a *plan participant* to receive additional services or to stay in the *medical care facility* for a greater length of time than has been *pre-certified,* the attending *physician* must request the additional services or days.

How to File a Concurrent Claim for Benefits under this Plan

Refer to the **Claims and Appeals** section, Concurrent Care Claims subsection, for details on how to *appeal* a denial of a concurrent review. No benefits will be paid for any charges related to days of confinement to a *hospital* or other *health care facility* that have not been determined to be *medically necessary* by the *Medical Management Administrator*.

C. Case Management

In certain complex medical situations case management may become necessary.

A case manager consults with the *plan participant*, the family, the attending *physician,* and the *Plan Administrator* in order to coordinate an effective treatment plan. This plan of care may include some or all of the following:

1. personal support and education to the *plan participant*
2. assistance and support to the family
3. monitoring *hospital* or *skilled nursing facility* stays
4. determining alternative care options
5. assisting in obtaining any necessary equipment and services

Note: Case management is a voluntary service. There are no reductions of benefits or penalties if the plan participant and family choose not to participate.

Each treatment plan is individually tailored to a specific plan participant and should not be seen as appropriate or recommended for any other plan participant, even one with the same diagnosis.

D. Courtesy Reviews

The *Medical Management Administrator* may perform *courtesy reviews*. *Courtesy reviews* are a pre-service assessment of *medical necessity* only and are not a guarantee of benefits. *Courtesy reviews* will be made as soon as possible after the request has been submitted, but no later than thirty (30) days. Completion of a *courtesy review* is not a requirement of the *Plan* and should not be a cause for delay in treatment of *medically necessary* care. Contact *Medical Management Administrator* with any questions. Refer to the **Claims and Appeals** section for timeframes and other information regarding filing *claims*.

SECTION IX—PRESCRIPTION DRUG BENEFITS

A. About Your Prescription Benefits

The Prescription Drug Benefits are separate from the Medical Benefits and are administered by Navitus Health Solutions (Navitus). This program allows you to use your ID card at a nationwide *network* of participating *pharmacies* to purchase your prescriptions.

If you purchase your *prescription drugs* from a *non-network pharmacy*, you will have to pay the full price of the prescription minus the *network* price of the prescription. When the *prescription drug* is purchased from a *network pharmacy,* when the *plan participant's* ID card is not used, the amount payable in excess of the amounts shown in the Schedule of Prescription Drug Benefits – HDHP Plan will be the contracted ingredient cost and contracted dispensing fee.

Claims for reimbursement of *prescription drugs* are to be submitted to Navitus Health Solutions at:

Navitus Health Solutions
Attn: Manual Claims
P.O. Box 999
Appleton, WI 54912

B. Co-Insurance

Once you have met the Medical *benefit year deductible*, the *Plan* pays 100% of the cost of the covered *pharmacy* drug or mail order drug charge as shown in the Schedule of Prescription Drug Benefits – HDHP Plan. Your *co-insurance* amount applies to the Medical *benefit year deductible* and *out-of-pocket limit*. Any one (1) *pharmacy* prescription is limited to a thirty (30) day supply or a ninety (90) day supply at participating '90-Day at Retail' *pharmacies*. Any one (1) mail order prescription is limited to a ninety (90) day supply.

C. Out-of-Pocket Limit

Prescription drug covered charges are payable at the amounts shown each *benefit year* until the *out-of-pocket maximum* shown in the Schedule of Medical Benefits – HDHP Plan is reached. Then, *prescription drug covered charges incurred* by a *plan participant* will be payable at 100% (except for the excluded charges) for the rest of the *benefit year*.

When a *family unit* reaches the *out-of-pocket limit*, covered *prescription drug* charges for that *family unit* will be payable at 100% (except for the charges excluded) for the rest of the *benefit year*.

D. Manufacturer Coupons

Any amounts in the form of manufacturer coupons or drug savings discount cards used for brand name drugs may apply to the *deductible* and *out-of-pocket limit*.

E. Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications; those medications that are taken for long periods of time (such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, CostCo, the mail order *pharmacy*, may be able to offer *plan participants* significant savings on their prescriptions.

F. Specialty Pharmacy Program

The Navitus Specialty Pharmacy Program through Lumicera is a specialty pharmacy program which covers some limited drugs, such as specialty injectables, cancer drugs, and certain respiratory therapies used to treat various chronic conditions. The SpecialtyRx program also provides personalized support, education, a proactive refill process, free delivery, as well as information about health care needs related to the chronic *disease*.

To start using Lumicera, call toll free at 1-855-847-3553 or visit **www.lumicera.com**.

G. Tablet Splitting

The tablet splitting program, which is optional for *plan participants,* has identified medications which are taken once daily. The price for a low or high dose tablet is on average the same. Because of this flat pricing of dosage strengths, splitting a tablet of a higher strength to get the desired dose lowers the cost of the medication by up to 50%.

H. Step Therapy Program

Step therapy is a program where you first try a proven, cost-effective medication (called a 'prerequisite drug' in this document) before moving to a more costly drug treatment option. With this program, trying one (1) or more prerequisite drugs is required before a certain prescription medication will be covered under your *pharmacy* benefits plan. Prerequisite drugs are FDA approved and treat the same condition as the corresponding step therapy drugs. Step therapy promotes the appropriate use of equally effective but lower-cost drugs first. You, your *physician,* or the person you appoint to manage your care can ask for an exception if it is *medically necessary* for you to use a more expensive drug on the step therapy list. If the request is approved, Navitus will notify you or your *physician*. The medication will then be covered at the applicable *co-insurance* under your *Plan*. You will also be notified of approvals where states require it. If the request is denied, Navitus will notify you and your *physician*. For information on which drugs are part of the step therapy program under your *Plan* call the Navitus Customer Service number on your ID card.

I. Medicare Part D Prescription Drug Plans for Medicare Eligible Participants

Plan participants enrolled in either Part A or Part B of *Medicare* are also eligible for *Medicare* Part D Prescription Drug benefits. It has been determined that the *prescription drug* coverage provided in this *Plan* is generally better than the standard *Medicare* Part D Prescription Drug benefits. Because this *Plan's prescription drug* coverage is considered *creditable coverage,* you do not need to enroll in *Medicare* Part D to avoid a late penalty under *Medicare*. If you enroll in *Medicare* Part D while covered under this *Plan*, payment under this *Plan* may coordinate benefit payment with *Medicare*. Refer to the **Coordination of Benefits** section for information on how this *Plan* will coordinate benefit payment.

J. Covered Prescription Drug Charges

1. **Abortion.** Drugs that induce abortion such as Mifepristone (RU-486).
2. **Compounded Prescription Drugs.** All compounded prescriptions dispensed by a participating retail *pharmacy* and containing at least one (1) prescription ingredient covered on the drug *formulary* in a therapeutic quantity.
3. **Diabetic.** Insulin and other *formulary* diabetic supplies (excluding insulin pumps and pump supplies) when prescribed by a *physician*.

   Visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of diabetic supplies related *preventive care* benefits.
4. **Growth Hormones. Pre-authorization is required.**
5. **Injectable Drugs.** Self-administered *formulary* injectable drugs or any prescription directing administration by injection.
6. **Prescribed by Physician.** All drugs prescribed by a *physician* that require a prescription either by federal or state law, subject to the drug *formulary* and excluding any drugs stated as not covered under this *Plan*.
7. **Prescription Drugs Mandated Under the Patient Protection and Affordable Care Act.** Certain preventive care medications (including contraceptives) received by a *network pharmacy* are covered at 100% and subject to the following limitations:
   a. Tier 1 *preventive care* medications are covered at 100%, and the *deductible/co-insurance* (if applicable) is waived.
   b. If no Tier 1 is available, then the Tier 2 will be covered at 100% and the *deductible/co-insurance* (if applicable) is waived.

   This provision includes, but is not limited to, the following categories of drugs (In order for these medications to be covered at 100%, a prescription is required from your *physician*, including over-the-counter drugs.):

a. **Breast Cancer Risk-Reducing Medications.** Medications such as tamoxifen or raloxifene for women who are at increased risk for breast cancer and at low risk for adverse medication effects.

b. **Contraceptives**. Women's contraceptives including, but not limited to: oral contraceptives, transdermal contraceptives (i.e., Ortho-Evra), vaginal rings (i.e., Nuvaring), implantable contraceptive devices, injectable contraceptives, and emergency contraception.

c. **Tobacco Cessation Products**. Nicotine gum, smoking deterrent patches, or generic tobacco cessation medications. These drugs are payable without cost sharing up to two (2), ninety (90)-day courses of treatment per *benefit year*, which applies to all products. Thereafter, tobacco cessation products are not covered under the *Plan*.

Please refer to the following websites for information on other types of payable *preventive care* medications **https://www.healthcare.gov/what-are-my-preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.**

K. Limits to This Benefit

This benefit applies only when a *plan participant incurs* a covered *prescription drug* charge. The covered drug charge for any one (1) prescription will be limited to:

1. refills only up to the number of times specified by a *physician*
2. refills up to one (1) year from the date of order by a *physician*
3. *plan participants* must use 75% of their retail *pharmacy prescription drug* (70% of their mail order *prescription drug*) before being eligible to refill

L. Dispense As Written (DAW) Program

The *Plan* requires that retail *pharmacies* dispense generic drugs when available. Should a *plan participant* choose a formulary brand or non-formulary drug rather than the generic equivalent, the *plan participant* will be responsible for the cost difference between the generic and formulary brand or non-formulary in addition to the formulary brand or non-preferred formulary drug *co-payment*. The *plan participant's* share of this *prescription drug* cost difference does not apply toward the *Plan's out-of-pocket limit*.

M. Prescription Drug Plan Exclusions

This benefit will not cover a charge for any of the following.

1. **Administration.** Administration of a covered medication.
2. **Biological Serums.**
3. **Clinic Packs.** Medications designated as clinic packs.
4. **Compound Medications.** Compounded medications obtained from a mail order *pharmacy*.
5. **Cosmetic.** Medications used for any *cosmetic* purpose.
6. **Devices.** Medications, devices, equipment, and supplies lawfully obtainable without a prescription, except as stated in the Covered Prescription Drug Charges subsection.
7. **Enhancement.** Medications for athletic performance or lifestyle enhancement.
8. **Excluded Condition.** Medications used to treat a condition not covered under this *Plan*. A charge excluded under the Medical Plan Exclusions subsection, unless specifically covered in this **Prescription Drug Benefits** section.
9. **Experimental/Investigational.** Medications labeled "Caution: Federal law prohibits dispensing without prescription," or words to that effect, and any *experimental* medications, except as stated in this *Plan*.
10. **FDA.** Drugs recently approved by the FDA may be excluded, until reviewed and approved by Navitus' Pharmacy and Therapeutics Committee, which determines the therapeutic advantage of the drug and the medically appropriate application. Non-FDA approved prescriptions, including compounded estrogen, progesterone, or testosterone products, except as authorized by Navitus.

11. **Fertility.** Medications to improve or achieve fertility or treat *infertility*.
12. **Injectable.** Certain categories of injectable medications. Charges for injectable medications requiring administration or supervision by a qualified *provider* or licensed/certified health professional, except for self-administered injectable medications authorized by Navitus.
13. **Inpatient.** Medications dispensed to a *plan participant* who is an *inpatient* in any facility.
14. **Lost/Stolen.** Charges for spilled, stolen, lost, or forgotten *prescription drugs*. Prescription refills for medications that are lost, stolen, spilled, spoiled, or damaged.
15. **Medication Delivery Implants.**
16. **Multi-Packaged.** Medications packaged with one (1) other or multiple other prescription products.
17. **Nasal Corticosteroids.**
18. **Over the Counter.** Medications packaged with over-the-counter (OTC) medications, supplies, medical foods, vitamins, or other excluded products, except as stated in the Covered Prescription Drug Charges subsection. Medications with primary therapeutic ingredients that are sold over-the-counter in any form, strength, packaging or name, except as stated in the Covered Prescription Drug Charges subsection or covered on the drug *formulary*. This does not apply to injectable insulin.
19. **Prior Authorization.** Charges for *prescription drugs* which require prior authorization unless approved by Navitus.
20. **Proton Pump Inhibitors.**
21. **Unit Dose Medication.** Including bubble pack or pre-packaged medications, except for medication that are unavailable in any other dose or packaging.
22. **Weight.** Medications designed for weight gain or loss, including but not limited to, Xenical® and Meridia®, regardless of the condition for which it is prescribed.
23. **Workers' Compensation.** *Prescription drugs* treating any condition, physical *sickness*, *injury*, or mental *illness* arising out of, or in the course of, employment for which benefits are available under any Workers' Compensation law, property and casualty law, or similar law.

SECTION X—CLAIMS AND APPEALS

This section contains the *claims* and *appeals* procedures and requirements for the Arizona Metropolitan Trust Employee Benefit Plan.

TIME LIMIT FOR FILING CLAIMS

All *claims* must be received by the *Plan* within twelve (12) months from the date of *incurring* the expense, or in accordance with applicable federal government regulations. The *Plan* will accept *network* adjustments of *claims* that are within the *network's* established guidelines.

The *Plan's* representatives will follow administrative processes and safeguards designed to ensure and to verify that benefit *claim* determinations are made in accordance with governing plan documents and that, where appropriate, the *Plan* provisions have been applied consistently with respect to similarly situated *claimants*.

There are four (4) types of *claims* covered by the procedures in this section:

1. **Pre-Service Claim.** Some *Plan* benefits are payable without a financial penalty only if the *Plan* approves services **before** services are rendered. These benefits are referred to as *pre-service claims* (also known as *pre-certification* or prior authorization). The services that require *pre-certification* are listed in the **Health Care Management Program** section of this document.
2. **Urgent Care Claim.** An *urgent care claim* is a *claim* (request) for medical care or treatment in which:
    a. applying the time periods for *pre-certification* could seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function
    b. 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*
    c. the *claim* involves urgent care
3. **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.
4. **Post-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 *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 *post-service claim*.

Following is a description of how the *Plan* processes *claims* for benefits and reviews the *appeal* of any *claim* that is denied.

If a *claim* is denied, in whole or in part, or if *Plan* coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an *adverse benefit determination*.

A *claimant* has the right to request a review of an *adverse benefit determination*. This request is an *appeal*. If the *claim* is denied at the end of the *appeal* process, as described later in this section, the *Plan's* final decision is known as a *final internal adverse benefit determination*. If the *claimant* receives notice of a *final internal adverse benefit determination*, or if the *Plan* does not follow the *appeal* procedures properly, the *claimant* then has the right to request an independent *external review* for certain limited types of *claims*.

External review is only available if the *final internal adverse benefit determination* involves a *claim*: (1) denied based upon a rescission of coverage or (2) which involves medical judgment (*medical necessity*, appropriateness of treatment, health care setting, level of care, or effectiveness of covered benefit) or a determination that treatment is *experimental* or *investigational*, which is to be decided by the external reviewer. There is no external appeal for *adverse benefit determinations* that a person is not eligible for coverage under the *Plan*.

The *external review* procedures are described below.

Both the **Claims and the Appeal** procedures are intended to provide a full and fair review. This means, among other things, that *claims* and *appeals* will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A *claimant* must follow all **Claims and Appeals** procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the *Plan Administrator* has not complied with the procedures described in this section. If a lawsuit is brought, it must be filed within two (2) years after the final determination of an *appeal*.

Any of the authority and responsibilities of the *Plan Administrator* under the **Claims and Appeal** procedures or the *external review* process, including the discretionary authority to interpret the terms of the *Plan*, may be delegated to a third party. If you have any questions regarding these procedures, please contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

A. Timeframes for Claim and Appeal Processes

The chart below outlines the companies acting as the appropriate *Claim Administrator* and types of *claims* managed.

	Post-Service Claims	Pre-Service Claim Types		
		Urgent Care Claim	Concurrent Care Claim	Other Pre-Service Claim
Claimant must submit *claim* for benefit determination within:	twelve (12) months	twenty-four (24) hours		
Plan must make initial *benefit determination* as soon as possible but no later than:	thirty (30) days	seventy-two (72) hours	Before the benefit is reduced or treatment terminated	fifteen (15) days
Extension permitted during initial *benefit determination*:	fifteen (15) days	No	No	fifteen (15) days
First-level *appeal* review must be submitted to the *Plan* within:	one hundred eighty (180) days	one hundred eighty (180) days	one hundred eighty (180) days	one hundred eighty (180) days
Plan must make first *appeal benefit determination* as soon as possible but no later than:	thirty (30) days per benefit *appeal*	thirty-six (36) hours	Before the benefit is reduced or treatment terminated	fifteen (15) days for each level of *appeal*
Extension permitted during *appeal* review:	No	No	No	No
Second-level appeal must be submitted in writing within:	sixty (60) days	sixty (60) days	sixty (60) days	sixty (60) days
Plan must make second *appeal benefit determination* as soon as possible but no later than:	thirty (30) days	36 hours	thirty (30) days	thirty (30) days
Appeal for external review must be submitted after a final adverse benefit determination within:	four (4) months	four (4) months	four (4) months	four (4) months
Plan will complete preliminary review of *IRO* request within:	five (5) business days	five (5) business days	five (5) business days	five (5) business days
Plan will notify *claimant* of preliminary review within:	one (1) business day	one (1) business day	one (1) business day	one (1) business day
IRO determination and notice within:	forty-five (45) days	seventy-two (72) hours	seventy-two (72) hours	forty-five (45) days

B. Assignment of Benefits

An *assignment of benefits* is an arrangement by which a patient requests that their health benefit payments under this *Plan* be made directly to a designated medical *provider* or facility. By completing an *assignment of benefits,* the *plan participant* authorizes the *Plan Administrator* to forward payment for a covered procedure directly to the treating medical *provider* or facility. The *Plan Administrator* expects that an *assignment of benefits* form to be completed, as between the *plan participant* and the *provider*.

C. Types of Claims Managed by the Medical Management Administrator

There are three (3) types of *claims* managed by the *Medical Management Administrator*:

1. *urgent care claims*
2. *concurrent care claims*
3. other *pre-service claims*

The process and procedures for each *pre-service claim* type are listed below.

D. Urgent Care Claims

Any *pre-service claim* for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health, or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*. Whether a *claim* is an *urgent care claim* will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any *claim* that a *physician,* with knowledge of the *claimant's* medical condition, determines is an *urgent care claim* (as described herein) shall be treated as an *urgent care claim* under the *Plan*. *Urgent care claims* are a subset of *pre-service claims*.

How to File an Urgent Care Claim

In order to file an *urgent care claim,* you or your *authorized representative* must call the *Medical Management Administrator* and provide the following:

1. information sufficient to determine whether, or to what extent, benefits are covered under the *Plan*
2. a description of the medical circumstances that give rise to the need for expedited review

If you or your *authorized representative*s fail to provide the *Plan* with the above information, the *Plan* will provide *notice* as soon as reasonably possible after receipt of your *claim*, but not later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. You will be afforded a reasonable amount of time to provide the specified information under the circumstance, but not less than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection.

Notification of Benefit Determinations of Urgent Care Claims

Notice of a *benefit determination* (whether adverse or not) will be provided as soon as possible, taking into account the medical circumstances, but no later than the deadline shown in the Timeframes for Claim and Appeal Processes subsection. However, if the *Plan* gives you *notice* of an incomplete *claim*, the *notice* will include a time period of no less than forty-eight (48) hours for you to respond with the requested specified information. The *Plan* will then provide you with the *notice* of *benefit determination* within forty-eight (48) hours after the earlier of:

1. receipt of the specified information
2. the end of the period of time given you to provide the information

If the *benefit determination* is provided orally, it will be followed in writing no later than three (3) days after the oral *notice*.

If the *urgent care claim* involves a *concurrent care decision*, a *notice* of the *benefit determination* (whether adverse or not) will be provided as soon as possible after receipt of your *claim* for extension of treatment or care, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection, as long as the *claim* is made within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection before the prescribed period of time expires or the prescribed number of treatments ends.

Notification of Adverse Benefit Determinations of Urgent Care Claims

If an *urgent care claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Plan Administrator's notification* of an *adverse benefit determination* may be oral followed by written or electronic *notification* within three (3) days of the oral *notification.* The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based
4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination,* either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and

that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request

6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request
7. a description of the expedited review process applicable to the *claim*
8. a description of the *Plan's* review or *appeal* procedures, including applicable time limits
9. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

How to File an Appeal of Urgent Care Claim

You may *appeal* any *adverse benefit determination* to the *Plan Administrator*. The *Plan Administrator* is the sole fiduciary of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes subsection for when a *claimant* may file a written request for an *appeal* to the decision upon *notification* of an *adverse benefit determination*. However, for concurrent care *claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Plan Administrator* will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *Plan Administrator* will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

A document, record, or other information shall be considered relevant to a *claim* if it:

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *Plan Administrator* issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* 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 neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of an Appeal of a Denied Urgent Care Claim

You or your *authorized representative* must file any *appeal* of an *adverse benefit determination* after receiving notification of the *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection.

Requests for *appeal* which do not comply with the above requirements will not be considered.

You may *appeal* an *adverse benefit determination* of an urgent care claim on an expedited basis, either orally or in writing. You may *appeal* orally by calling the *Medical Management Administrator* at 1-855-778-9053. All necessary information, including the *Medical Management Administrator's benefit determination* on review, will be transmitted between the *Medical Management Administrator* and you by telephone, facsimile, or other available similarly expeditious method.

Time Period for Deciding Appeals of Urgent Care Claims

Appeals of *urgent care claims* will be decided by the *Plan Administrator* as soon as possible after the *Plan Administrator* or its designee receives the *appeal*, taking into account the *medical emergencies*, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. A decision communicated orally will be followed-up in writing.

Notification of Appeal Denials of Urgent Care Claims

The *Plan Administrator* shall provide *notification* of the decision on an *urgent care claim* orally, but a follow-up written *notification* after the oral *notice* will be provided no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. The *notice* will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   You and your *Plan* may have other voluntary alternative 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.
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational,* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request
7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary
8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures
9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures
10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

E. Concurrent Care Claims

Your *claim* for medical care or treatment is a *concurrent care claim* if your *claim* has been approved to provide an ongoing course of treatment over a period of time, which either involves a reduction or termination by the *Plan* of such course of treatment (other than by *Plan* amendment or termination), or a request by you or on your behalf to extend or expand your treatment.

If your request involves concurrent care (the continuation/reduction of an ongoing course of treatment), you may file the *claim* by writing (orally for an expedited review) to the *Medical Management Administrator*.

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 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* or 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 opportunity to respond prior to that date.
3. A *concurrent care claim* that is an *urgent care claim* will be processed according to the initial review and *appeals* procedures and timeframes noted under the Urgent Care Claim subsection (above).
4. If a *concurrent care claim* does not involve urgent care, the request may be treated as a new benefit *claim* and decided within the timeframe appropriate to the type of *claim*, i.e., as a *pre-service claim* or a *post-service claim*. Such *claims* will be processed according to the initial review and *appeals* procedures and timeframes applicable to the claim-type, as noted under the Other Pre-Service Claims subsection (below) or the Post-Service Claims subsection listed later in this section.
5. If the *concurrent care claim* is approved, you will be *notified* orally followed by written (or electronic, as applicable) *notice* provided after the oral *notice* no later than the timeframe shown in the Timeframes for Claim and Appeal Processes.

F. Other Pre-Service Claims

Claims that require *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan* are considered *other pre-service claims* (e.g. a request for *pre-certification* under the Health Care Management Program). Refer to the **Heath Care Management Program** section to review the list of services that require *pre-certification*.

How to File Other Pre-Service Claims

Typically, the *other pre-service claim* is made on a *claimant's* behalf by the treating *physician*. However, it is the *claimant's* responsibility to ensure that the *other pre-service claim* has been filed. The *claimant* can accomplish this by having his or her *health care provider* contact the *Medical Management Administrator* to file the *other pre-service claim* on behalf of the *claimant*.

Other pre-service claims must *include* the following information:

1. the name of this *Plan*
2. the identity of the *claimant* (name, address, and date of birth)
3. the proposed date(s) of service
4. the name and credentials of the *health care provider*
5. an order or request from the *health care provider* for the requested service
6. the proposed place of service
7. a specific diagnosis

8. a specific proposed service code for which approval or payment is requested [current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format]

9. clinical information for this *Plan* to make a *medical necessity* determination

Under certain circumstances provided by federal law, if you or your *authorized representative* fail to follow the *Plan's* procedures for filing *other pre-service claims*, the *Plan* will provide *notice* of the failure and the proper procedures to be followed. This *notification* will be provided as soon as reasonably possible, but no later than five (5) days after receipt of the *claim*. You will then have up to forty-five (45) days from receipt of the *notice* to follow the proper procedures.

Notification of Benefit Determination of Other Pre-Service Care Claims

After receipt of the *claim*, *notice* of a *benefit determination* (whether adverse or not) will be provided in writing within a reasonable period appropriate to the medical circumstances, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. However, this period may be extended one (1) time by the *Plan* for up to an additional fifteen (15) days if the *Plan* both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original timeframe shown in the Timeframes for Claim and Appeal Processes subsection, of the circumstances requiring the extension and the date by which the *Plan* expects to render a decision. Refer to the Incomplete Claims subsection below, if such an extension is necessary due to your failure to submit the information necessary to decide the *claim*.

Notification of Adverse Benefit Determination of Other Pre-Service Care Claims

If the *other pre-service claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Plan Administrator* shall provide written or electronic *notification* of the *adverse benefit determination*. This *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request

2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*

3. reference to the specific *Plan* provisions on which the determination was based

4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary

5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination,* either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request

6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request

7. a description of the *Plan's* review or *appeal* procedures, including applicable time limits

8. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

How to File an Appeal of Other Pre-Service Claims

You may *appeal* any *adverse benefit determination* to the *Plan Administrator*. The *Plan Administrator* is the sole fiduciary of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes subsection in which a *claimant* may file a written request for an *appeal* of the decision after receiving *notification* of an *adverse benefit determination*. However, for concurrent care *claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within thirty (30) days. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Plan Administrator* will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *Plan Administrator* will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

A document, record, or other information shall be considered relevant to a *claim* if it:

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *Plan Administrator* issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* 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 neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of an Appeal of Other-Pre-Service Claims

You or your *authorized representative* must file any *appeal* of an *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection after receiving notification of the *adverse benefit determination*.

Requests for *appeal* which do not comply with the above requirements will not be considered.

All requests for a review of a denied *pre-service claim* (other than *urgent care claim*) must be in writing and should include a copy of the *adverse benefit determination*, if applicable, and any other pertinent information that you wish the *Medical Management Administrator* to review in conjunction with your *appeal*. Send all information to:

AmeriBen Medical Management
P.O. Box 7186
Boise, ID 83707

Time Period for Deciding Appeals of Other Pre-Service Claims

Appeals of other *pre-service claims* will be decided by the *Plan Administrator* within a reasonable period of time appropriate to the medical circumstances, after the *Plan Administrator* or its designee receives the *appeal*, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. The *Plan Administrator's* decision will be provided to you in writing.

Notification of Appeal Denials of Other Pre-Service Claims

If your *appeal* is denied, in whole or in part, the *Plan Administrator* will provide written *notification* of the *adverse benefit determination* on *appeal*. The *notice* will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   You and your *Plan* may have other voluntary alternative 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.
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational,* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request
7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary
8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures
9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures
10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

G. Second Level Appeals Process for Urgent Care, Concurrent Care, and Other Pre-Service Claims

If your *appeal* of a *claim* is denied, you or your *authorized representative* may request further review by the *Plan Administrator*. This request for a second-level *appeal* must be made in writing within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. This second-level review is mandatory; i.e., you are required to undertake this second-level *appeal* before you may pursue civil action.

The *Plan Administrator* will promptly conduct a full and fair review of your *appeal*, independently from the individual(s) who considered your first-level *appeal* or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* 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 consulted neither in connection with the *adverse benefit determination* nor the initial *appeal* denial and who is not a subordinate of any such individuals.

Second-level *appeals* of *claims* will be decided by the *Plan Administrator* within a reasonable period of time after the *Plan Administrator* or its designee receives the *appeal*, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. The *Plan Administrator's* decision will be provided to you in writing, and if the decision is a second denial, the *notification* will include all of the information described in the subsection entitled Notification of Appeal Denials above.

H. External Review of Pre-Service Claims

Refer to the **External Review of Claims** section for the full description of the external review process under the *Plan*.

I. Incomplete Claims

Incomplete *pre-service claims* and/or *post-service claims* can be addressed through the extension of time described herein. If the reason for the extension is the failure to provide necessary information and the *claimant* is appropriately *notified*, this *Plan's* period of time to make a decision is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the *claimant* responds or should have responded.

The *notification* will include a timeframe of at least forty-five (45) days in which the necessary information must be provided. Once the necessary information has been provided, This *Plan* will decide the *claim* within the extension described herein.

However, if the time period for the *benefit determination* is extended due to your failure to submit information necessary to decide a *claim*, the time period for making the *benefit determination* will be suspended from the date the *notice* of extension is sent to you until the earlier of:

1. the date on which you respond to the request for additional information
2. the date established by the *Plan* for the furnishing of the requested information [at least forty-five (45) days]

If the requested information is not provided within the time specified, the *claim* may be denied. If your *claim* is denied based on your failure to submit information necessary to decide the *claim*, the *Plan* may, in its sole discretion, renew its consideration of the denied *claim* if the *Plan* receives the additional information within one hundred eighty (180) days after original receipt of the *claim*. In such circumstances, you will be *notified* of the *Plan's* reconsideration and subsequent *benefit determination*.

J. Post-Service Claims

The *Claims Administrator* manages the *claims* and first level *appeal* process of *post-service claims*. The *Plan Administrator* manages the second-level appeal process of *post-service claims*.

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 *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 *post-service claim*.

How to File a Post-Service Claim

In order to file a post-service claim, you or your *authorized representative* must submit the *claim*, in writing, on a form pre-approved by the *Plan*. Pre-approved *claim* forms are available from your *employer*.

All *claims* must be received by the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection from the date of the expense to be eligible for coverage under the *Plan*.

All *claims* for reimbursement must include the following information:

1. the *plan participant's* name, Social Security Number, and address
2. patient's name, Social Security Number, and address if different from the *plan participant's*
3. *provider's* name, tax identification number, address, degree, and signature
4. date(s) of service
5. diagnosis
6. procedure codes (describes the treatment or services rendered)
7. assignment of benefits, signed (if payment is to be made to the *provider*)
8. release of information statement, signed
9. Coordination of Benefits (COB) information if another plan is the primary payer
10. sufficient medical information to determine whether and to what extent the expense is a covered benefit under the *Plan*

Send complete information to:

AmeriBen
P.O. Box 7186
Boise, ID 83707

Notification of Benefit Determinations of Post-Service Claims

After receipt of the *claim*, the *Plan* will *notify* you or your *authorized representative* of its *benefit determination (*whether adverse or not), in writing, within a reasonable period of time, but not later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. However, this period may be extended one (1) time by the *Plan* for up to the timeframe shown in the Timeframes for Claim and Appeal Processes subsection if the *Plan* both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original period, of the circumstances requiring the extension and the date by which the *Plan* expects to render a decision.

The applicable time period for the benefit determination begins when your claim is filed in accordance with the reasonable procedures of the *Plan*, even if you haven't submitted all the information necessary to make a benefit determination. Refer to the Incomplete Claims subsection for information regarding incomplete *pre-service claims* and *post-service claims*.

The applicable time period for the *benefit determination* begins when your *claim* is filed in accordance with the reasonable procedures of the *Plan*, even if you haven't submitted all the information necessary to make a *benefit determination*. However, if the time period for the *benefit determination* is extended due to your failure to submit information necessary to decide a *claim*, the time period for making the *benefit determination* will be suspended from the date the *notice* of extension is sent to you until the earlier of: (a) the date on which you respond to the request for additional information, or (b) the date established by the *Plan* for the furnishing of the requested information [at least forty-five (45) days].

If your *claim* is denied based on your failure to submit information necessary to decide the *claim*, the *Plan* may, in its sole discretion, renew its consideration of the denied *claim* if the *Plan* receives the additional information within one hundred eighty (180) days after original receipt of the *claim*. In such circumstances, you will be *notified* of the *Plan's* reconsideration and subsequent *benefit determination*.

Notification of Adverse Benefit Determination of a Post-Service Claim

If a *claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Plan Administrator* shall provide written or electronic notification of the *adverse benefit determination*. The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of *provider*, *claim* amount (if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial codes and its corresponding meaning, and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based
4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination* either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request
7. a description of the *Plan's* review or *appeal* procedures, including applicable time limits with respect to any *claim* denied after an *appeal*
8. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

How to File an Appeal of a Post-Service Claim

You may *appeal* any *adverse benefit determination* to the *Plan Administrator*. The *Plan Administrator* is the sole fiduciary of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes subsection in which a *claimant* may file a written request for an *appeal* of the decision. However, for concurrent care claims, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Plan Administrator* will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *Plan Administrator* will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

A document, record, or other information shall be considered relevant to a *claim* if it:

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determination*s are made in accordance with *Plan* documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time an *appeal* is filed in writing in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *Plan Administrator* issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* 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 neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of an Appeal of a Denied Post-Service Claim

You or your *authorized representative* must file any *appeal* of an *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection after receiving *notification* of the *adverse benefit determination*.

Requests for *appeal* which do not comply with the above requirements will not be considered.

All requests for a review of a denied *post-service claim* must be in writing and should include a copy of the *adverse benefit determination* and any other pertinent information that you wish the *Plan Administrator* to review in conjunction with your *appeal*. Send all information to:

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707

Time Period for Deciding Appeals of Post-Service Claims

Appeals of *post-service claims* will be decided by the *Plan Administrator* within a reasonable period of time after the *Plan Administrator* or its designee receives the *appeal*, but not later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. The *Plan Administrator's* decision will be provided to you in writing.

Notification of Appeal Denials of Post-Service Claims

If your *appeal* is denied, in whole or in part, the *Plan Administrator* or its designee will provide written *notification* of the *adverse benefit determination* on *appeal*. The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of *provider*, *claim* amount (if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial codes and its corresponding meaning, and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   You and your *Plan* may have other voluntary alternative 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.
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request
7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary
8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures
9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures
10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

K. Second Level Appeal Process of Post-Service Claims

The *Plan Administrator* or his/her designee manages the second-level *appeal* process for *post-service claim decisions*.

The *Plan Administrator* or his/her designee will be identified in the *notification* of denial of your first-level *appeal* and will not be the individual who made the original decision regarding the denial of your first-level *appeal* or a subordinate of such individual.

If your *appeal* of a *claim* is denied, you or your *authorized representative* may request further review by the *Plan Administrator*. This request for a second-level appeal must be made, in writing, within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection.

The *Plan Administrator* will promptly conduct a full and fair review of your *appeal*, independently from the individual(s) who considered your first level *appeal* or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information, as described in more detail under the section entitled Post-Service Claims above.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* 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 consulted neither in connection with the *adverse benefit determination* nor the initial *appeal* denial and who is not a subordinate of any such individuals.

Second-level appeals of *post-service claims* will be decided by the *Plan Administrator* at the next regularly scheduled Trust meeting following receipt of the *appeal*. The *Plan Administrator's* decision will be provided to you in writing, and if the decision is a second denial, the *notification* will include all of the information described in the provision entitled Notification of Appeal Denials above.

L. External Review Rights

If your final *appeal* for a *claim* is denied, you will be *notified* in writing that your *claim* is eligible for an *external review* and you will be informed of the time frames and the steps necessary to request an *external review*. You must complete all levels of the internal **Claims and Appeals** procedures before you can request a voluntary *external review*.

If you decide to seek *external review*, an *Independent Review Organization* (*IRO*) will be assigned your *claim*, and the *IRO* will work with a neutral, independent clinical reviewer with appropriate medical expertise. The *IRO* does not have to give deference to any earlier *claims* and *appeals* decisions, but it must observe the written terms of the *Plan* document. In other words, the *IRO* is not bound by any previous decision made on your *claim*. The ultimate decision of the IRO will be binding on you, the *Third Party Administrator*, and the *Plan*.

M. External Review of Claims

If your *appeal* is denied, and the *claim* is one for which an *external review* is available, you or your *authorized representative* may request further review by an *Independent Review Organization* (*IRO*). This request for *external review* must be made, in writing, within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection beginning the date you are *notified* of an *adverse benefit determination* or *final internal adverse benefit determination*. *External review* is only available if the *final adverse benefit determination* involves a *claim*: (1) denied based upon a rescission of coverage or (2) which involves medical judgment (*medical necessity*, appropriateness of treatment, health care setting, level of care, or effectiveness of covered benefit) or a determination that treatment is *experimental* or *investigational*, which is to be decided by the external reviewer. There is no external *appeal* for *final adverse benefit determinations* that a person is not eligible for coverage under the *Plan*.

The *Plan* will complete a preliminary review of the request within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection following the date of the receipt of the *external review* request to determine whether:

1. the *claimant* is or was covered under the *Plan* at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the *Plan* at the time the health care item or service was provided
2. the *adverse benefit determination* or the *final adverse benefit determination* does not relate to the *claimant's* failure to meet the requirements for eligibility under the terms of the group health *Plan* (e.g., worker classification or similar determination)
3. the *claimant* has exhausted the *Plan's* internal *appeal* process
4. the *claimant* has provided all the information and forms required to process an *external review*

The *Plan* will notify the *claimant* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection of completion of its preliminary review if:

1. the request is complete but not eligible for *external review*, in which case the *notice* will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration [toll-free number 866-444-EBSA (3272)];
2. the request is not complete, in which case the *notice* will describe the information or materials needed to make the request complete, and allow the *claimant* to perfect the request for *external review* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection, or within the forty-eight (48) hour period following receipt of the *notification*, whichever is later

Note: If the *adverse benefit determination* or *final internal adverse benefit determination* relates to a *plan participant's* or beneficiary's failure to meet the requirements for eligibility under the terms of the *Plan*, it is not within the scope of the *external review* process, and no *external review* may be taken.

If the request is complete and eligible, the *Plan Administrator* will assign the request to an *IRO*. Once that assignment is made, the following procedure will apply:

1. The assigned *IRO* will utilize legal experts where appropriate to make coverage determinations under the *Plan*.
2. The assigned *IRO* will timely *notify* the *claimant*, in writing, of the request's eligibility and acceptance for *external review*. This *notice* will include a statement that the *claimant* may submit in writing to the assigned *IRO* within ten (10) business days following the date of receipt of the *notice* additional information that the *IRO* must consider when conducting the *external review*. The *IRO* is not required to, but may, accept and consider additional information submitted after ten (10) business days.
3. Within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection after the date of assignment of the IRO, the *Plan* must provide to the assigned *IRO* the documents and any information considered in making the *adverse benefit determination* or *final internal adverse benefit determination*. Failure by the *Plan* to timely provide the documents and information must not delay the conduct of the *external review*. If the *Plan* fails to timely provide the documents and information, the assigned *IRO* may terminate the *external review* and make a decision to the *adverse benefit determination* or *final internal adverse benefit determination*. The *IRO* must *notify* the *claimant* and the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection after making the decision.
4. Upon receipt of any information submitted by the *claimant*, the assigned *IRO* must forward the information to the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. Upon receipt of any such information, the *Plan* may reconsider its *adverse benefit determination* or *final internal adverse benefit determination* that is the subject of the *external review*. Reconsideration by the *Plan* must not delay the *external review*. The *external review* terminated as a result of the reconsideration only if the *Plan* decides, upon completion of its reconsideration, to reverse its *adverse benefit determination* or *final internal adverse benefit determination* and provide coverage or payment. The *Plan* must provide written *notice* of its decision to the *claimant* and the assigned *IRO* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. The assigned *IRO* must terminate the *external review* upon receipt of the *notice* from the *Plan*.
5. The *IRO* will review all of the information and documents timely received. In reaching a decision, the assigned *IRO* will review the *claim* de novo and not be bound by any decisions or conclusions reached during the *Plan's* internal *claims* and *appeals* processes. In addition to the documents and information provided, the assigned *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, will consider the following in reaching a decision:
    a. the *claimant's* medical records
    b. the attending health care professional's recommendation
    c. reports from appropriate health care professionals and other documents submitted by the *Plan*, *claimant*, or the *claimant's* treating *provider*
    d. the terms of the *claimant's Plan* to ensure that the *IRO's* decision is not contrary to the terms of the *Plan*, unless the terms are inconsistent with applicable law
    e. appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations
    f. any applicable clinical review criteria developed and used by the *Plan*, unless the criteria are inconsistent with the terms of the *Plan* or with applicable law
    g. the opinion of the *IRO's* clinical reviewer or reviewers after considering the information described in this *notice* to the extent the information or documents are available
6. The assigned *IRO* must provide written notice of the final *external review* decision after the *IRO* receives the request for the *external review* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. The *IRO* must deliver the *notice* of final *external review* decision to the *claimant* and the *Plan*.
7. The assigned *IRO's* decision notice will contain the following:
    a. 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, the health care *provider*, the *claim* amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial).

b. The date the *IRO* received the assignment to conduct the *external review* and the date of the *IRO* decision.

c. The references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.

d. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

e. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health *Plan* or to the *claimant*.

f. A statement that judicial review may be available to the *claimant*.

g. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Generally, a *claimant* must exhaust the *Plan's* **Claims and Appeals** procedures in order to be eligible for the *external review* process. However, in some cases the *Plan* provides for an expedited *external review* if:

1. The *claimant* receives an *adverse benefit determination* that involves a medical condition for which the time for completion of the *Plan's* internal **Claims and Appeals** procedures would seriously jeopardize the *claimant's* life or health or ability to regain maximum function and the *claimant* has filed a request for an expedited internal review; or
2. The *claimant* receives a *final internal adverse benefit determination* that involves a medical condition where the time for completion of a standard *external review* process would seriously jeopardize the *claimant's* life or health or the *claimant's* ability to regain maximum function, or if the *final internal adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item, or service for which the *claimant* received *emergency services*, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited *external review*, the *Plan* must determine and *notify* the *claimant* whether the request satisfies the requirements for expedited review, including the eligibility requirements for *external review* listed above. If the request qualifies for expedited review, it will be assigned to an *IRO*. The *IRO* must make its determination and provide a *notice* of the decision as expeditiously as the *claimant's* medical condition or circumstances require after the *IRO* receives the request for an expedited *external review,* but in no event more than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. If the original *notice* of its decision is not in writing, the *IRO* must provide written confirmation of the decision to both the *claimant* and the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection.

N. Designation of Authorized Representative

A *plan participant* is permitted to appoint an *authorized representative* to act on his or her behalf with respect to a benefit *claim* or *appeal* of a denial. In connection with a *claim* involving urgent care, the *Plan* will permit a health care professional with knowledge of the *plan participant's* medical condition to act as the *plan participant's authorized representative*. In the event a *plan participant* designates an *authorized representative*, all future communications from the *Plan* will be with the representative, rather than the *plan participant*, unless the *plan participant* directs the *Plan Administrator*, in writing, to the contrary. If you wish to change/alter your authorized representative, or the time frame, you will need to submit these changes in writing.

O. Physical Examinations

The *Plan* reserves the right to have a *physician* of its own choosing examine any *plan participant* whose condition, *illness,* or *injury* is the basis of a *claim*. All such examinations shall be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan* may reasonably require during the pendency of a *claim*. The *plan participant* must comply with this requirement as a necessary condition to coverage.

P. Managed Care Recommendations

The *Plan*, together with the *Medical Management Administrator* and the *Third Party Administrator*, have the option to override certain *Plan* limitations, exclusions, or *pre-certification* requirements when it is in the best interest of the *Plan* to allow a more cost-effective type of alternative care. Subject to all other terms and conditions of this *Plan* as set forth in this *Plan* document, if a *plan participant* suffers from a covered *injury* or *illness* which requires treatment for which there is no *network provider*, as confirmed by the medical review administrator and approved by the

reinsurance carrier, the *Plan* may elect to pay for treatment by an *non-network provider* at the *network provider* level.

Q. Autopsy

The *Plan* reserves the right to have an autopsy performed upon any deceased *plan participant* whose condition, *illness*, or *injury* is the basis of a *claim*. This right may be exercised only where not prohibited by law.

R. Payment of Benefits

All benefits under this *Plan* are payable, in U.S. Dollars, to the *plan participant* whose *illness* or *injury*, or whose covered *dependent's illness* or *injury*, is the basis of a *claim*. In the event of the death or incapacity of a *plan participant* and in the absence of written evidence to this *Plan* of the qualification of a guardian for his or her estate, this *Plan* may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this *Plan*, is or was providing the care and support of such *employee*.

S. Assignments

Benefits for medical expenses covered under this *Plan* may be assigned by a *plan participant* to the *provider* as consideration in full for services rendered; however, if those benefits are paid directly to the *employee*, the *Plan* shall be deemed to have fulfilled its obligations with respect to such benefits. The *Plan* will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the *plan participant* and the assignee, has been received before the proof of loss is submitted.

No *plan participant* shall at any time, either during the time in which he or she is a *plan participant* in the *Plan*, or following his or her termination as a *plan participant,* in any manner, have any right to assign his or her right to sue to recover benefits under the *Plan*, to enforce rights due under the *Plan* or to any other causes of action which he or she may have against the *Plan* or its fiduciaries.

A *provider* which accepts an *assignment of benefits*, in accordance with this *Plan* as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

T. Non-U.S. Providers

Medical expenses for care, supplies, or services which are rendered by a *provider* whose principal place of business or address for payment is located outside the United States (a non U.S. *provider*) are payable under the *Plan*, subject to all *Plan* exclusions, limitations, maximums, and other provisions, under all of the following conditions:

1. benefits may not be assigned to a non U.S. *provider*
2. the *plan participant* is responsible for making all payments to non U.S. *providers*, and submitting receipts to the *Plan* for reimbursement;
3. benefit payments will be determined by the *Plan* based upon the exchange rate in effect on the *incurred* date
4. the non U.S. *provider* shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements
5. *claims* for benefits must be submitted to the *Plan* in English

U. Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the *Plan's* terms, conditions, limitations or exclusions, or should otherwise not have been paid by the *Plan*. As such this *Plan* may pay benefits that are later found to be greater than the *maximum allowable charge*. In this case, this *Plan* may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the *plan participant* or *dependent* on whose behalf such payment was made.

A *plan participant*, *dependent*, *provider*, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the *Plan* or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the *Plan* within thirty (30) days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *Plan Administrator* shall have the sole discretion to choose who will repay the *Plan* for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a *plan participant* or other entity does not comply with the provisions of this section, the *Plan Administrator* shall have the authority, in its sole discretion, to deny payment of any *claims* for benefits by the *plan participant* and to deny or reduce future benefits payable (including payment of future benefits for other *injuries* or *illnesses*) under the *Plan* by the amount due as reimbursement to the *Plan*. The *Plan Administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) under any other group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the *Plan* or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this *Plan* and agree to submit *claims* for reimbursement in strict accordance with their State's health care practice acts, ICD-9/ICD-10 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator* or insurer. Any payments made on *claims* for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the *Plan* must bring an action against a *plan participant*, *provider,* or other person or entity to enforce the provisions of this section, then that *plan participant*, *provider,* or other person or entity agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

Further, *plan participant* and/or their *dependents*, beneficiaries, estate, heirs, guardian, personal representative, or assigns (*plan participant*) shall assign or be deemed to have assigned to the *Plan* their right to recover said payments made by the *Plan*, from any other party and/or recovery for which the *plan participant(s)* are entitled, for or in relation to facility-acquired condition(s), *provider* error(s), or damages arising from another party's act or omission for which the *Plan* has not already been refunded.

The *Plan* reserves the right to deduct from any benefits properly payable under this *Plan* the amount of any payment which has been made:

1. in error
2. pursuant to a misstatement contained in a proof of loss or a fraudulent act
3. pursuant to a misstatement made to obtain coverage under this *Plan* within two (2) years after the date such coverage commences
4. with respect to an ineligible person
5. in anticipation of obtaining a recovery if a *plan participant* fails to comply with the *Plan's* **Reimbursement, Subrogation, and Recovery Provisions**
6. Pursuant to a *claim* for which benefits are recoverable under any policy or act of law providing for coverage for occupational *injury* or *disease* to the extent that such benefits are recovered

   This provision (6) shall not be deemed to require the *Plan* to pay benefits under this *Plan* in any such instance.

The deduction may be made against any *claim* for benefits under this *Plan* by a *plan participant* or by any of his or her covered *dependents* if such payment is made with respect to the *plan participant* or any person covered or asserting coverage as a *dependent* of the *plan participant*.

If the *Plan* seeks to recoup funds from a *provider*, due to a *claim* being made in error, a *claim* being fraudulent on the part of the *provider*, and/or the *claim* that is the result of the *provider's* misstatement, said *provider* shall, as part of its *assignment of benefits* from the *Plan*, abstain from billing the *plan participant* for any outstanding amount(s).

SECTION XI—COORDINATION OF BENEFITS

A. Coordination of the Benefit Plans

Coordination of benefits sets out rules for the order of payment of *covered charges* when two (2) or more plans, including *Medicare*, are paying. When a *plan participant* is covered by this *Plan* and another plan, or the *plan participant's* spouse is covered by this *Plan* and by another plan or the couple's covered *dependents* are covered under two (2) or more plans, the plans will coordinate benefits when a *claim* is received.

Non-Duplication/Maintenance of Benefits

The plan that pays first according to the rules will pay as if there were no *other plan* involved. The secondary will pay up to its own plan formula minus whatever the primary plan paid.

Example: Assume all *deductibles* are met, billed services are considered *covered charges* under both plans, the primary plan pays 80% of the *allowable amount*, and the secondary plan pays 90% of the *allowable amount*. A *plan participant* incurs a *claim* with a *network* provider in which the *allowable amount* is $1,000.

Primary Plan	$800
Secondary Plan	$100
Patient Responsibility	$100
Total Amount Paid	$1,000

If the *plan participant* is *Medicare* primary, *claims* are coordinated with the *Plan* according to the *Medicare* allowed amounts. The coordination of these *claims* is standard coordination of benefits. The plan that pays first according to the rules will pay as if there were no *other plan* involved. The secondary and subsequent plans will pay the balance due up to 100% of the total *allowable charges*.

B. Excess Insurance

If at the time of *injury*, *illness*, *disease*, or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this *Plan* shall apply only as an excess over such other sources of coverage.

The *Plan's* benefits will be excess to, whenever possible:

1. any primary payer besides the *Plan*
2. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage
3. any policy of insurance from any insurance company or guarantor of a third party
4. Workers' Compensation or other liability insurance company
5. any other source, including but not limited to crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payment

C. Allowable Charge

For a charge to be allowable it must be a *maximum allowable charge* and at least part of it must be covered under this *Plan*.

In the case of HMO (Health Maintenance Organization) or other *network*-only plans: This *Plan* will not consider any charges in excess of what an HMO or *network provider* has agreed to accept as payment in full. Also, when an HMO or *network* plan is primary and the *plan participant* does not use an HMO or *network provider*, this *Plan* will not consider as an *allowable charge* any charge that would have been covered by the HMO or *network* plan had the *plan participant* used the services of an HMO or *network provider*.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the *allowable charge*.

D. General Limitations

When medical payments are available under any other insurance source, the *Plan* shall always be considered the secondary carrier.

E. Application to Benefit Determinations

The plan that pays first according to the rules in the subsection entitled Benefit Plan Payment Order will pay as if there were no *other plan* involved. The secondary and subsequent plans will pay will pay up to its own plan formula minus whatever the primary plan paid. When there is a conflict in the rules, this *Plan* will never pay more than 50% of allowable expenses when paying secondary. Benefits will be coordinated as referenced in the Claim Determination Period subsection.

When medical payments are available under automobile insurance, this *Plan* will pay excess benefits only, without reimbursement for automobile plan *deductibles*. This *Plan* will always be considered the secondary carrier regardless of the individual's election under Personal Injury Protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the *other plan* will be ignored for the purposes of determining the benefits under this *Plan*. This is the case when either:

1. the *other plan* would, according to its rules, determine its benefits after the benefits of this *Plan* have been determined
2. the rules in the subsection entitled Benefit Plan Payment Order would require this *Plan* to determine its benefits before the *other plan*

F. Benefit Plan Payment Order

When two (2) or more plans provide benefits for the same *allowable charge*, benefit payment will adhere to these rules in the following order:

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits up to the *allowable charge*:
    a. The benefits of the plan which covers the person directly (that is, as an employee, member, or subscriber) are determined before those of the plan which covers the person as a dependent.
    b. The benefits of a plan which covers a person as an employee who is neither laid off or retired are determined before those of a plan which covers that person as a laid-off nor retired employee. The benefits of a plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers a person as a dependent of a laid off or retired employee. 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 does not apply.
    c. The benefits of a plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
    d. When a child is covered as a *dependent* and the parents are not separated or divorced, these rules will apply:
        i. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
        ii. If both parents have the same birthday, the benefits of the plan which has covered the patient for the longer time are determined before those of the plan which covers the other parent.
    e. When a child's parents are divorced or legally separated, these rules will apply:
        i. This rule applies when the parent with custody of the child has not remarried. The plan of the parent with custody will be considered before the plan of the parent without custody.
        ii. This rule applies when the parent with custody of the child has remarried. The plan of the parent with custody will be considered first. The plan of the step-parent that covers the child as a dependent will be considered next. The plan of the parent without custody will be considered last.

iii. This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before *other plans* that cover the child as a dependent.

iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

v. For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

f. If there is still a conflict after these rules have been applied, the plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the *Plan* will never pay more than 50% of *allowable charges* when paying secondary.

g. When a married *dependent* child is covered as a *dependent* on both a spouse's plan and a parent's plan, and the policies are both effective on the same day, the benefits of the policy holder whose birthday falls earlier in a year are determined before those of the policy holder whose birthday falls later in that year.

3. *Medicare* will pay primary, secondary, or last to the extent stated in federal law. Refer to the Medicare publication Your Guide to Who Pays First at **http://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance/which-insurance-pays-first.** When *Medicare* would be the primary payer if the person had enrolled in *Medicare*, this *Plan* will base its payment upon benefits that would have been paid by *Medicare* under Parts A and B, regardless of whether or not the person was enrolled under any of these parts. The *Plan* reserves the right to coordinate benefits with respect to *Medicare* Part D. The *Plan Administrator* will make this determination based on the information available through Centers for Medicare & Medicaid Services (CMS). If CMS does not provide sufficient information to determine the amount *Medicare* would pay, the *Plan Administrator* will make reasonable assumptions based on published *Medicare* fee schedules.

4. If a *plan participant* is under a disability extension from a *prior plan*, that plan will pay first and this *Plan* will pay second.

5. When an adult *dependent* is covered by his or her spouse's plan and is also covered by his or her parent's plan, the benefits of the benefit plan which has covered the patient for the longest time are determined before those of the *other plan*.

6. When an adult *dependent* is covered by multiple parents' plans, the benefits of the benefit plan of the parent whose birthday falls earlier in the year are determined before those of the benefit plan of the parent whose birthday falls later in that year. Should both/all parents have the same birthday, the benefits of the benefit plan which has covered the patient the longest shall be determined first.

7. The *Plan* will pay primary to Tricare and a State Child Health Insurance Plan to the extent required by federal law.

G. Coordination with Government Programs

1. **Medicaid/IHS.** If a *plan participant* is covered by both this *Plan* and Medicaid or Indian Health Services (IHS), this *Plan* pays first and Medicaid or IHS pays second.

2. **Veterans Affairs or Military Medical Facility Services.** If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of a military service-related *illness* or *injury*, benefits are not covered by this *Plan*. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of any other condition that is not a military service-related *illness* or *injury*, benefits are covered by the *Plan* to the extent those services are *medically necessary* and the charges are within this *Plan's maximum allowable charge*.

3. **Other Coverage Provided by State or Federal Law.** If you are covered by both this *Plan* and any other coverage (not already mentioned above) that is 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, unless applicable law dictates otherwise.

H. Claims Determination Period

Benefits will be coordinated on a *benefit year* basis. This is called the claims determination period.

I. Right to Receive or Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any *other plan*, this *Plan* may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the *Plan* deems to be necessary for such purposes. Any person claiming benefits under this *Plan* shall furnish to the *Plan* such information as may be necessary to implement this provision.

J. Facility of Payment

Whenever payments which should have been made under this *Plan* in accordance with this provision have been made under any *other plans*, the *Plan Administrator* may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this *Plan* and, to the extent of such payments, this *Plan* shall be fully discharged from liability. This *Plan* may repay *other plans* for benefits paid that the *Plan Administrator* determines it should have paid. That repayment will count as a valid payment under this *Plan*.

K. Right of Recovery

In accordance with the **Claims and Appeals** section, whenever payments have been made by this *Plan* with respect to *allowable charges* in a total amount, at any time, in excess of the *maximum amount* of payment necessary at that time to satisfy the intent of this article, the *Plan* shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this *Plan* shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies or any other individuals or organizations which the *Plan* determines are responsible for payment of such *allowable charges*, and any future benefits payable to the *plan participant* or his or her *dependents*. Please see the Recovery of Payments provision for more details.

SECTION XII—MEDICARE

A. Application to Active Employees and Their Spouses

An *active employee* and his or her spouse (when eligible for *Medicare*) may, at the option of such *employee*, elect or reject coverage under this *Plan*. If such *employee* elects coverage under this *Plan*, the benefits of this *Plan* shall be determined before any benefits provided by *Medicare*. If coverage under this *Plan* is rejected by such *employee*, benefits listed herein will not be payable even as secondary coverage to *Medicare*.

B. Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this *Plan* will pay before any *Medicare* benefits. There are some circumstances under which *Medicare* would be required to pay its benefits first. In these cases, benefits under this *Plan* would be calculated as secondary payer (as described under the section entitled **Coordination of Benefits**). The *plan participant* will be assumed to have full *Medicare* coverage (that is, both Part A & B) whether or not the *plan participant* has enrolled for the full coverage. If the *provider* accepts assignment with *Medicare*, *covered charges* will not exceed the *Medicare* approved expenses.

C. Applicable to Medicare Services Furnished to Covered Plan Participants on Dialysis

If any *plan participant* is eligible for *Medicare* benefits because of dialysis treatment, the benefits of the *Plan* will be determined before *Medicare* benefits for the first eighteen (18) months of *Medicare* entitlement (with respect to charges *incurred* on or after February 1, 1991 and before August 5, 1997), and for the first thirty (30) months of *Medicare* entitlement (with respect to charges *incurred* on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the *Plan* will be determined in accordance with such law.

SECTION XIII—REIMBURSEMENT, SUBROGATION, AND RECOVERY PROVISIONS

A. Payment Condition

The *Plan*, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an *injury*, *illness*, or disability is caused in whole or in part by, or results from the acts or omissions of *plan participants*, and/or their *dependents*, beneficiaries, estate, heirs, guardian, personal representative, or assigns [collectively referred to hereinafter; in this section' as *plan participant(s)*] or a third party, where any party besides the *Plan* may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine *injury* compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third-party assets, third-party insurance, guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively coverage).

Plan participant(s), his or her attorney, and/or *legal guardian* of a minor or incapacitated individual agrees that acceptance of the *Plan's* conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the *Plan's* conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the *Plan* or the *Plan's* assignee. The *Plan* shall have an equitable lien on any funds received by the *plan participant(s)* and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The *plan participant(s)* agrees to include the *Plan's* name as a co-payee on any and all settlement drafts. Further, by accepting benefits the *plan participant(s)* understands that any recovery obtained pursuant to this section is an asset of the *Plan* to the extent of the amount of benefits paid by the *Plan* and that the *plan participant* shall be a trustee over those *Plan* assets.

In the event a *plan participant(s)* settles, recovers, or is reimbursed by any coverage, the *plan participant(s)* agrees to reimburse the *Plan* for all benefits paid or that will be paid by the *Plan* on behalf of the *plan participant(s)*. When such a recovery does not include payment for future treatment, the *Plan's* right to reimbursement extends to all benefits paid, or that will be paid by the *Plan* on behalf of the *plan participant(s)* for charges *incurred* up to the date such coverage ends or third party is fully released from liability, including any such charges not yet submitted to the *Plan*. If the *plan participant(s)* fails to reimburse the *Plan* out of any judgment or settlement received, the *plan participant(s)* will be responsible for any and all expenses (fees and costs) associated with the *Plan's* attempt to recover such money. Nothing herein shall be construed as prohibiting the *Plan* from claiming reimbursement for charges *incurred* after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one (1) party responsible for charges paid by the *Plan*, or may be responsible for charges paid by the *Plan*, the *Plan* will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the *plan participant(s)* is/are only one (1) or a few, that unallocated settlement fund is considered designated as an identifiable fund from which the *Plan* may seek reimbursement.

B. Subrogation

As a condition to participating in and receiving benefits under this *Plan*, the *plan participant(s)* agrees to assign to the *Plan* the right to subrogate and pursue any and all *claims*, causes of action or rights that may arise against any person, corporation and/or entity and to any coverage to which the *plan participant(s)* is entitled, regardless of how classified or characterized, at the *Plan's* discretion, if the *plan participant(s)* fails to so pursue said rights and/or action.

If a *plan participant(s)* receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the *Plan* to any *claim*, which any *plan participant(s)* may have against any coverage and/or party causing the *illness* or *injury* to the extent of such conditional payment by the *Plan* plus reasonable costs of collection. The *plan participant* is obligated to notify the *Plan* or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The *plan participant* is also obligated to hold any and all funds so received in trust on the *Plan's* behalf and function as a trustee as it applies to those funds until the *Plan's* rights described herein are honored and the *Plan* is reimbursed.

The *Plan* may, at its discretion, in its own name or in the name of the *plan participant(s)* commence a proceeding or pursue a *claim* against any party or coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the *Plan*.

If the *plan participant(s)* fails to file a *claim* or pursue damages against:

1. the responsible party, its insurer, or any other source on behalf of that party
2. any primary payer besides the *Plan*

3. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state
4. any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an *employer's* policy
5. Workers' Compensation or other liability insurance company
6. any other source of coverage, including, but not limited to the following:
    a. crime victim restitution funds
    b. civil restitution funds
    c. no-fault restitution funds such as vaccine *injury* compensation funds
    d. any medical, applicable disability or other benefit payments
    e. school insurance coverage

The *plan participant(s)* authorizes the *Plan* to pursue, sue, compromise, and/or settle any such *claims* in the *plan participant(s)'* and/or the *Plan's* name and agrees to fully cooperate with the *Plan* in the prosecution of any such *claims*. The *plan participant(s)* assigns all rights to the *Plan* or its assignee to pursue a *claim* and the recovery of all expenses from any and all sources listed above.

C. Right of Reimbursement

The *Plan* shall be entitled to recover 100% of the benefits paid or payable benefits *incurred*, that have been paid and/or will be paid by the *Plan*, or were otherwise *incurred* by the *plan participant(s)* prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, without regard to whether the *plan participant(s)* is fully compensated by his or her recovery from all sources. The *Plan* shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the *Plan's* equitable lien and right to reimbursement. The obligation to reimburse the *Plan* in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the *plan participant(s)'* recovery is less than the benefits paid, then the *Plan* is entitled to be paid all of the recovery achieved. Any funds received by the *plan participant* are deemed held in constructive trust and should not be dissipated or disbursed until such time as the *plan participant*'s obligation to reimburse the *Plan* has been satisfied in accordance with these provisions. The *plan participant* is also obligated to hold any and all funds so received in trust on the *Plan's* behalf and function as a trustee as it applies to those funds until the *Plan's* rights described herein are honored and the *Plan* is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the *Plan's* recovery without the prior, expressed written consent of the *Plan*. Additionally, the *plan participant* shall indemnify the *Plan* against any of the *plan participant's* attorney's fees, costs, or other expenses related to the *plan participant's* recovery for which the *Plan* becomes responsible by any means other than the *Plan's* explicit written consent.

The *Plan's* right of subrogation and reimbursement will not be reduced or affected as a result of any fault or *claim* on the part of the *plan participant(s)* whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating *Plan's* recovery will not be applicable to the *Plan* and will not reduce the *Plan's* reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the *Plan* and signed by the *plan participant(s)*.

This provision shall not limit any other remedies of the *Plan* provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable *illness*, *injury*, or disability.

D. Participant is a Trustee Over Plan Assets

Any *plan participant* who receives benefits and is therefore subject to the terms of this section is hereby deemed a

recipient and holder of Plan assets and is therefore deemed a trustee of the *Plan* solely as it relates to possession of any funds which may be owed to the *Plan* as a result of any settlement, judgment or recovery through any other means arising from any *injury* or *accident*. By virtue of this status, the *plan participant* understands that he or she is required to:

1. notify the *Plan* or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds
2. instruct his or her attorney to ensure that the *Plan* and/or its authorized representative is included as a payee on all settlement drafts
3. in circumstances where the *plan participant* is not represented by an attorney, instruct the insurance company or any third party from whom the *plan participant* obtains a settlement, judgment or other source of coverage to include the *Plan* or its authorized representative as a payee on the settlement draft
4. hold any and all funds so received in trust, on the *Plan's* behalf, and function as a trustee as it applies to those funds, until the *Plan's* rights described herein are honored and the *Plan* is reimbursed

To the extent the *plan participant* disputes this obligation to the *Plan* under this section, the *plan participant* or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the *Plan's* interests, and without reduction in consideration of attorney's fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No *plan participant*, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the *Plan's* interest on the *Plan's* behalf.

E. Release of Liability

The *Plan's* right to reimbursement extends to any incident related care that is received by the *plan participant(s)* (*incurred*) prior to the liable party being released from liability. The *plan participant(s)*' obligation to reimburse the *Plan* is therefore tethered to the date upon which the claims were *incurred*, not the date upon which the payment is made by the *Plan*. In the case of a settlement, the *plan participant(s)* has an obligation to review the "lien" provided by the *Plan* and reflecting *claims* paid by the *Plan* for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the *Plan* of any incident related care *incurred* prior to the proposed date of settlement and/or release, which is not listed but has been or will be *incurred*, and for which the *Plan* will be asked to pay.

F. Excess Insurance

If at the time of *injury*, *illness*, or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this *Plan* shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the *Plan's* **Coordination of Benefits** section.

The *Plan's* benefits shall be excess to any of the following:

1. the responsible party, its insurer, or any other source on behalf of that party
2. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state
3. any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an *employer's* policy
4. Workers' Compensation or other liability insurance company
5. any other source of coverage, including, but not limited to, the following:
    a. crime victim restitution funds
    b. civil restitution funds
    c. no-fault restitution funds such as vaccine *injury* compensation funds
    d. any medical, applicable disability or other benefit payments

e. school insurance coverage

G. Separation of Funds

Benefits paid by the *Plan*, funds recovered by the *plan participant(s)* and funds held in trust over which the *Plan* has an equitable lien exist separately from the property and estate of the *plan participant(s)* such that the death of the *plan participant(s)* or filing of bankruptcy by the *plan participant(s)* will not affect the *Plan's* equitable lien, the funds over which the *Plan* has a lien, or the *Plan's* right to subrogation and reimbursement.

H. Wrongful Death

In the event that the *plan participant(s)* dies as a result of his or her *injuries* and a wrongful death or survivor *claim* is asserted against a third party or any coverage, the *Plan's* subrogation and reimbursement rights shall still apply, and the entity pursuing said *claim* shall honor and enforce these *Plan* rights and terms by which benefits are paid on behalf of the *plan participant(s)* and all others that benefit from such payment.

To the extent the wrongful death or survivor claim is not seeking, or cannot seek as a matter of law, recovery from the third-party the cost of the medical expenses paid by the *Plan* for the treatment of the decedent between the time of the injury causing event and the death of the decedent, the *Plan* will not seek reimbursement from such wrongful death/survivor claim.

I. Obligations

It is the *plan participant's* obligation at **all** times, both prior to and after payment of medical benefits by the *Plan*:

1. to cooperate with the *Plan*, or any representatives of the *Plan*, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the *Plan's* rights
2. to provide the *Plan* with pertinent information regarding the *illness*, disability, or *injury*, including *accident* reports, settlement information and any other requested additional information
3. to take such action and execute such documents as the *Plan* may require to facilitate enforcement of its subrogation and reimbursement rights
4. to do nothing to prejudice the *Plan's* rights of subrogation and reimbursement
5. to promptly reimburse the *Plan* when a recovery through settlement, judgment, award, or other payment is received
6. to notify the *Plan* or its authorized representative of any settlement prior to finalization of the settlement
7. to *notify* the *Plan* or its *authorized representative* of any incident-related claims or care which may not be identified within the lien (but has been *incurred*) and/or reimbursement request submitted by or on behalf of the *Plan*
8. to not settle or release, without the prior consent of the *Plan*, any *claim* to the extent that the *plan participant* may have against any responsible party or coverage
9. to instruct his or her attorney to ensure that the *Plan* and/or its authorized representative is included as a payee on any settlement draft
10. in circumstances where the *plan participant* is not represented by an attorney, instruct the insurance company or any third party from whom the *plan participant* obtains a settlement to include the *Plan* or its authorized representative as a payee on the settlement draft
11. to make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the *Plan* and *plan participant* over settlement funds is resolved

If the *plan participant(s)* and/or his or her attorney fails to reimburse the *Plan* for all benefits paid, to be paid, *incurred*, or that will be *incurred* prior to the date of the release of liability from the relevant entity, as a result of said *injury* or condition, out of any proceeds, judgment or settlement received, the *plan participant(s)* will be responsible for any and all expenses (whether fees or costs) associated with the *Plan's* attempt to recover such money from the *plan participant(s)*.

The *Plan's* rights to reimbursement and/or subrogation are in no way dependent upon the *plan participant(s)* cooperation or adherence to these terms.

J. Offset

If timely repayment is not made, or the *plan participant* and/or their attorney fails to comply with any of the requirements of the *Plan*, the *Plan* has the right, in addition to any other lawful means of recovery, to deduct the value of the *plan participant's* amount owed to the *Plan*. To do this, the *Plan* may refuse payment of any future medical benefits and any funds or payments due under this *Plan* on behalf of the *plan participant(s)* in an amount equivalent to any outstanding amounts owed by the *plan participant* to the *Plan*. This provision applies even if the *plan participant(s)* has disbursed settlement funds.

K. Minor Status

In the event the *plan participant(s)* is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the *Plan* to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these **Reimbursement, Subrogation, and Recovery Provisions** are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the *Plan* shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

L. Language Interpretation

The *Plan Administrator* retains sole, full, and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the *Plan's* subrogation and reimbursement rights with respect to this provision. The *Plan Administrator* may amend the *Plan* at any time without notice.

M. Severability

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

SECTION XIV—CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain *employees* and their families covered under the Arizona Metropolitan Trust Employee Benefit Plan (the *Plan*) will be entitled to the opportunity to elect a temporary extension of health coverage (called COBRA continuation coverage) where coverage under the *Plan* would otherwise end. This notice is intended to inform *plan participants* and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

Refer to the Quick Reference Information Chart for the COBRA Administrator's contact information. Complete instructions on COBRA, as well as election forms and other information, will be provided by the *Plan Administrator,* or its designee, to *plan participants* who become *qualified beneficiaries* under COBRA.

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a thirty (30) day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

A. COBRA Continuation Coverage

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain *plan participants* and their eligible family members (called *qualified beneficiaries*) at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the *Plan* (the *qualifying event*). The coverage must be identical to the *Plan* coverage that the *qualified beneficiary* had immediately before the *qualifying event*, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated *active employees* who have not experienced a *qualifying event* (in other words, similarly situated non-COBRA beneficiaries).

B. Qualified Beneficiary

In general, a *qualified beneficiary* can be:

1. Any individual who, on the day before a *qualifying event*, is covered under a *Plan* by virtue of being on that day either a covered *employee*, the spouse of a covered *employee*, or a *dependent* child of a covered *employee*. If, however, an individual who otherwise qualifies as a *qualified beneficiary* is denied or not offered coverage under the *Plan* under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the *Plan* coverage and will be considered a *qualified beneficiary* if that individual experiences a *qualifying event*.
2. Any child who is born to or placed for adoption with a covered *employee* during a period of COBRA continuation coverage, and any individual who is covered by the *Plan* as an *alternate recipient* under a *Qualified Medical Child Support Order*. If, however, an individual who otherwise qualifies as a *qualified beneficiary* is denied or not offered coverage under the *Plan* under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the *Plan* coverage and will be considered a *qualified beneficiary* if that individual experiences a *qualifying event*.
3. A covered *employee* who retired on or before the date of substantial elimination of *Plan* coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the *employer*, as is the spouse, surviving spouse, or *dependent* child of such a covered *employee* if, on the day before the bankruptcy *qualifying event*, the spouse, surviving spouse, or *dependent* child was a beneficiary under the *Plan*.

The term covered *employee* includes any individual who is provided coverage under the *Plan* due to his or her performance of services for the *employer* sponsoring the *Plan,* self-employed individuals, independent contractor, or corporate director. However, this provision does not establish eligibility of these individuals. Eligibility for *Plan* coverage shall be determined in accordance with *Plan's* eligibility provisions.

An individual is not a *qualified beneficiary* if the individual's status as a covered *employee* is attributable to a period in which the individual was a non-resident alien who received from the individual's *employer* no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a *qualified beneficiary*, then a spouse or *dependent* child of the individual will also not be considered a *qualified beneficiary* by virtue of the relationship to the individual. A domestic partner is not a *qualified beneficiary*.

Each *qualified beneficiary* (including a child who is born to or placed for adoption or foster care with a covered *employee* during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

C. Qualifying Event

A The following are considered to be qualifying events if they would cause the *plan participant* to lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the *qualifying event*) in the absence of COBRA continuation coverage:

1. the death of a covered *employee*
2. the termination (other than by reason of the *employee*'s gross misconduct) or reduction of hours of a covered *employee's* employment
3. the divorce or legal separation of a covered *employee* from the *employee's* spouse

   If the *employee* reduces or eliminates the *employee's* spouse's plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a *qualifying event* even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.
4. a covered *employee's* enrollment in any part of the *Medicare* program
5. a *dependent* child ceasing to satisfy the *Plan*'s requirements for a *dependent* child (for example, attainment of the maximum age for dependency under the *Plan*)
6. a proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an *employer* from whose employment a covered *employee* retired at any time

If the *qualifying event* causes the covered *employee*, the covered spouse, or a *dependent* child of the covered *employee*, to cease to be covered under the *Plan* under the same terms and conditions as in effect immediately before the *qualifying event* (or in the case of the bankruptcy of the *employer*, any substantial elimination of coverage under the *Plan* occurring within twelve (12) months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become *qualified beneficiaries* under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered *employee*, the spouse, or a *dependent* child of the covered *employee*, for coverage under the *Plan* that results from the occurrence of one (1) of the events listed above is a loss of coverage.

The taking of leave under the *Family and Medical Leave Act of 1993* (*FMLA*) does not constitute a *qualifying event*. A *qualifying event* will occur, however, if an *employee* does not return to employment at the end of the *FMLA leave* and all other COBRA continuation coverage conditions are present. If a *qualifying event* occurs, it occurs on the last day of *FMLA leave* and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the *Plan* provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered *employee* and family members will be entitled to COBRA continuation coverage even if they failed to pay the *employee* portion of premiums for coverage under the *Plan* during the *FMLA leave*.

D. Notice of Unavailability of Continuation Coverage

The *Plan* may sometimes deny a request for COBRA coverage, including an extension of coverage, when the *Plan Administrator* determines the *plan participant* is not entitled to receive it.

When a *Plan Administrator* makes the decision to deny a request for COBRA coverage from a *plan participant*, the *Plan* must give the *plan participant* a notice of unavailability of COBRA coverage. The notice must be provided within fourteen (14) days after the request is received relating to a *qualifying event*, second *qualifying event*, or determination of disability by the Social Security Administration, and the notice must explain the reason for denying the request.

E. Factors to Consider in Electing COBRA Continuation Coverage

When considering options for health coverage, *qualified beneficiaries* should consider:

1. **Premiums.** This *Plan* can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the marketplace, may be less expensive. *Qualified beneficiaries* have

special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within thirty (30) days after *Plan* coverage ends due to one (1) of the *qualifying events* listed above.

2. **Provider Networks.** If a *qualified beneficiary* is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a *network* in considering options for health coverage.
3. **Drug Formularies.** For *qualified beneficiaries* taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. *Qualified beneficiaries* should check to see if current medications are listed in drug formularies for other health coverage.
4. **Severance Payments.** If COBRA rights arise because the *employee* has lost his or her job and there is a severance package available from the *employer*, the former *employer* may have offered to pay some or all of the *employee's* COBRA payments for a period of time. This can affect the timing of coverage available in the marketplace. In this scenario, the *employee* may want to contact the Department of Labor at 1-866-444-3272 to discuss options.
5. **Service Areas.** If benefits under the *Plan* are limited to specific service or coverage areas, benefits may not be available to a *qualified beneficiary* who moves out of the area.
6. **Other Cost Sharing.** In addition to premiums or contributions for health coverage, the *Plan* requires *participants* to pay *co-payments*, *deductibles*, *co-insurance*, or other amounts as benefits are used. *Qualified beneficiaries* should check to see what the cost sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher *deductible* and higher *co-payments*.

Other Coverage Options

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for *qualified beneficiaries* through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a 'special enrollment period'. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

F. Procedure for Obtaining COBRA Continuation Coverage

The *Plan* has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

G. The Election Period

The election period is the timeframe within which the *qualified beneficiary* must elect COBRA continuation coverage under the *Plan*. The election period must begin no later than the date the *qualified beneficiary* would lose coverage on account of the *qualifying event* and ends sixty (60) days after the later of the date the *qualified beneficiary* would lose coverage on account of the *qualifying event* or the date notice is provided to the *qualified beneficiary* of her or his right to elect COBRA continuation coverage. If coverage is not elected within the sixty (60) day period, all rights to elect COBRA continuation coverage are forfeited.

H. Responsibility for Informing the Plan Administrator of the Occurrence of a Qualifying Event

The *Plan* will offer COBRA continuation coverage to *qualified beneficiaries* only after the *Plan Administrator* or its designee has been timely notified that a *qualifying event* has occurred. The *employer* (if the *employer* is not the *Plan Administrator*) will notify the *Plan Administrator* of the *qualifying event* within thirty (30) days following the date coverage ends when the *qualifying event* is any of the following:

1. the end of employment or reduction of hours of employment
2. death of the *employee*
3. commencement of a proceeding in bankruptcy with respect to the *employer*
4. entitlement of the *employee* to any part of *Medicare*

IMPORTANT:

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify your Human Resources Department in writing within sixty (60) days after the qualifying event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing during the sixty (60) day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.

Notice Procedures

Any notice that you provide must be *in writing*. Oral notice, including notice by telephone, is not acceptable. You must mail, fax, or hand-deliver your notice to your Human Resources Department.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state all of the following:

1. the name of the plan or plans under which you lost or are losing coverage
2. the name and address of the *employee* covered under the *Plan*
3. the name(s) and address(es) of the *qualified beneficiary(ies)*
4. the *qualifying event* and the date it happened

If the *qualifying event* is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once Human Resources receives timely notice that a *qualifying event* has occurred, COBRA continuation coverage will be offered to each of the *qualified beneficiaries*. Each *qualified beneficiary* will have an independent right to elect COBRA continuation coverage. Covered *employees* may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each *qualified beneficiary* who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that *Plan* coverage would otherwise have been lost. If you or your spouse or *dependent* children do not elect continuation coverage within the sixty (60) day election period described above, the right to elect continuation coverage will be lost.

I. Waiver before the End of the Election Period

If, during the election period, a *qualified beneficiary* waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to Human Resources, as applicable.

J. If a Qualified Beneficiary has other group health plan coverage or Medicare

Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to *Medicare* benefits on or before the date on which COBRA is elected. However, a *qualified beneficiary's* COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to *Medicare* or becomes covered under other group health plan coverage.

K. When a Qualified Beneficiary's COBRA Continuation Coverage May be Terminated

During the election period, a *qualified beneficiary* may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a *qualified beneficiary* must extend for at least the period beginning on the date of the *qualifying event* and ending not before the earliest of the following dates:

1. the last day of the applicable maximum coverage period
2. the first day for which *timely payment* is not made to the *Plan* with respect to the *qualified beneficiary*
3. the date upon which the *employer* ceases to provide any group health *Plan* (including a successor plan) to any *employee*

4. the date, after the date of the election, that the *qualified beneficiary* first becomes covered under any *other plan*
5. the date, after the date of the election, that the *qualified beneficiary* first enrolls in the *Medicare* program (either part A or part B, whichever occurs earlier)
6. in the case of a *qualified beneficiary* entitled to a disability extension, the later of:
    a. twenty-nine (29) months after the date of the *qualifying event*
    b. the first day of the month that is more than thirty (30) days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled *qualified beneficiary* whose disability resulted in the *qualified beneficiary's* entitlement to the disability extension is no longer disabled, whichever is earlier
    c. the end of the maximum coverage period that applies to the *qualified beneficiary* without regard to the disability extension

The *Plan* can terminate for cause the coverage of a *qualified beneficiary* on the same basis that the *Plan* terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent *claim*.

In the case of an individual who is not a *qualified beneficiary* and who is receiving coverage under the *Plan* solely because of the individual's relationship to a *qualified beneficiary*, if the *Plan's* obligation to make COBRA continuation coverage available to the *qualified beneficiary* ceases, the *Plan* is not obligated to make coverage available to the individual who is not a *qualified beneficiary*.

When the *Plan* terminates COBRA coverage early for any of the reasons listed above, the *Plan Administrator* must give the *qualified beneficiary* a notice of early termination. The notice must be given as soon as practicable after the decision is made, and it must describe all of the following:

a. the date of termination of COBRA coverage
b. the reason for termination
c. any rights the *qualified beneficiary* may have under the plan or applicable law to elect alternative group or individual coverage, such as a right to convert to an individual policy

L. Maximum Coverage Periods for COBRA Continuation Coverage

The maximum coverage periods are based on the type of the *qualifying event* and the status of the *qualified beneficiary*, as shown below.

1. In the case of a *qualifying event* that is a termination of employment or reduction of hours of employment, the maximum coverage period ends eighteen (18) months after the *qualifying event* if there is not a disability extension and twenty-nine (29) months after the *qualifying event* if there is a disability extension.
2. In the case of a covered *employee's* enrollment in the *Medicare* program before experiencing a *qualifying event* that is a termination of employment or reduction of hours of employment, the maximum coverage period for *qualified beneficiaries* other than the covered *employee* ends on the later of:
    a. thirty-six (36) months after the date the covered *employee* becomes enrolled in the *Medicare* program
    b. eighteen (18) months[or twenty-nine (29) months, if there is a disability extension] after the date of the covered *employee's* termination of employment or reduction of hours of employment
3. In the case of a *qualified beneficiary* who is a child born to or placed for adoption with a covered *employee* during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the *qualifying event* giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
4. In the case of any other *qualifying event* than that described above, the maximum coverage period ends thirty-six (36) months after the *qualifying event*.

M. Circumstances in Which the Maximum Coverage Period Can be Expanded

If a *qualifying event* that gives rise to an eighteen (18) month or twenty-nine (29) month maximum coverage period is followed, within that eighteen (18) or twenty-nine (29) month period, by a second *qualifying event* that gives rise to a thirty-six (36) months maximum coverage period, the original period is expanded to thirty-six (36) months, but only for

individuals who are *qualified beneficiaries* at the time of and with respect to both *qualifying events*. In no circumstance can the COBRA maximum coverage period be expanded to more than thirty-six (36) months after the date of the first *qualifying event*. The *Plan Administrator* must be notified of the second qualifying event within sixty (60) days of the second *qualifying event*. This notice must be sent to the COBRA Administrator (either AmeriBen or your *employer*) in writing.

N. How a Qualified Beneficiary Becomes Entitled to a Disability Extension

A disability extension will be granted if an individual (whether or not the covered *employee*) who is a *qualified beneficiary* in connection with the *qualifying event* that is a termination or reduction of hours of a covered *employee's* employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first sixty (60) days of COBRA continuation coverage. To qualify for the disability extension, the *qualified beneficiary* must also provide the *Plan Administrator* with notice of the disability determination on a date that is both within sixty (60) days of the date of the determination and before the end of the original eighteen (18) month maximum coverage. Said notice shall be provided to the *Plan Administrator*, in writing, and should be sent to the COBRA Administrator (either AmeriBen or your *employer*).

O. Payment for COBRA Continuation Coverage

For any period of COBRA continuation coverage under the *Plan*, *qualified beneficiaries* who elect COBRA continuation coverage must pay for COBRA continuation coverage. *Qualified beneficiaries* will pay 102% of the applicable premium and 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled *qualified beneficiary* due to a disability extension. The *Plan* will terminate a *qualified beneficiary's* COBRA continuation coverage as of the first day of any period for which *timely payment* is not made.

The *Plan* must allow payment for COBRA continuation coverage to be made in monthly installments. The *Plan* is also permitted to allow for payment at other intervals.

P. Initial Payment for COBRA Continuation Coverage

Payment will be applied to the COBRA *participant's* account upon receipt. However, coverage is not activated until all of the initial payment is received.

Example: If one (1) month's payment is received, yet three (3) months payment is due: the one (1) month payment will be applied; however, *claims* will not process until the additional two (2) months' payment is received.

Q. Timely Payment for COBRA Continuation Coverage

Timely payment means a payment made no later than thirty (30) days after the first day of the coverage period.

Notwithstanding the above paragraph, the *Plan* does not require payment for any period of COBRA continuation coverage for a *qualified beneficiary* earlier than forty-five (45) days after the date on which the election of COBRA continuation coverage is made for that *qualified beneficiary*. Payment is considered made on the date on which it is postmarked to the *Plan*.

If *timely payment* is made to the *Plan* in an amount that is not significantly less than the amount the *Plan* requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the *Plan's* requirement for the amount to be paid, unless the *Plan* notifies the *qualified beneficiary* of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A reasonable period of time is thirty (30) days after the notice is provided. A shortfall in a *timely payment* is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

R. Non-Sufficient Funds Payments (NSF)

Non-Sufficient Funds (NSF) payments are payments that are received timely but are later returned by the bank. The following conditions will apply to NSF payments:

1. If notification that a *timely payment* is being returned as a NSF payment within the grace period for the month the payment was for, a replacement payment can be submitted before the end of the grace period.
2. If notification that a *timely payment* is being returned due to a NSF payment after the grace period has expired and a subsequent payment was not received timely, COBRA continuation coverage will be retro terminated.

3. If notification that a *timely payment* is being returned as a NSF payment after the grace period has expired and a subsequent payment was postmarked within the grace period for the month the NSF payment was for, the subsequent payment will be accepted and a replacement payment (via a money order or cashier's check) will be required for the end of the current grace period.

S. COBRA Continuation Coverage Availability for Domestic Partners and Children of Domestic Partners

Federal law does not recognize a domestic partner or his or her children as *qualified beneficiaries*. However, COBRA will be offered to same sex domestic partners who were legally married in a state that recognizes such unions.

T. If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the *Plan Sponsor*. For more information about COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa.**

U. Keep Your Human Resources Department Informed of Address Changes

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

V. If You Wish to Appeal

In general, COBRA-related *claims* are not governed by federal regulations. In an effort to provide all *qualified beneficiaries* with a fair and thorough review process for COBRA-related *claims*, all determinations regarding COBRA eligibility and coverage will be made in accordance with this **Continuation Coverage Rights Under COBRA** section of this governing plan document. Accordingly, if a *qualified beneficiary* wishes to appeal a COBRA eligibility or coverage determination made by the *Plan*, such *claims* must be submitted consistent with the *appeals* procedure set forth in the **Claims and Appeals** section of this document. The *Plan* will respond to all complete *appeals* in accordance with the *appeals* procedure set forth in the **Claims and Appeals** section of this document. The *Plan* offers two (2) levels of appeal. A *qualified beneficiary* who files an *appeal* with the *Plan* must exhaust the administrative remedies afforded by the *Plan* prior to pursuing civil action in federal court under COBRA.

SECTION XV—RESPONSIBILITIES FOR PLAN ADMINISTRATION

A. Plan Administrator

Arizona Metropolitan Trust (AzMT) Employee Benefit Plan is the benefit *Plan* of its *participating entities*. The Trustees of AzMT serve as the *Plan Administrator*.

The *Plan Administrator* shall administer this *Plan* in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this *Plan* that the *Plan Administrator* shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the *Plan*, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a *plan participant's* rights, and to decide questions of *Plan* interpretation and those of fact relating to the *Plan*. The decisions of the *Plan Administrator* will be final and binding on all interested parties.

Service of legal process may be made upon the *Plan Administrator* through its legal counsel.

B. Duties of the Plan Administrator

The duties of the *Plan Administrator* are to:

1. administer the *Plan* in accordance with its terms
2. interpret the *Plan*, including the right to remedy possible ambiguities, inconsistencies, or omissions
3. decide disputes that may arise relative to a *plan participant's* rights
4. prescribe procedures for filing a *claim* for benefits and to review *claim* denials
5. keep and maintain the plan documents and all other records pertaining to the *Plan*
6. appoint a *Third Party Administrator* to pay *claims*
7. delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate

C. Amending and Terminating the Plan

The *Plan Sponsor* expects to maintain this *Plan* indefinitely; however, as the settlor of the *Plan*, the *Plan Sponsor*, through its directors and officers, may, in its sole discretion, at any time, amend, suspend, or terminate the *Plan* in whole or in part. This includes amending the benefits under the *Plan* or the Trust Agreement.

Any such amendment, suspension, or termination shall be enacted, if the *Plan Sponsor* is a corporation, by resolution of the *Plan Sponsor's* directors and officers, which shall be acted upon as provided in the *Plan Sponsor's* Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. In the event that the *Plan Sponsor* is a different type of entity, then such amendment, suspension, or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the *Plan Sponsor* is a sole proprietorship, then such action shall be taken by the sole proprietor, in his or her own discretion.

If the *Plan* is terminated, the rights of the *plan participant* are limited to expenses *incurred* before termination. All amendments to this *Plan* shall become effective as of a date established by the *Plan Sponsor*.

D. Plan Administrator Compensation

The *Plan Administrator* serves without compensation; however, all expenses for *Plan Administrator*, including compensation for hired services, will be paid by the *Plan*.

E. Third Party Administrator is Not a Fiduciary

A *Third Party Administrator* is not a fiduciary under the *Plan* by virtue of paying *claims* in accordance with the *Plan's* rules as established by the *Plan Administrator*.

SECTION XVI—FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the *Plan* is funded as follows:

A. For Employee and Dependent Coverage

The *employer* shares the cost of *employee* and *dependent* coverage under this *Plan* with the covered *employees*. Funding is derived from the funds of the *employer* and contributions made by the covered *employees*.

The level of any *employee* contributions will be set by the *employer*. These *employee* contributions will be used in funding the cost of the *Plan* as soon as practicable after they have been received from the *employee* or withheld from the *employee's* pay through payroll deduction. The *employer* reserves the right to change the level of *employee* contributions.

Benefits are paid directly from the *Plan* through the *Third Party Administrator*.

B. Plan is Not an Employment Contract

The *Plan* is not to be construed as a contract for or of employment.

C. Clerical Error

Any clerical error by the *Plan Administrator* or an agent of the *Plan Administrator* in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a *Plan* reimbursement amount, the *Plan* retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the amount paid in error. In the case of a *plan participant* the amount of overpayment may be deducted from future benefits payable.

SECTION XVII—FEDERAL NOTICES

A. Mental Health Parity and Addiction Equity Act of 2008

Regardless of any limitations on benefits for *mental disorders* and *substance use disorder* treatment otherwise specified in the *Plan*, any aggregate *lifetime maximum*, annual limit, financial requirement, *non-network* exclusion or treatment limitation on *mental disorders* and *substance use disorder* benefits imposed by the *Plan* shall comply with federal parity requirements, if applicable.

B. Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA Title I applies to group health plans sponsored by local government *employer*s; Title I generally prohibits discrimination in group premiums based on *genetic information* and the use of *genetic information* as a basis for determining eligibility or setting premiums, and places limitations on genetic testing and the collection of *genetic information* in group health plan coverage. GINA provides clarification with respect to the treatment of *genetic information* under privacy regulations promulgated pursuant to *the* Health Insurance Portability and Accountability Act of 1996 (HIPAA).

C. Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not do any of the following:

1. restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section
2. set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) or ninety-six (96) hours, as applicable, stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay
3. require that a *physician* or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) or ninety-six (96) hours, as applicable

However, the plan or issuer may pay for a shorter stay than forty-eight (48) hours following a vaginal delivery, or ninety-six (96) hours following a delivery by cesarean section if the attending provider (e.g., your *physician*, nurse midwife or physician assistant), discharges the mother or newborn after consultation with the mother.

D. Non-Discrimination Policy

This *Plan* will not discriminate against any *plan participant* based on race, color, religion, national origin, disability, gender, sexual orientation, or age. This *plan* will not establish rules for eligibility based on health status, medical condition, *claims* experience, receipt of health care, medical history, evidence of insurability, *genetic information*, or disability.

This *Plan* intends to be nondiscriminatory and to meet the requirements under applicable provisions of the Internal Revenue Code of 1986. If the *Plan Administrator* determines before or during any *plan year* that this *Plan* may fail to satisfy any non-discrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated individuals, the *Plan Administrator* shall take such action as the *Plan Administrator* deems appropriate, under rules uniformly applicable to similarly situated covered *employees*, to assure compliance with such requirements or limitation.

E. Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Employees going into or returning from military service may elect to continue *Plan* coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (*USERRA*) under the following circumstances. These rights apply only to *employees* and their *dependents* covered under the *Plan* immediately before leaving for military service.

1. The maximum period of coverage of an *employee* and the *employee's dependents* under such an election shall be the lesser of:
    a. the twenty-four (24) month period beginning on the date on which the person's absence begins

b. the day after the date on which the person was required to apply for or return to a position of employment and fails to do so

2. A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the *Plan*, except a person on active duty for thirty (30) days or less cannot be required to pay more than the *employee's* share, if any, for the coverage.
3. An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any *illness* or *injury* determined by the Secretary of Veterans Affairs to have been *incurred* in, or aggravated during, the performance of *uniformed service*.

If the *employee* wishes to elect this coverage or obtain more detailed information, contact your Human Resources Department. The *employee* may also have continuation rights under *USERRA*. In general, the *employee* must meet the same requirements for electing *USERRA* coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The *employee* may elect *USERRA* continuation coverage for the *employee* and their *dependents*. Only the *employee* has election rights. *Dependents* do not have any independent right to elect *USERRA* health plan continuation.

F. Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires that you be informed of your rights to *surgery* and prostheses following a covered *mastectomy*.

The *Plan* will pay charges *incurred* for a *plan participant* who is receiving benefits in connection with a *mastectomy* and then elects breast reconstruction in connection with the *mastectomy*. Coverage will include:

1. reconstruction of the breast on which the *mastectomy* has been performed
2. *surgery* and reconstruction of the other breast to produce a symmetrical appearance
3. prosthesis and treatment of physical complications of all stages of *mastectomy*, including lymphedemas

These benefits are subject to all regular *Plan* provisions, including *deductibles*, *co-payments*, and *co-insurance* payable, if applicable, and as shown in the Schedule of Medical Benefits – HDHP Plan.

G. Medicaid and the Children's Health Insurance Program (CHIP)

If you are eligible for health coverage from your *employer*, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid (AHCCCS in Arizona) or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid (AHCCCS) or CHIP, you can contact the Arizona Medicaid (AHCCCS) or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid (AHCCCS) or CHIP, and you think you or any of your dependents might be eligible for either of these programs you can contact:

ARIZONA – CHIP
http://www.azahcccs.gov/applicants/default.aspx
1-602-417-5422

1-877-KIDS NOW
www.insurekidsnow.gov

Once it is determined that you or your *dependents* are eligible for premium assistance under Medicaid (AHCCCS) or CHIP, your employer's health plan is required to permit you and your *dependents* to enroll in the plan—as long as you and your *dependents* are eligible, but not already enrolled in the employer's *Plan*. This is called a special enrollment opportunity, and you must request coverage within sixty (60) days of being determined eligible for premium assistance.

To research the availability of, and your eligibility for, premium assistance in other states, please contact the following agencies:

U.S. Department of Labor
Employee Benefits Security Administration

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

www.dol.gov/ebsa
1-866-444-EBSA (3272)

www.cms.hhs.gov
1-877-267-2323, Ext. 61565

SECTION XVIII—COMPLIANCE WITH HIPAA PRIVACY STANDARDS

A. Compliance with HIPAA Privacy Standards

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996.

Certain members of the *employer's* workforce perform services in connection with administration of the *Plan*. In order to perform these services, it is necessary for these *employees* from time to time to have access to Protected Health Information (PHI) (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the *Privacy Standards*), these *employees* are permitted to have such access subject to the following:

1. **General.** The *Plan* shall not disclose Protected Health Information to any member of the *employer's* workforce unless each of the conditions set out in this **Compliance with HIPAA Privacy Standards** section is met. Protected Health Information shall have the same definition as set out in the *Privacy Standards* but generally shall mean individually identifiable health information about the past, present, or future physical or mental health condition of an individual, including information about treatment or payment for treatment.
2. **Permitted Uses and Disclosures.** Protected Health Information disclosed to business associates and members of the *employer's* workforce shall be used or disclosed by them only for purposes of *Plan* administrative functions. The *Plan's* administrative functions shall include all *Plan* payment and health care operations. The terms 'payment' and 'health care operations' shall have the same definitions as set out in the *Privacy Standards*, but the term 'payment' generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill *Plan* responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. Health care operations generally shall mean activities on behalf of the *Plan* that are related to quality assessment; evaluation, training or accreditation of health care *providers*; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management, and general administrative activities. *Genetic information* will not be used or disclosed for underwriting purposes.
3. **Authorized Employees.** The *Plan* shall disclose Protected Health Information only to members of the *employer's* workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the *Plan*. For purposes of this **Compliance with HIPAA Privacy Standards** section, members of the *employer's* workforce shall refer to all *employees* and other persons under the control of the *employer*.
    a. **Updates Required.** The *employer* shall amend the *Plan* promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
    b. **Use and Disclosure Restricted.** An authorized member of the *employer's* workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the *Plan*.
    c. **Resolution of Issues of Noncompliance.** In the event that any member of the *employer's* workforce uses or discloses Protected Health Information other than as permitted by the *Privacy Standards*, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
        i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and whether the Protected Health Information was compromised
        ii. applying appropriate sanctions against the person(s) causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment
        iii. mitigating any harm caused by the breach, to the extent practicable
        iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages
        v. providing notification in accordance with HIPAA requirements
4. **Certification of Employer.** The *employer* must provide certification to the *Plan* that it agrees to **all** of the following:

a. not use or further disclose the Protected Health Information other than as permitted or required by the plan documents or as required by law

b. ensure that any agent or subcontractor to whom it provides Protected Health Information received from the *Plan* agrees to the same restrictions and conditions that apply to the *employer* with respect to such information

c. not 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 *employer*

d. report to the *Plan* any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law

e. make available Protected Health Information to individual *Plan* members in accordance with Section 164.524 of the *Privacy Standards*

f. make available Protected Health Information for amendment by individual *Plan* members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the *Privacy Standards*

g. make available the Protected Health Information required to provide any accounting of disclosures to individual *Plan* members in accordance with Section 164.528 of the *Privacy Standards*

h. make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the *Plan* available to the Department of Health and Human Services for purposes of determining compliance by the *Plan* with the *Privacy Standards*

i. if feasible, return or destroy all Protected Health Information received from the *Plan* that the *employer* still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible

j. ensure the adequate separation between the *Plan* and member of the *employer's* workforce, as required by Section 164.504(f)(2)(iii) of the *Privacy Standards*

5. The following members of *participating entity's* workforce are designated as authorized to receive Protected Health Information from Arizona Metropolitan Trust Employee Benefit Plan (the *Plan*) in order to perform their duties with respect to the *Plan*:

    a. Trustee and Alternate Trustee

    b. Regional and Area Vice President (Broker)

    c. Senior Account Executive (Broker)

    d. Human Resources Director

    e. HR Manager

    f. HR Technician

    g. HR Analyst

    h. Administrative Services Director

    i. Administrative Manager

    j. Administrative Assistant

    k. Senior Wellbeing Consultant

    l. Account Manager (Broker)

    m. Accountant

    n. Finance Director

    o. Finance Clerk

    p. IT Manager

    q. Assistant Chief

B. Compliance with HIPAA Electronic Security Standards

Under the *Security Standards* for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the *Security Standards*), the *employer* agrees to the following:

1. The *employer* agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the *employer* creates, maintains or transmits on behalf of the *Plan*. Electronic Protected Health Information shall have the same definition as set out in the *Security Standards*, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
2. The *employer* shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
3. The *employer* shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in the **Compliance with HIPAA Privacy Standards**, Authorized Employees and Certification of Employers provisions.

SECTION XIX—GENERAL PLAN INFORMATION

A. Type of Administration

The *Plan* is a self-funded group health *Plan* and the *claims* administration is provided through a *Third Party Administrator*. The *Plan* is not insured.

B. Plan Name

The name of the *Plan* is the Arizona Metropolitan Trust Employee Benefit Plan.

Arizona Metropolitan Trust
c/o Gallagher Benefit Services
8800 E Raintree Dr., Ste 250
Scottsdale, AZ 85260
1-928-391-2297
TIN# 30-6316739

C. Plan Year

The *plan year* is the twelve (12) month period beginning July 1 and ending June 30.

D. Plan Effective Date

July 1, 2024

E. Type of Plan

The *Plan* is established pursuant to Arizona Revised Statute Section 11-952.01 et. seq. as a self-funded governmental employee benefit pool and, therefore, is exempt from the federal Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA.

F. Plan Sponsor

The *participating entity employers* are the *Plan Sponsors*.

G. Plan Administrator

The Board of Trustees of the *Plan* serves as the *Plan Administrator*. The name, address, and telephone number of the *Plan Administrator* is:

Arizona Metropolitan Trust
c/o Gallagher Benefit Services
8800 E Raintree Dr., Ste 250
Scottsdale, AZ 85260
1-928-391-2297

H. Third Party Administrator

The *Plan Administrator* has contracted with a *Third Party Administrator (TPA)* to assist the *Plan Administrator* with *claims* adjudication. The *TPA's* name, address, and telephone number are:

AmeriBen
P.O. Box 7186
Boise, ID 83707
1-855-350-8699

I. Agent for Service of Legal Process

The names of the person designated as agent for service of legal process and the address where a processor may serve legal process upon the *Plan* are:

Michael Hensley, Legal Counsel
Jones Skelton & Hochuli
2901 No. Central Ave., Ste. 800
Phoenix, AZ 85012
1-602-263-1775

J. Employer's Right to Terminate

The *employer* reserves the right to amend or terminate this *Plan* at any time. Although the *employer* currently intends to continue this *Plan*, the *employer* is under absolutely no obligation to maintain the *Plan* for any given length of time. If the *Plan* is amended or terminated, an authorized officer of the *employer* will sign the documents with respect to such amendment or termination. There are no vested rights under this *Plan*.

SECTION XX—DEFINED TERMS

The following terms have special meanings and when used in this *Plan* will be italicized. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise.

Accident

A sudden and unforeseen event or a deliberate act resulting in unforeseen consequences.

Active Employment

Performance by the *employee* of all the regular duties of his or her occupation at an established business location of the participating *employer*, or at another location to which he or she may be required to travel to perform the duties of his or her employment. An *employee* shall be deemed actively at work if the *employee* is absent from work due to a health factor. In no event will an *employee* be considered actively at work if he or she has effectively terminated employment.

Acute Care

Medically necessary inpatient treatment in a licensed general *hospital* or other facility *provider* for sustained medical intervention by a *physician* and skilled nursing care to safeguard a *plan participant's* life and health. The immediate medical goals of acute care if to stabilize the *plan participant's* condition, rather than upgrade or restore a *plan participant's* abilities.

Adoptive Cell Therapy

A type of immunotherapy in which T cells (a type of immune cell) are given to a patient to help the body fight diseases, such as cancer. In cancer therapy, T cells are usually taken from the patient's own blood or tumor tissue, grown in large numbers in the laboratory, and then given back to the patient to help the immune system fight the cancer. Sometimes, the T cells are changed in the laboratory to make them better able to target the patient's cancer cells and kill them. Types of adoptive cell therapy include, but not limited to, chimeric antigen receptor T-cell (CAR T-cell) therapy and tumor-infiltrating lymphocyte (TIL) therapy. Also called adoptive cell transfer, cellular adoptive immunotherapy, and T-cell transfer therapy.

Adverse Benefit Determination

Any of the following: a denial, reduction, rescission, termination of a *claim* for benefits, or a failure to provide or make payment for such a *claim* (in whole or in part) including determinations based upon a *claimant's* eligibility for such benefits, the application of any review under the **Health Care Management Program**, and determinations that an item or service is *experimental/investigational* or not *medically necessary* or appropriate.

Allowable/Allowed Charges

The *maximum allowable charge* for any *medically necessary*, contracted amount, and eligible item of expense, at least a portion of which is covered under a plan. When some *other plan* pays first in accordance with the Application to Benefit Determinations subsection in the **Coordination of Benefits** section herein, this *Plan's* allowable charges shall in no event exceed the *other plan's* allowable charges. When some *other plan* provides benefits in the form of services rather than cash payments, the *reasonable* cash value of each service rendered, in the amount that would be payable in accordance with the terms of the *Plan* shall be deemed to be the benefit. Benefits payable under any *other plan* include the benefits that would have been payable had *claim* been duly made therefore.

Alternate Recipient

Any child of a *plan participant* who is recognized under a *Medical Child Support Order* as having a right to enrollment under this *Plan* as the *plan participant's* eligible *dependent*. For purposes of the benefits provided under this *Plan*, an alternate recipient shall be treated as an eligible *dependent* and have the same status as a *plan participant*.

Ambulatory Surgical Center

A licensed facility, with a staff of *physicians*, which:

1. has permanent facilities and equipment for the primary purpose of performing *surgical procedures* on an outpatient basis

2. provides treatment by or under the supervision of *physicians* and provides skilled nursing care while the *plan participant* is in the facility
3. does not provide *inpatient* accommodations appropriate for a stay of longer than twelve (12) hours
4. is not primarily a facility used as an office or clinic for the private practice of a *physician* or other professional *provider*

Appeal

A review by the *Plan* of an *adverse benefit determination*, as required under the *Plan's* internal *claims* and appeals procedures.

Applied Behavioral Analysis (ABA) Therapy

Applied Behavioral Analysis (ABA) Therapy is an umbrella term describing principles and techniques used in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors. The goal of ABA Therapy is to teach new skills, promote generalization of these skills, and reduce challenging behaviors with systematic reinforcement. ABA Therapy is a combination of services for adaptive behavior treatment, which applies the principles of how people learn and motivations to change behavior. ABA Therapy is designed to address multiple areas of behavior and function such as to increase language and communication, enhance attention and focus, and help with social skills and memory. It generally includes psychosocial interventions, should address factors that may exacerbate behavioral challenges, and is most effective when initiated as soon as feasible after diagnosis is made.

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is described in **any** of the following subparagraphs:

1. The study or investigation is approved or funded by one or more of the following:
    a. The National Institutes of Health
    b. The Centers for Disease Control and Prevention
    c. The Agency for Health Care Research and Quality
    d. The Centers for Medicare and Medicaid Services
    e. a cooperative group or center of any of the entities described in sub-clauses a. through d. above, the Department of Defense, or the Department of Veterans Affairs
    f. a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    g. any of the following if the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs
        ii. The Department of Defense
        iii. The Department of Energy
2. The study or investigation is conducted under an *investigational* new drug application reviewed by the Food and Drug Administration.
3. The study or investigation is a drug trial that is exempt from having such an *investigational* new drug application.

Assignment of Benefits

An arrangement by which a *plan participant* requests that their health benefit payments under this *Plan* be made directly to a designated medical *provider* or facility. By completing an assignment of benefits, the *plan participant* authorizes the *Plan Administrator* to forward payment for a covered procedure directly to the treating medical *provider* or facility. The *Plan Administrator* expects that an assignment of benefits form to be completed, as between the *plan participant* and the *provider*.

Authorized Representative

An authorized representative is a person or organization a *plan participant* has designated to act on their behalf to submit or *appeal* a *claim*. By authorizing a person or organization to act on your behalf, you are giving them permission to see your protected health information (PHI) and act on all matters related to your *claim* and/or *appeal*. If you choose to authorize a person to act on your behalf, all future communications shall be with the designee. When an *urgent care claim* is involved, a health care professional with knowledge of the medical condition will be permitted to act as a *claimant's* authorized representative without a prior written authorization.

Autism Spectrum Disorder

Autistic Disorder, Asperger's Syndrome, or Pervasive Developmental Disorder (not otherwise specified) and referenced in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Balance Bill/Surprise Bill

Balance bill refers to the difference between a non-network provider's total billed charges and the *allowable charges* off of which the *Plan* will base its reimbursement.

Non-network providers have no obligation to accept the allo*wab*le *charge*. You are responsible to pay a *non-network* provider's billed charges, even though reimbursement is based on the *allowable charge*.

Any amounts paid for balance bills do not count toward the *deductible*, *co-insurance*, or *out-of-pocket limit*.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

Benefit Determination

The *Plan's* decision regarding the acceptance or denial of a *claim* for benefits under the *Plan*.

Benefit Maximum

Some benefits may have a specific benefit maximum or limit based on dollar amount, number of days or visits, type, timeframe (*benefit year* or benefit plan), age, gender, or other factors. If you reach a benefit maximum, any further services are not covered under that benefit and you may have to pay the *provider's* billed charges for those services. However, if you reach the benefit maximum on a particular line of a *claim*, you will be responsible for paying only up to the *allowed charge* for the remaining charges on that line of the *claim*.

All benefit maximums are included in the applicable benefit description located in the Schedule of Medical Benefits – HDHP Plan, Covered Medical Charges, and the **Transplant Program** sections.

Benefit Year

The twelve (12) month period beginning July 1 and ending June 30. All annual *deductibles* and *benefit maximums* accumulate during the benefit year.

Birthing Center

Any freestanding health facility, place, professional office, or institution which is not a *hospital* or in a *hospital*, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located.

The birthing center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a *physician* and either a Registered Nurse (R.N.) or a licensed nurse midwife; and have a written agreement with a *hospital* in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Bone Marrow Transplant

As used in the **Transplant Program** section; a medical or surgical procedure comprised of several stages, including:

1. administration of high dose chemotherapy and high dose radiotherapy as prescribed by the treating physician
2. harvesting of stem cells from the bone marrow or the blood of a third-party donor (allogeneic transplant) or the member (autologous transplant) and all component parts of the procedure
3. hospitalization and management of reasonably anticipated complications
4. infusion of the harvested stem cells

5. processing and storage of the stem cells after harvesting

Brand Name

A trade name medication.

Caregiver

As used in the **Transplant Program** section: The individual primarily responsible for providing daily care, basic assistance and support to a *plan participant* or donor who is eligible for transport lodging and reimbursement. Caregivers may perform a wide variety of tasks to assist the *plan participant* or donor in his or her daily life, such as preparing meals, assisting with doctors' appointments, giving medications, or assisting with personal care and emotional needs.

Cellular Immunotherapy

A type of therapy that uses substances to stimulate or suppress the immune system to help the body fight cancer, infection, and other diseases. Some types of immunotherapy only target certain cells of the immune system. Others affect the immune system in a general way. Types of immunotherapy include cytokines, vaccines, bacillus Calmette-Guerin (BCG), and some monoclonal antibodies.

Center of Excellence

Medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The *Plan Administrator* shall determine what *network* Centers of Excellence are to be used.

Any *plan participant* in need of an organ transplant may contact the *Third Party Administrator* as outlined in the Quick Reference Information Chart to initiate the *pre-certification* process resulting in a referral to a Center of Excellence. The *Third Party Administrator* acts as the primary liaison with the Center of Excellence, patient and attending *physician* for all transplant admissions taking place at a Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to *plan participant(s)* and updated as requested.

Claim

Any request for a *Plan* benefit, made by a *claimant* or by a representative of a *claimant*, in accordance with a *Plan's* reasonable procedure for filing benefit claims.

Some requests made to the *Plan* are specifically not claims for benefits; for example:

1. an inquiry as to eligibility which does not request benefits
2. a request for prior approval where prior approval is not required by the *Plan*
3. casual inquiries about benefits such as verification of whether a service/item is a covered benefit or the estimated cost for a service

Claimant

Any *plan participant* or beneficiary making a *claim* for benefits. Claimants may file *claims* themselves or may act through an *authorized representative*.

Clean Claim

A *claim* that can be processed in accordance with the terms of this plan document without obtaining additional information from the service *provider* or a third party. It is a *claim* which has no defect, impropriety, or special circumstance that delays timely payment. A clean claim does not include:

1. *claims* under investigation for fraud and abuse
2. *claims* under review for *medical necessity*
3. any other matter that may prevent the expense(s) from being considered a *covered charge*

The claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A *claim* will not be considered to be a clean claim if the *participant* has failed to submit required forms or additional information to the *Plan* as well.

Co-Insurance

The portion of medical expenses (after the *deductible* has been satisfied) for which a *plan participant* is responsible.

Concurrent Care Claim

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.

Co-Payment

A co-payment is a specific dollar amount a *plan participant* is required to pay and is typically payable to the health care *provider* at the time services or supplies are rendered.

Cosmetic

Surgery, procedures, treatment, and other services performed primarily to enhance or improve appearance, including but not limited to, those *surgeries*, procedures, treatments, and other services performed in the absence of a functional impairment of a body part or organ as documented in the medical record, even if such services will improve emotional, psychological, or mental condition or function.

Cost Sharing Amounts

The dollar amount a *plan participant* is responsible for paying when covered services are received from a *provider*. Cost sharing amounts include *co-insurance, co-payments, deductible amounts, and out-of-pocket limits. Providers* may bill you directly or request payment of *co-insurance* and/or *co-payments* at the time services are provided. Refer to the various **Schedules of Benefits** for the specific cost sharing amounts that apply to this *Plan*.

Courtesy Review

A pre-service review of requested services for benefits which are neither on the *pre-certification* list nor an exclusion of the *Plan*.

Covered Charges

The *maximum allowable charge*, *usual and customary*, or *reasonable* amount for *medically necessary* service, treatment, or supply, meant to improve a condition or *plan participant's* health, which is eligible for coverage in this *Plan*. Covered charges will be determined based upon all other *Plan* provisions. When more than one (1) treatment option is available, and one (1) option is no more effective than another, the covered charges is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the **Schedules of Benefits, Medical Benefits, and Transplant Program** sections and as determined elsewhere in this document.

Custodial Care

Care (including *room and board* needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, are provided when *acute care* is not required or do not require continued administration by licensed skilled medical personnel. Examples of custodial care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Deductible

A specified portion of the *covered charges* that must be incurred by a *plan participant* before the *Plan* has any liability.

Dentist

A person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent

For information regarding eligibility for *dependents*, refer to the section entitled **Eligibility, Effective Date, and Termination Provisions**.

Developmental Delay

A delay in the appearance of normal developmental milestones achieved during infancy and early childhood, caused by organic, psychological, or environmental factors. Conditions are marked by delayed development or functional limitations especially in learning, language, communication, cognition, behavior, socialization, or mobility.

Diagnosis Related Grouping (DRG)

A method for reimbursing hospitals for inpatient services. A DRG amount can be higher or lower than the actual billed charge because it is based on an average for that grouping of diagnoses and procedures.

Diagnostic Service

A test or procedure performed for specified symptoms to detect or to monitor a *disease* or condition. It must be ordered by a *physician* or other professional *provider*.

Disease

Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the *Plan* is furnished showing that the individual concerned is covered as an employee under any Workers' Compensation Law, Occupational Disease Law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the *Plan*, be regarded as a *sickness, illness,* or disease.

Durable Medical Equipment (DME)

Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an *illness* or *injury,* and is appropriate for use in the home.

Emergency Services

A medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the *hospital* emergency department, including routine ancillary services, to evaluate a *medical emergency* and such further medical examination and treatment as are within the capabilities of the staff and facilities of the *hospital* and required under EMTALA to stabilize the patient.

Employee

A person who is an active, regular employee of the *employer*, has begun to perform the duties of his/her job with the *employer*, and is regularly scheduled to work for the *employer* on a full-time basis in an employee/*employer* relationship.

Employer

City of Apache Junction, City of El Mirage, Litchfield Park, Sun City Fire, Town of Fountain Hills, Town of Paradise Valley, Town of Wickenburg, or Town of Youngtown.

Enrollment Date

The first day of coverage or, if there is a waiting period, the first day of the waiting period.

Essential Health Benefits

Benefits set forth under the *Patient Protection and Affordable Care Act of 2010* (*PPACA*), including the categories listed in the state of Utah benchmark plan.

Experimental/Investigational

Services, supplies, care, and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The *Plan Administrator* must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The *Plan Administrator* shall be guided by a reasonable interpretation of *Plan* provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the *claim* and the proposed treatment. The decision of the *Plan Administrator* will be final and binding on the *Plan*.

The *Plan Administrator* will be guided by the following principles, any of which comprise a definition of experimental/investigational:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished
2. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval
3. if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis
4. if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Benefits covered under the Clinical Trials provisions are not considered experimental or investigational.

Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Expenses related to off-label drug use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when **all** of the following criteria have been satisfied:

1. the named drug is not specifically excluded under the *Plan*
2. the named drug has been approved by the FDA
3. the off-label drug use is appropriate and generally accepted by the medical community for the condition being treated
4. if the drug is used for the treatment of cancer, the American Hospital Formulary Service Drug Information or the NCCN Drugs and Biologics Compendia recognize it as an appropriate treatment for that form of cancer

Expenses for drugs, devices, services, medical treatments, or procedures related to an experimental and/or investigational treatment (related services), and complications from an experimental and/or investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the experimental and/or investigational treatment.

Final determination of experimental and/or investigational, *medical necessity,* and/or whether a proposed drug, device, medical treatment, or procedure is covered under the *Plan* will be made by and in the sole discretion of the *Plan Administrator*.

Explanation of Benefits

A document sent to the participant by the *Third Party Administrator* after a *claim* for reimbursement has been processed. It includes the patient's name, *claim* number, type of service, *provider*, date of service, charges submitted for the services, amounts covered by this *Plan*, non-covered services, *cost sharing amounts,* and the amount of the charges that are the *plan participant's* responsibility. This form should be carefully reviewed and kept with other important records.

External Review

A review of an *adverse benefit determination*, including a *final internal adverse benefit determination* under applicable state or federal external review procedures.

Family and Medical Leave Act of 1993 (FMLA)

The Family and Medical Leave Act of 1993 as amended.

Family Unit

The covered *employee* and the family members who are covered as *dependents* under the *Plan*.

Final Internal Adverse Benefit Determination

An *adverse benefit determination* that has been upheld by the *Plan* at completion of the *Plan's* internal *appeals* procedures; or an *adverse benefit determination* for which the internal *appeals* procedures have been exhausted under the deemed exhausted rule contained in the *appeals* regulations. For plans with two (2) levels of *appeals*, if the second-level *appeal* results in a final internal adverse benefit determination, that may trigger the right to *external review*.

FMLA Leave

A *leave of absence* which the company is required to extend to an *employee* under the provisions of *Family and Medical Leave Act of 1993 (FMLA)*.

Formulary

A list of prescription medications compiled by the third-party payor of safe or effective therapeutic drugs specifically covered by this *Plan*.

Foster Child

A *child* under the limiting age shown in the **Eligibility, Effective Date, and Termination Provisions** section of this *Plan,* for whom a covered *employee* has assumed a legal obligation in connection with the child's placement with a state, county, or private foster care agency.

A covered foster child is not a child temporarily living in the covered *employee's* home; one placed in the covered *employee's* home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Gene Therapy

Human gene therapy seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use. It is a technique that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms:

1. replacing a disease-causing gene with a healthy copy of the gene
2. inactivating a disease-causing gene that is not functioning properly
3. introducing a new or modified gene into the body to help treat a disease

Generic Drug

A *prescription drug* which has the equivalency of the *brand name* drug with the same use and metabolic disintegration. This *Plan* will consider as a generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information

Information about the genetic tests of an individual or his or her family members, and information about the manifestations of disease or disorder in family members of the individual. A genetic test means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, which detects genotypes, mutations, or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Habilitative Services/Habilitation Services

Treatment and services that help a *plan participant* keep, learn, or improve skills and functions for daily living that they may not be developing as expected for their age range. These services may include physical and occupational

therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings.

Home Health Care Agency

An organization that meets all of these tests: its main function is to provide *home health care services and supplies*; it is federally certified as a home health care agency; and is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan

Must meet these tests: it must be a formal written plan made by the patient's attending *physician* which is reviewed at least every thirty (30) days; it must state the diagnosis; it must certify that the home health care is in place of *hospital* confinement; and it must specify the type and extent of home health care required for the treatment of the patient.

Home Health Care Services and Supplies

Home health care services and supplies include: part-time or intermittent nursing care by or under the supervision of a Registered Nurse (R.N.); part-time or intermittent home health aide services provided through a *home health care agency* (this does not include general housekeeping services); physical, occupational, and speech therapy; medical supplies; and laboratory services by or on behalf of the *hospital*.

Hospice Agency

An organization where its main function is to provide *hospice care services and supplies* and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan

A plan of terminal patient care that is established and conducted by a *hospice agency* and supervised by a *physician*.

Hospice Care Services and Supplies

Hospice care services and supplies are those provided through a *hospice agency* and under a *hospice care plan* and include *inpatient* care in a *hospice unit* or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit

A facility or separate *hospital* unit that provides treatment under a *hospice care plan* and admits at least two (2) unrelated persons who are expected to die within six (6) months.

Hospital (Acute or Long-Term Acute Care Facility)

A provider licensed and operated as required by law, which provides all of the following and is fully accredited by The Joint Commission:

1. room, board, and nursing care
2. a staff with one (1) or more doctors on hand at all times
3. twenty-four (24) hour nursing service
4. all the facilities on site are needed to diagnose, care, and treat an *illness* or *injury*

The term hospital does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. custodial care
6. educational care
7. subacute care

Refer to the defined terms for *Residential Treatment Facility* and *Substance Use Disorder/Mental Health Treatment Center* for the specific requirements applicable to those facility types.

Illness

For a Covered Employee and Covered Spouse: A bodily disorder, congenital defect, *disease*, physical *illness,* or *mental disorder*. *Illness* includes *pregnancy*, childbirth, miscarriage, or complications of *pregnancy*.

For a Covered Dependent Other Than a Spouse: A bodily disorder, congenital defect, *disease*, physical *illness,* or *mental disorder*, not including *pregnancy* or its complications**.**

Incurred

An expense for a service or supply is incurred on the date the service or supply is furnished. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Review Organization (IRO)

An entity that performs independent *external reviews* of *adverse benefit determination*s and *final internal adverse benefit determination*s.

Infertility

Inability to produce offspring.

Injury

An accidental bodily injury, which does not arise out of, which is not caused or contributed by, and which is not a consequence of, any employment or occupation for compensation or profit.

Inpatient

Treatment in an approved facility during the period when charges are made for *room and board*.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a *hospital* solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a coronary care unit or an *acute care* unit. It has facilities for special nursing care not available in regular rooms and wards of the *hospital*; special lifesaving equipment which is immediately available at all times; at least two (2) beds for the accommodation of the critically ill; and at least one (1) Registered Nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

Investigational

See *Experimental/Investigational*.

Laboratory, Pathology Services, X-ray, and Radiology Services

Laboratory and pathology services: Testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material which has been removed from the body. Diagnostic medical procedures requiring the use of technical equipment for evaluation of body systems are also considered laboratory services. Examples include: electrocardiograms (EKGs) and electroencephalograms (EEGs).

X-ray and radiology services: Services including the use of radiology, nuclear medicine, and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

Late Enrollee

A *plan participant* who enrolls under the *Plan* other than during the first thirty-one (31) day period in which the individual is eligible to enroll under the *Plan* or during a Special Enrollment Period.

Leave of Absence

A period of time during which the *employee* does not work, but which is of a stated duration after which time the *employee* is expected to return to active work.

Legal Guardian

A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Life-Threatening Disease or Condition

Any *disease* or condition from which the likelihood of death is probable unless the course of the *disease* is interrupted.

Long Term Acute Care Hospitals

Facilities that specialize in the treatment of patients with serious medical conditions that require care on an ongoing basis but no longer require intensive care or extensive diagnostic procedures.

Long Term Care

Generally refers to non-medical care for patients who need assistance with basic daily activities such as dressing, bathing, and using the bathroom. Long-term care may be provided at home or in facilities that include nursing homes and assisted living.

Maintenance Care

Therapy or treatment intended primarily to maintain general physical conditions, including, but not limited to routine, long-term, or maintenance care which is provided after the resolution of an acute medical problem. This includes services performed solely to preserve the present level of function or prevent regression for an *illness*, *injury*, or condition that is resolved or stable.

Mastectomy

The surgical removal of all or part of a breast.

Maximum Amount/Maximum Allowable Charge

The benefit payable for a specific coverage item or benefit under the *Plan*. Maximum allowable charge(s) will be based on one (1) of the following options, depending on the circumstances of the *claim* and at the discretion of the *Plan Administrator*:

1. the *usual and customary* and/or *reasonable* amount
2. the negotiated rate established in a contractual arrangement with a *provider*
3. the actual billed charges for the *covered charges*
4. a percentage of the *Medicare* rate

   Non-network claims cannot exceed 150% of the Medicare rate for non-emergency services or 250% of the Medicare rate for emergency facility services. If there is not a Medicare-like rate available, or if a claim is considered under the Special Reimbursement Provisions, the *non-network* claim will be priced at 80% of the *usual and customary* and/or *reasonable* amount.
5. *network* allowed amount
6. *network* non-participating provider rate

The maximum allowed amount for emergency care from a *non-network* provider will be determined using the median plan *network* contract rate paid to *network* providers for the geographic area where the service is provided.

The *Plan* has the discretionary authority to decide if a charge is *usual and customary* and/or *reasonable* for a *medically necessary* service.

The maximum allowable charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medical Care Facility

A *hospital*, a facility that treats one (1) or more specific ailments, or any type of *skilled nursing facility*.

Medical Child Support Order

Any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. provides for child support with respect to a *plan participant's* child or directs the *plan participant* to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan

Medical Emergency

A medical condition of recent onset and severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part or would place the person's health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.

Medical Management Administrator

A group of medical care professionals selected to conduct *pre-certification* review, emergency admission review, continued stay review, discharge planning, patient consultation, and individual benefits management. For more information, see the **Health Care Management Program** section of this document.

Medically Necessary/Medical Necessity

Care and treatment is recommended or approved by a *physician* or *dentist*; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or *provider* of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a *physician* recommends or approves certain care does not mean that it is medically necessary.

The *Plan Administrator* has the discretionary authority to decide whether care or treatment is medically necessary.

Medicare

The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder

Any disease or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Mental Health or Substance Use Disorder Hold

An involuntary detainment, by an officer of the court, in an *inpatient facility*, of an individual who is either posing a danger to themselves or others, or determined to be gravely disabled due to a mental health condition. Typically lasting up to seventy-two (72) hours.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If

these benefits are covered by the group health *Plan* (or health insurance coverage is offered in connection with such a plan).

2. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

Morbid Obesity

Severity of obesity judged appropriate for procedure, as indicated by one (1) or more of the following:

1. adult patient has BMI of thirty-five (35) or greater
2. adolescent patient [thirteen (13) to seventeen (17) years of age] has a BMI of forty (40) (or 140% of the 95th percentile in age and sex matched growth chart) or greater
3. adult patient has BMI of thirty (30) or greater and a clinically serious condition related to obesity (e.g. type 2 diabetes, obesity hypoventilation, obstructive sleep apnea, non-alcoholic steatohepatitis, pseudotumor cerebri, severe osteoarthritis, difficult to control hypertension)
4. adolescent patient [thirteen (13) to seventeen (17) years of age] has a BMI of thirty-five (35) (or 120% of the 95th percentile in age and sex matched growth chart) or greater and a clinically serious condition related to obesity (e.g. type 2 diabetes, obstructive sleep apnea, non-alcoholic steatohepatitis, pseudotumor cerebri, Blount disease, slipped capital femoral epiphysis
5. adult patient has BMI of thirty (30) or greater with type 2 diabetes mellitus with inadequately controlled hyperglycemia despite optimal medical treatment (e.g. oral medication, insulin)
6. as outlined in the *Medical Management Administrator's medical necessity* criteria in use at the time of a morbid obesity *surgical procedure*

Network

An arrangement under which services are provided to *plan participants* through a select group of *providers*.

No Fault Auto Insurance

The basic preparations provision of a law providing for payments without determining fault in connection with automobile *accidents*.

Non-Network

Services rendered by a non-participating *provider* within the designated *network* area.

Notice/Notify/Notification

The terms notice, notify, or notification refer to the delivery or furnishing of information to a *claimant* as required by federal law.

Other Plan

Other plan shall include but is not limited to:

1. any primary payer besides the *Plan*
2. any other group health plan
3. any other coverage or policy covering the *plan participant*
4. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage
5. any policy of insurance from any insurance company or guarantor of a responsible party
6. any policy of insurance from any insurance company or guarantor of a third party
7. Workers' Compensation or other liability insurance company
8. any other source, including but not limited to crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payment

Out-of-Pocket Limit

A *Plan's* limit on the amount a *plan participant* must pay out of their own pocket for medical expenses incurred during a *benefit year*. Out-of-pocket limits accumulate on an individual, family, or combined basis. After a *plan participant* reaches the out-of-pocket limit, the *Plan* pays benefits at a higher rate.

Outpatient Care and/or Services

Treatment including services, supplies, and medicines provided and used at a *hospital* under the direction of a *physician* to a person not admitted as a registered bed patient; or services rendered in a *physician's* office, laboratory or x-ray facility, an a*mbulatory surgical center*, or the patient's home.

A licensed establishment where covered *prescription drugs* are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Participating Entity

Means a group or *employer* which or whom participates in the Arizona Metropolitan Trust.

Patient Protection and Affordable Care Act of 2010 (PPACA)

The Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Jointly, these laws are referred to as PPACA.

Pharmacy

A licensed establishment where covered *prescription drugs* are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician

A Certified Nurse First Assist (CRNFA), Certified Nurse Midwife, Certified Registered Nurse Anesthetist (CRNA), Doctor of Chiropractic (D.C.), Doctor of Dental Surgery (D.D.S.), Doctor of Medical Dentistry (D.M.D.), Doctor of Medicine (M.D.), Doctor of Optometry (O.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), First Assist (FA), Licensed clinical social worker, Licensed independent substance use disorder counselor, Licensed marriage and family therapist, Licensed nurse practitioner (L.P.N), Licensed professional counselor, Physician Assistant (PA), Psychologist (Ph.D., Ed.D. and Psy.D.), Perfusionist, Registered Dietician, Registered Nurse First Assist (RNFA), Speech, occupational or physical therapist, or Surgical Assist (SA); who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license, unless specifically excluded herein.

Plan

Arizona Metropolitan Trust, which is a benefits Plan for eligible *employees* of *participating entities* and is described in this document. Arizona Metropolitan Trust is a distinct entity, separate from the legal entity that is your *employer*.

Plan Administrator

Arizona Metropolitan Trust which exercises all discretionary authority and control over the administration of the *Plan* and the management and disposition of *Plan* assets.

Plan Participant

Any *employee* or *dependent* that is covered under this *Plan*.

Plan Sponsor

Buckeye Valley Fire District, City of Apache Junction, City of El Mirage, Litchfield Park, Sun City Fire, Town of Fountain Hills, Town of Paradise Valley, Town of Wickenburg, or Town of Youngtown.

Plan Year

The twelve (12) month period beginning on the effective date of the *Plan*.

Post-Service Claim

Any *claim* for a benefit under the *Plan* related to care or treatment that the *plan participant* or beneficiary has already received.

Pre-Certification/Pre-Certified/Pre-Certify

An evaluation conducted by a *Medical Management Administrator* through the **Health Care Management Program** to determine the *medical necessity* and reasonableness of a *plan participant's* course of treatment.

Pregnancy

Childbirth and conditions associated with pregnancy, including complications.

Prescription Drug

Any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed *physician*. Such drug must be *medically necessary* in the treatment of a *sickness* or *injury*.

Pre-Service Claim

Any *claim* that requires *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan*. For example, a request for *pre-certification* under the **Health Care Management Program** is a pre-service claim.

Preventive Care

Certain preventive services mandated under the *Patient Protection and Affordable Care Act (PPACA)* which are available without *cost sharing amounts* when received from a *network provider*. To comply with *PPACA*, and in accordance with the recommendations and guidelines, the *Plan* will provide *network* coverage for:

1. evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations
2. recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention
3. comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA)
4. comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA)

Copies of the recommendations and guidelines may be found here: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.** For more information, you may contact the *Plan Administrator/employer* as outlined in the Quick Reference Information Chart.

Primary Care Provider/Physician (PCP)

A health care professional who generally specializes in or focuses on the following practice areas: internal medicine, family practice, general practice, obstetrics and/or gynecology, pediatrics, or any other classification of *provider* approved as a PCP. This *Plan* does not require you to have a PCP or to have a PCP authorize *specialist* referrals.

Prior Plan

The coverage provided on a group or group type basis by the group insurance policy, benefit plan, or service plan that was terminated on the day before the effective date of the *Plan* and replaced by the *Plan*.

Privacy Standards

The standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

Provider

Eligible providers include the properly licensed, certified, or registered providers listed below, when acting within the scope of their practice.

Professional	Facility Ancillary
• Certified Nurse First Assist (CRNFA) • Certified Nurse Midwife • Certified Registered Nurse Anesthetist (CRNA) • Doctor of Chiropractic (D.C.) • Doctor of Dental Surgery (D.D.S.) • Doctor of Medical Dentistry (D.M.D.) • Doctor of Medicine (M.D.) • Doctor of Optometry (O.D.) • Doctor of Osteopathy (D.O.) • Doctor of Podiatry (D.P.M.) • First Assist (FA) • Licensed Clinical Social Worker (L.C.S.W.) • Licensed Independent Substance Use Disorder Counselor • Licensed Marriage and Family Therapist • Licensed Nurse Practitioner (L.N.P.) • Licensed Professional Counselor • Physician Assistant (PA) • Psychologist (Ph.D., Ed.D. and Psy.D.) • Perfusionist • Registered Dietician • Registered Nurse First Assist (RNFA) • Speech, Occupational, or Physical Therapist • Surgical Assist (SA) • Surgical Technician (ST)	• Ambulance • Ambulatory Surgical Center (ASC) • Audiology Center • Birthing Center • Clinical Laboratory • Diagnostic Radiology • Dialysis Center • Durable Medical Equipment (DME) • Extended Active Rehabilitation (EAR) • Home Health Agency (HHA) • Home Infusion Therapy • Hospice • Hospital, Acute Care • Hospital, Long Term Acute Care (LTAC) • Hospital, Psychiatric • Orthotics/Prosthetics • Rehabilitation Treatment Centers (Substance Use Disorder Centers) • Retail, Mail Order, and Specialty Pharmacies • Skilled Nursing Facility • Specialty Laboratory • Sleep Lab • Urgent Care

Psychiatric Day Treatment Facility

A public or private facility, licensed and operated according to the law, which provides: treatment for all its patients for not more than eight (8) hours in any twenty-four (24) hour period; a structured psychiatric program based on an individualized treatment plan that includes specific attainable goals and objectives appropriate for the patient; and supervision by a *physician* certified in psychiatry by the American Board of Psychiatry and Neurology.

The facility must be accredited by the Program for Psychiatric Facilities or the Joint Commission on Accreditation of Hospitals.

Qualified Individual

An individual who is a covered participant or beneficiary in this *Plan* and who meets the following conditions:

1. the individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening *disease* or condition; and
2. either:
    a. The referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.
    b. The *participant* or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.

Qualified Medical Child Support Order (QMCSO)

A *Medical Child Support Order* that creates or recognizes the existence of an *alternate recipient's* right to, or assigns to an *alternate recipient* the right to, receive benefits for which a *plan participant* or eligible *dependent* is entitled under this *Plan*.

Qualifying Event

As referenced in the section entitled **Continuation Coverage Rights Under COBRA**.

Reasonable

In the *Plan Administrator's* discretion, services, supplies, or fees for services or supplies which are necessary for the care and treatment of *illness* or *injury* not caused by the treating *provider*. Determination that fee(s) or services are reasonable will be made by the *Plan Administrator*, taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of *injury* or *illness* necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities:

1. The National Medical Associations, Societies, and organizations
2. The Food and Drug Administration

To be reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care, and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The *Plan Administrator* retains discretionary authority to determine whether service(s) and/or fee(s) are reasonable based upon information presented to the *Plan Administrator*. A finding of *provider* negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not reasonable.

Charge(s) and/or services are not considered to be reasonable, and as such are not eligible for payment (exceed the *maximum allowable charge*), when they result from *provider* error(s) and/or facility-acquired conditions deemed reasonably preventable through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The *Plan* reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the *Plan*, to identify charge(s) and/or service(s) that are not reasonable and therefore not eligible for payment by the *Plan*.

Reconstructive/Reconstruction

Procedures are considered reconstructive when intended to address a significant variation from normal related to accidental *injury*, *disease*, trauma, treatment of a *disease*, or a congenital defect.

Rehabilitation Hospital

An *institution* which mainly provides therapeutic and restorative services to *ill* or *injured* people. It is recognized as such if:

1. It carries out its stated purpose under all relevant federal, state, and local laws.
2. It is accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities.

Residential Treatment Center/Facility

A provider licensed and operated as required by law, which includes:

1. room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with twenty-four (24) hour availability
2. a staff with one (1) or more doctors available at all times
3. residential treatment takes place in a structured facility-based setting
4. the resources and programming to adequately diagnose, care, and treat a psychiatric and/or substance use disorder
5. facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care

6. is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

The term residential treatment center/facility does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. custodial care
6. educational care

Room and Board

A *hospital's* charge for any of the following:

1. room and linen service
2. dietary service, including meals, special diets, and nourishment
3. general nursing service
4. other conditions of occupancy which are *medically necessary*

Security Standards

The final rule implementing HIPAA's security standards for the Protection of Electronic PHI, as amended.

Sickness

See *illness*.

Skilled Nursing Care

Those services, furnished pursuant to physician orders, which meets **all** of the following:

1. require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists
2. must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the individual and to achieve the medically desired result
3. are not custodial in nature

Skilled Nursing Facility

A facility that fully meets **all** of these tests:

1. It is licensed to provide professional nursing services on an *inpatient* basis to persons recovering from *injury* or *sickness*. The service must be rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a R.N. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a *physician*.
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time R.N.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, *custodial care*, or educational care.

This term also applies to charges incurred in a facility referring to itself as an extended acute rehabilitation facility, long-term *acute care* facility, or any other similar nomenclature.

Specialist

Either a *physician* or other health care professional who practices in a specific area other than those practiced by *primary care providers*, or a properly licensed, certified, or registered individual health care *provider* whose practice is limited to rendering mental health services. This definition of specialist does not apply to *dentists*. This *Plan* does not require you to obtain a referral to see a specialist.

Spinal Manipulation/Chiropractic Care

Skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a *physician* to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Substance Use Disorder

The DSM-5 definition is applied as follows: Substance use disorder describes a problematic pattern of using alcohol or another substance (whether obtained legally or illegally) that results in impairment in daily life or noticeable distress. An individual must display two (2) of the following eleven (11) symptoms within twelve (12) months:

1. consuming more alcohol or other substance than originally planned
2. worrying about stopping or consistently failed efforts to control one's use
3. spending a large amount of time using drugs/alcohol, or doing whatever is needed to obtain them
4. use of the substance results in failure to fulfill major role obligations such as at home, work, or school
5. craving the substance (alcohol or drug)
6. continuing the use of a substance despite health problems caused or worsened by it

   This can be in the domain of mental health (psychological problems may include depressed mood, sleep disturbance, anxiety, or blackouts) or physical health.
7. continuing the use of a substance despite its having negative effects in relationships with others (for example, using even though it leads to fights or despite people's objecting to it)
8. repeated use of the substance in a dangerous situation (for example, when having to operate heavy machinery, when driving a car)
9. giving up or reducing activities in a person's life because of the drug/alcohol use
10. building up a tolerance to the alcohol or drug

    Tolerance is defined by the DSM-5 as either needing to use noticeably larger amounts over time to get the desired effect or noticing less of an effect over time after repeated use of the same amount.
11. experiencing withdrawal symptoms after stopping use

    Withdrawal symptoms typically include, according to the DSM-5: anxiety, irritability, fatigue, nausea/vomiting, hand tremor, or seizure in the case of alcohol.

Substance Use Disorder/Mental Health Treatment Center

An *institution* which provides a program for the treatment of *substance use disorder* by means of a written treatment plan approved and monitored by a *physician*. This *institution* must be at least one (1) of the following:

1. affiliated with a *hospital* under a contractual agreement with an established system for patient referral
2. accredited as such a facility by the Joint Commission or CARF
3. licensed, certified or approved as an alcohol or substance use disorder treatment program or center, psychiatric hospital, or facility for mental health by a state agency having legal authority to do so
4. is a facility operating primarily for the treatment of substance use disorder and meets these tests:
   a. maintains permanent and full-time facilities for bed care and full-time confinement of at least twenty-four (24) hour-per-day nursing service by a registered nurse (R.N.)
   b. has a full-time psychiatrist or psychologist on the staff
   c. is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of *substance use disorder*

Surgery/Surgical Procedure

Any of the following:

1. the incision, excision, debridement, or cauterization of any organ or part of the body, and the suturing of a wound
2. the manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction
3. the removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body
4. the induction of artificial pneumothorax and the injection of sclerosing solutions
5. arthrodesis, paracentesis, arthrocentesis, and all injections into the joints or bursa
6. obstetrical delivery and dilatation and curettage
7. biopsy
8. surgical injection

Temporomandibular Joint (TMJ)

Temporomandibular Joint (TMJ) Syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves, and other tissues related to the temporomandibular joint.

Third Party Administrator

AmeriBen has been hired as the Third Party Administrator by the *Plan Administrator* to perform *claims* processing and other specified administrative services in relation to the *Plan*. The Third Party Administrator is not an insurer of health benefits under this *Plan*, is not a fiduciary of the *Plan*, and does not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator*. The Third Party Administrator is not responsible for *Plan* financing and does not guarantee the availability of benefits under this *Plan*.

Timely Payment

As referenced in the section entitled **Continuation Coverage Rights Under COBRA**. Timely payment means a payment made no later than thirty (30) days after the first day of the coverage period.

Total Disability (Totally Disabled)

In the case of a *dependent* child, the complete inability as a result of *injury* or *sickness* to perform the normal activities of a person of like age and sex in good health.

Uniformed Services

The Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

Urgent Care Claim

Any *claim* for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health, or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*. Whether a *claim* is an urgent care claim will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. However, any *claim* that a *physician* with knowledge of the *claimant's* medical condition determines is an urgent care claim as described herein shall be treated as an urgent care claim under the *Plan*. Urgent care claims are a subset of *pre-service claims*.

Urgent Care Facility

A free-standing facility, regardless of its name, at which a *physician* is in attendance at all times that the facility is open, that is engaged primarily in providing minor emergency and episodic medical care to a participant.

Usual and Customary Charge

Covered charges which are identified by the *Plan Administrator*, taking into consideration the fee(s) which the *provider* most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the *provider* for providing the services, the prevailing range of fees charged in the same 'area' by *providers* of similar training and experience for the service or supply, and the *Medicare* reimbursement rates. The term(s) 'same geographic locale' and/or 'area' shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of *providers*, persons, or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be usual and customary and/or reasonable, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term 'usual' refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, *pharmacies*, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was *incurred*.

The term 'customary' refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one (1) individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age, and who has received such services or supplies within the same geographic locale.

The term 'usual and customary' does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a *plan participant* by a *provider* of services or supplies, such as a *physician*, therapist, nurse, *hospital*, or pharmacist. The *Plan Administrator* will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service, or supply is customary.

The *Plan Administrator* has the discretionary authority to decide whether a charge is usual and customary and/or reasonable.

Walk-In Clinic

A medical establishment which is managed by several *providers* working in cooperation and sharing the same facilities.

SECTION XXI—PLAN ADOPTION

A. Severability

In the event that any provision of this document is held by a court of competent jurisdiction to be excessive in scope or otherwise invalid or unenforceable, such provision shall be adjusted rather than voided, if possible, so that it is enforceable to the maximum extent possible, and the validity and enforceability of the remaining provisions of this document will not in any way be affected or impaired thereby.

B. Adoption

Arizona Metropolitan Trust, hereby adopts the provisions of this *Plan*, and its duly authorized officer has executed this HDHP Plan Document and Summary Plan Description effective the first day of July 2024.

By: _____ Date: _____

Title: _____

If you have questions about your *Plan* benefits,
please contact the *Third Party Administrator* at
1-855-350-8699

P.O. Box 7186
Boise ID 83707