The Cochise Combined Trust

Plan Document
and Summary Plan Description

Exclusive Provider Organization (EPO) Plan

Buy-Up Exclusive Provider Organization (Buy-Up EPO) Plan

High Deductible Health Plan (HDHP)

Amended and Restated Effective
July 1, 2023

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SECTION I—INTRODUCTION

The COCHISE COMBINED TRUST, hereinafter called the *Plan*, assures the *plan participants*, during the continuance of this *Plan*, that all benefits hereinafter described shall be paid to them or on their behalf in the event the *plan participant incurs covered charges* as defined herein. The HDHP is designed to be used with a *health savings account (HSA)*, while the EPO and EPO Buy-Up are not designed to be used with a *health savings account (HSA)*. 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.

This *Plan* is subject to all the terms, provisions, conditions, and limitations stated on the pages hereof.

This revised *Plan* of benefits for the Cochise Combined Trust is effective as of July 1, 2023. 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**.

Your benefit *Plan* has been designed with many cost containment features to ensure that coverage can continue to be provided to you at a reasonable cost. You can assist in controlling costs by using this *Plan* and medical services responsibly and effectively. Some of the ways you can help are:

1. receive approval from the *Medical Review Administrator* prior to receiving services that require *pre-certification*
2. receive care from a provider in the *network* to maximize your benefits
3. have *surgery* and x-ray/laboratory work done on an *outpatient* basis whenever possible
4. use *hospital* emergency rooms only in the event of a serious *medical emergency*
5. audit all *hospital* and *physician* billings and the *Explanation of Benefits (EOB)* to be sure you and the *Plan* have only been billed for the services you received

IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR COVERAGE

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

A referral from a *network* provider to any *non-network* provider (i.e., laboratory, radiology, *physician*, etc.) does NOT make the *claim* from the *non-network* provider payable at the *network* rate.

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* 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.

Your Human Resources Department or Personnel Office and the *Plan's Third Party Administrator* are available to answer questions and assist you in exploring options for coverage, but ultimately it is your responsibility to understand this *Plan*.

A *plan participant* should contact the *Plan Administrator* to obtain additional information, free of charge, about *Plan* coverage of a specific benefit, particular drug, treatment, test, or any other aspect of *Plan* benefits or requirements.

TAKE CARE OF YOURSELF. Eat right, control your weight, exercise, stop smoking, never drink and drive, and always wear your seat belt. Good habits will help you live a long, happy life and will save you money too!

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 Chart:

QUICK REFERENCE INFORMATION	
Information Needed	Whom to Contact
Plan Administrator • Second-Level *Appeals* of *Post-Service Claims*	Cochise Combined Trust c/o Gallagher Benefit Services 333 E. Osborn Rd. Suite 270 Phoenix, AZ 85012 (928) 391-2296 **www.CCTBenefits.org**
Medical Claims Administrator/Third Party Administrator & COBRA Administrator *(Medical,* COBRA, & *Short Term Disability)* • Claim Forms (Medical) • Medical Claims • First Level *Appeals* of Post-Service *Claims* • Eligibility for Coverage • Plan Benefit Information • Continuation Coverage	**Medical** AmeriBen P.O. Box 7186 Boise, ID 83707 (855) 258-6455 **www.MyAmeriBen.com** **COBRA** AmeriBen P.O. Box 7565 Boise, ID 83707 Phone: (855) 258-6455 Fax: (208) 424-0595
Medical Review Administrator *(Pre-certification, Second Opinions)* • Pre-Certification, Concurrent Review, and Case Management • First Level Appeals of Pre-*Service Claims*	AmeriBen Medical Management P.O. Box 7186 Boise, ID 83707 (800) 388-3193
EPO/PPO Provider Network *(Names of Physicians & Hospitals)* • Network Provider Directory – see website	BlueCross® BlueShield® of Arizona P.O. Box 13466 Phoenix, AZ 85002 (800) 232-2345 **www.azblue.com/CHSnetwork**
Out-of-Area Provider Network Available to participants living or traveling outside AZ	PHCS Healthy Directions (800) 678-7427 **www.multiplan.com/search**
Employee Assistance Program (EAP) • EAP Counseling and Referral Services	SupportLinc (800) 490-1585 **www.SupportLinc.com**
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, LLC 5 Innovation Court Appleton, WI 54914 (866) 333-2757 **www.navitus.com** **Mail Order** Costco Pharmacy Mail Order 802 134th St. SW, Ste 140 Everett, WA 98204 (800) 607-6861 www.costco.com/pharmacy/home-delivery
Health Savings Account (HSA) • Health Savings Account Administration • On-Line Tools	HealthEquity (866) 346-5800 **www.healthequity.com/home**
Plan Consultant and Privacy Officer	Gallagher Benefit Services 333 E Osborn Rd. Suite 270 Phoenix, AZ 85012 (928) 391-2296

B. Plan is Not an Employment Contract

The *Plan* is not to be construed as a contract for or of employment.

C. Plan Administrator

The *employer* is the *Plan Administrator*. The name, address, and telephone number of the *Plan Administrator* are:

Cochise Combined Trust
c/o Gallagher Benefit Services
333 E Osborn Rd., Suite 270
Phoenix, AZ 85012
(928) 391-2296

The *Plan* is administered by the *Plan Administrator* in accordance with these provisions. An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* shall appoint a new *Plan Administrator* as soon as reasonably possible.

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 (including the determination of what services, supplies, care, and treatments are *experimental*), 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* as to the facts related to any *claim* for benefits and the meaning and intent of any provision of the *Plan*, or its application to any *claim*, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this *Plan* will be paid only if the *Plan Administrator* decides, in its discretion, that the *plan participant* is entitled to them.

Service of legal process may be made upon the *Plan Administrator*.

D. 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

E. 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 (if any).

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.

If 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. If 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*.

F. Plan Administrator Compensation

The *Plan Administrator* serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the *Plan*.

G. 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.

H. Plan Name

The name of the *Plan* is the Cochise Combined Trust.

I. Type of Plan

The *Plan* is established pursuant to Arizona Revised Statute Section 11-952.01 as an employee benefit trust, and therefore, is exempt from the Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA.

J. Plan Year

The *plan year* is the twelve (12) month period beginning July 1 and ending June 30.

K. Plan Effective Date

July 1, 2023

L. Trustees

The Cochise Combined Board of Trustees
c/o Gallagher Benefit Services
333 E. Osborn Rd., Suite 270
Phoenix, AZ 85012(928) 391-2296

M. Plan Sponsor

The *employer* is the *Plan Sponsor*.

N. 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
(855) 258-6455

A *Third Party Administrator* is **not** a fiduciary under the *Plan*.

O. Trust's Right to Terminate

The Trust reserves the right to amend or terminate this *Plan* at any time. Although the Trust currently intends to continue this *Plan*, the Trust 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 Trust will sign the documents with respect to such amendment or termination.

SECTION II—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 provided by *non-network* providers or facility
2. covered 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*.

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 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.

PPO Plans - 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.

EPO Plans - However, 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, you will be responsible for all charges

Non-Network Services Provided at a Network Facility

PPO Plans - 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.

EPO Plans - When you receive covered services from a *non-network* provider at a *network* facility, your *claims* will not be covered 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 all *non-network* charges for those services.

All Plans - This requirement does not apply to ancillary services. Ancillary services are the following 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 no 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-shares, 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 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 median plan *network* contract rate 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 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*.

D. Appeals

If you receive emergency services from a *non-network* provider or covered services from a *non-network* provider at a *network* facility and believe those services are covered by 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 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

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):

1. 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.

The *network* and/or the *Third Party Administrator*, either through the price comparison/shoppable services tool(s) associated with you *Plan* or through Member Services at the phone number on the back of you ID card you can receive 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 a *non-network* provider's services based on the *network's* reasonable estimate based on what the *network* would pay a *non-network* provider 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 its 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 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. 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 III—ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

A. Eligible Classes of Employees

All benefit eligible positions as determined by the participating *employer* of the Cochise Combined Trust, provided the *employee* regularly works a minimum of twenty (20) hours per week at their customary place of employment and performs all of the duties of their employment.

The minimum hourly work week requirement does not have to be met to be eligible for benefits under this *Plan* by *employees* of a school who is a member entity of CCT during those weeks that school is not in session due to Official School Breaks. These school *employees*, must, however, comply with the minimum hourly work week requirement at all other times to be eligible for benefits under this *Plan*.

Eligibility Requirements for Employee Coverage - Cochise College

1. All new *employees* will be eligible for coverage on the first day of *active employment* on the month following Governing Board approval of hire.
2. All new Governing Board members will be eligible for coverage on the first day of the month following the date of taking office.

Coverage will be effective provided proper enrollment has been made and any required contributions have been authorized.

Eligibility Requirements for Employee Coverage – Central Arizona College

1. All new *employees* will be eligible for coverage on the first day of *active employment* on the month following Governing Board approval of hire.
2. All new Governing Board members will be eligible for coverage on the first day of the month following the date of taking office.

Coverage will be effective provided proper enrollment has been made and any required contributions have been authorized.

Eligibility Requirements for Employee Coverage - Cochise County

All new *employees* will be eligible for coverage on the first day of the month following the date of *active employment*.

Active Employee Requirement

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

Effective Date of Employee Coverage - Cochise College

1. An *employee* will be covered under this *Plan* as of the first day of *active employment* on the month following Governing Board approval of hire.
2. A Governing Board member will be covered under this *Plan* on the first day of the month following the date of taking office.

Coverage will be effective provided proper enrollment has been made and any required contributions have been authorized.

The minimum hourly work week requirement does not have to be met to be eligible for benefits under this *Plan* by *employees* of a school who is a member entity of CCT during those weeks that school is not in session due to official school breaks. These school *employees*, must, however, comply with the minimum hourly work week requirement at all other times to be eligible for benefits under this *Plan*.

Effective Date of Employee Coverage – Central Arizona College

1. An *employee* will be covered under this *Plan* as of the first day of *active employment* on the month following Governing Board approval of hire.
2. A Governing Board member will be covered under this *Plan* on the first day of the month following the date of taking office.

Coverage will be effective provided proper enrollment has been made and any required contributions have been authorized.

The minimum hourly work week requirement does not have to be met to be eligible for benefits under this *Plan* by *employees* of a school who is a member entity of CCT during those weeks that school is not in session due to official school breaks. These school *employees*, must, however, comply with the minimum hourly work week requirement at all other times to be eligible for benefits under this *Plan*.

Effective Date of Employee Coverage - Cochise County

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*

B. Eligible Retirees - Cochise College

A covered Cochise College *employee* will be eligible to continue coverage under this *Plan** as a *retiree* until the earlier of eligibility for *Medicare* or until the age of sixty-five (65) provided either:

1. the *employee* is fifty-five (55) years of age and has met the terms and conditions of regular retirement with the Arizona State Retirement System and has completed ten (10) consecutive years of benefit eligible employment with Cochise College immediately prior to retirement
2. the *employee* has eighty (80) points of age and credited service with the Arizona Retirement System and has completed ten (10) consecutive years of benefit eligible employment with Cochise College immediately prior to retirement

The *retiree* must also continue to make all required contributions to cover the full cost of coverage for the *retiree* and any eligible *dependents*.

*Cochise College *retirees* are eligible for the EPO and HDHP options only; the Buy-Up EPO option is unavailable.

C. Eligible Retirees – Central Arizona College

A Central Arizona College employee with ten (10) years of consecutive service and a fulltime start date prior to January 1, 1996 who opts for retirement under Arizona State Retirement System (ASRS) or the Public Safety Personnel Retirement System (PSPRS) and has not reached age sixty-five (65), may be eligible to participate in the work agreement program.

1. Participation in this program is limited to employees who voluntarily leave employment with the College. An employee whose employment is terminated for cause is not eligible for participation.
2. Eligible employees who elect to participate in the work agreement program must work at least eight (8) clock hours in a fiscal year. The Talent Development department will coordinate the issuance of work agreements.
3. The College will pay premiums for the employee medical, dental, vision and group life insurance during the period the employee is in the work agreement program. Retiree dependents are not eligible for benefit coverage.
4. If during the course of participation in the work agreement program the retiree becomes benefits eligible from any other employer, the retiree must immediately notify the College. The retiree is no longer eligible for the program and will be terminated from the College's insurance plans.
5. the *employee* has ten (10) years of consecutive service and start date prior to January 1, 1996.

The *retiree* must also continue to make all required contributions to cover the full cost of coverage for the *retiree*.

*Central Arizona College *retirees* are eligible for the EPO, EPO Buy-up and HDHP options.

D. Eligible Retirees - Cochise County

A covered Cochise County *employee* will be eligible to continue coverage under this *Plan* as a *retiree* until the earlier of eligibility for *Medicare* or until the age of sixty-five (65) provided he or she meets all of the following:

1. The *retiree* has completed no less than fifteen (15) consecutive and continuous years of employment with Cochise County in a position that was eligible for medical benefits coverage under the *Plan* on the effective date of retirement.
2. The *retiree* has met all the terms and conditions for eligibility for retirement from Cochise County and the Arizona Public Employee Retirement System which applies to them (i.e., ASRS, PSPRS, EORP, or CORP) (the Applicable Retirement System) and have in fact actually retired under the Applicable Retirement System.
3. The *retiree* is actually receiving, and continues to receive, pension benefits from the Applicable Retirement System beginning from the effective date of retirement from Cochise County.
4. The *retiree*, either as a *retiree* or as a *dependent* of a non-retired and active Cochise County *employee*, remains on the *Plan* continually without a break in coverage from the effective date of retirement.
5. The *retiree* makes the required *retiree* contributions to receive benefits as a *retiree* by the fifteenth (15th) of the month or the active *employee* pays the required contributions for *dependent* coverage, whichever is applicable. Failure to remit payment by the due date will result in cancellation of coverage without notice.
6. The *retiree* signs the required form to waive COBRA coverage.

If the *retiree* is obtaining medical benefits under the *Plan* as a *retiree* only, and not as a *retiree* obtaining benefits as a *dependent* of a non-retired and active Cochise County *employee*, the following *dependent* coverage eligibility applies:

a. A *dependent* spouse of a Cochise County *retiree* is eligible to continue their coverage as a *dependent* of the *Plan* provided they were covered on the date the covered *employee* became a *retiree*. Coverage will be provided through the earlier of the date the spouse of the *retiree* dies, reaches *Medicare* eligibility or the age of sixty five (65), as long as both of the following are met:
    i. as long as the spouse of the *retiree* continues to meet all other provisions of the County Medical plan pertaining to eligibility for *dependent* coverage
    ii. the *retiree* or spouse continues to make the required contributions in a timely manner as determined by the County's medical plan provider
b. Dependent children of Cochise County *retirees* are eligible to continue their coverage as *dependents* after their County *employee* parent(s) retire provided both of the following are met:
    i. they were covered as *dependent* children on the date of the covered *employee's* retirement as provided herein through the earlier of the date the child of the *retiree* dies, becomes *Medicare* eligible or otherwise no longer qualifies as a *dependent* child under the provisions of this *Plan* that are applicable to the *dependent* children of *employees*
    ii. the *retiree* or child continues to make the required contributions in a timely manner as determined by the County's medical plan provider
c. If a *retiree's dependent* spouse or *dependent* child(ren) terminates coverage for any reason, coverage cannot be reinstated at a later date.

Dependents of a covered *retiree* are eligible for coverage provided they were covered *dependents* of this *Plan* immediately prior to the date of the covered *employee's* retirement, or who qualify for addition to the *Plan* under applicable provisions of the Federal *Health Insurance Portability and Accountability Act (HIPAA)*. If a *retiree's* coverage terminates for any reason, coverage cannot be reinstated at a later date.

E. Eligible Classes of Dependents, excluding Central Arizona College Retirees

Eligible *dependents* shall include a covered *employee's* or a covered *retiree's*:

1. lawful spouse to whom the covered *employee* is married pursuant to and as permitted by Arizona law, provided they are not legally separated
2. natural born children, stepchildren, eligible *foster children*, and legally adopted children (from the date of placement in the *employee's* home for the purpose of 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. Coverage will end on the last day of the month in which the child reaches the applicable limiting age.

   The term eligible *foster child* means an individual who is placed with the covered *employee* by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.
3. any child for whom the covered *employee* has obtained legal guardianship

   Coverage will remain in effect until as shown within the timeframe shown in the Qualifying Events Chart subsection, regardless of any applicable age of emancipation of minors resulting in the covered *employee* no longer being considered such child's *legal guardian*.

Note: *Dependent* eligibility under this *Plan* may be different than the definition of a qualified *dependent* by the IRS; therefore, coverage for certain *dependents* may be subject to taxation.

Disabled Dependents

An unmarried child who has reached the specified age limit will continue to be eligible if:

1. the child is incapable of self-support due to a mental or physical disability
2. the child became disabled prior to the attainment of age twenty-six (26)
3. the *Plan* is provided with proof of the child's disability and continued dependency within thirty-one (31) days prior to termination of the child's *dependent* status

   NOTE: This does not apply to newly hired *employees*

The *Plan* will require the covered *employee* to obtain a *physician's* statement certifying the physical or mental disability prior to approval and every two (2) years following the *dependent's* reaching the limiting age as continuing proof of the *dependent's total disability*.

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 and any required contributions have been authorized.

Ineligible Dependents

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 person who is on active duty in any military service of any country
4. a person who is covered as an *employee* under the *Plan*
5. any other person not defined above in the subsection entitled Eligible Classes of Dependents

Restrictions on Elections

An *employee* may not be covered under this *Plan* as both an *employee* and as a *dependent*.

If both spouses and/or parents are *employees*, their children will be covered as *dependents* of one (1) *employee*, but not of both.

An *employee* may not enroll their *dependents* without enrolling themselves in the *Plan*.

Eligibility Requirements for Dependent Coverage

A *dependent* of an *employee* will become eligible for *dependent* coverage on the first day that the *employee* is eligible for *employee* coverage and the family member satisfies the requirements for *dependent* coverage.

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

F. Change of Status

If the *plan participant* has any of the following qualifying change of status situations during the year, the *plan participant* will be allowed to make a mid-year change in their coverage selections and change who is covered under the medical coverage:

1. Change in legal marital status: Marriage, divorce, legal separation, annulment, or death of spouse.
2. Change in the number of dependents: Birth, adoption, or death of *dependent* child.
3. Change in employment status or work schedule: Start or termination of employment or change in employment status of the *employee*, their spouse or their *dependent* child.
4. Change in *dependent* status under the terms of this *Plan*: Age, or any other reason provided under the definition of an eligible *dependent*.
5. Change of residence or worksite: If the change impairs the *plan participant's* ability to access the services of *network* providers.
6. Change required under the terms of a *Qualified Medical Child Support Order (QMCSO)*.
7. Increase to the *employee* in the cost of the benefits.
8. Significant changes in the benefits.
9. Changes in employer coverage of a spouse, former spouse, or *dependent*.

Two (2) rules apply to making changes to the benefit selections during the year. If both rules are not met, the eligible *employee* or *dependent* will have to wait until the next *open enrollment period* to make any change in the coverage:

a. any changes to be made to the benefit selections must be necessary, appropriate to and consistent with the change in status, and approved as such by the *Plan Administrator* or its designee

b. the *Plan* must be notified in writing as shown within the timeframe shown in the Qualifying Events Chart subsection

G. Enrollment

Enrollment Requirements

An *employee* must enroll for coverage for himself or herself and any eligible *dependents* by completing the enrollment process along with the appropriate payroll deduction authorization.

Enrollment Requirements for Newborn Children

A newborn child will be automatically enrolled for thirty-one (31) days from birth. In order for coverage to continue, a covered *employee* must complete an enrollment application within the timeframe shown in the Qualifying Events Chart subsection.

If the newborn child (and mother/covered parent) is not enrolled in this *Plan* on a timely basis, there will be no payment from the *Plan* beyond the initial thirty-one (31) days from birth. The covered parent will be responsible for all further costs and will have to wait until the next *open enrollment period* to add the child as a *dependent*.

H. 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 initially becomes eligible for coverage, or within the timeframe shown in the Qualifying Events Chart subsection, for each type of special enrollment period.

Late Enrollment

An enrollment is late if it is not made on a timely basis or during a special enrollment period.

Employees and *dependents* that do not enroll for coverage within thirty-one (31) days of their eligibility date are called *late enrollees*. If an *employee* does not enroll themselves or their *dependents* within the thirty-one (31) days following their initial eligibility date, they cannot enroll in this *Plan* until the next *open enrollment period*. Excluded from this provision are certain qualified family status changes (as stated in the Special Enrollment Period subsection) if enrollment is made within thirty-one (31) days of the event.

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*.

I. Special Enrollment Rights

Federal law provides special enrollment provisions under some circumstances. If an *employee* is declining enrollment for themselves or their *dependents* (including a 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 *employee* stops contributing towards the other coverage). However, a request for enrollment must be made within the timeframe shown in the Qualifying Events Chart subsection after the coverage ends (or after the *employer* stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this *Plan*. However, a request for enrollment must be made within the timeframe shown in the Qualifying Events Chart subsection.

The special enrollment rules are described in more detail below. To request special enrollment or obtain more detailed information of these portability provisions, contact the *Plan Sponsor*.

J. Special Enrollment Periods

The *enrollment date* for anyone who enrolls under a special enrollment period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the *Plan* and the first day of coverage is not treated as a *waiting period*.

1. **Individuals Losing Other Coverage Creating a Special Enrollment Right**

   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 shown within the timeframe shown in the Qualifying Events Chart subsection. Failure to enroll under this Special Enrollment provision means you must follow the Open Enrollment or Late Enrollment provisions to enroll in this *Plan*.

2. **Special Enrollments for a Newly Acquired Spouse or Dependent Child**

   When the following criteria are met, then the *dependent* (and if not otherwise enrolled, the *employee*) may be enrolled under this *Plan*:

   a. If there are no eligible *dependents* when the *employee's* coverage begins, the *employee* can enroll a newly acquired spouse by marriage, or child by birth or adoption, and/or any *dependent* children as shown within the timeframe shown in the Qualifying Events Chart subsection.

   b. If the *employee* is not enrolled in the *Plan* and then acquires an eligible *dependent* by marriage, birth, or adoption, the *employee* can enroll themselves and/or any eligible *dependent* as shown within the timeframe shown in the Qualifying Events Chart subsection.

   c. If the *employee* did not enroll their spouse when the spouse was initially eligible for coverage and the *employee* subsequently acquires an eligible *dependent* child, the spouse may be enrolled along with any *dependent* child as shown within the timeframe shown in the Qualifying Events Chart subsection.

   The special enrollment period for *dependents* is as shown within the timeframe shown in the Qualifying Events Chart subsection. To be eligible for this special enrollment, the *dependent* and/or *employee* must request enrollment as shown within the timeframe shown in the Qualifying Events Chart subsection.

3. The coverage of the *dependent* and/or *employee* enrolled in the special enrollment period will be effective as shown within the timeframe shown in the Qualifying Events Chart subsection. **Loss of Coverage under Medicaid or State Child Health Insurance Programs or Eligibility for a State Premium Assistance Subsidy**

   If you or your *dependents* did not enroll in the *Plan* when initially eligible because you and/or your *dependents* were covered under Medicaid or a *State Children's Health Insurance Program (SCHIP)* and your coverage terminates or you or your *dependents* become eligible for a state premium assistance subsidy under Medicaid or *SCHIP*, you may enroll for coverage under this *Plan* for yourself and your *dependents* after Medicaid or *SCHIP* coverage terminates or after you or your *dependents*' eligibility for a state assistance subsidy under Medicaid or *SCHIP* is determined.

   You must submit the appropriate election and enrollment forms to your Human Resources Department within the timeframe shown in the Qualifying Events Chart subsection after eligibility for a state premium assistance subsidy under Medicaid or *SCHIP* is determined. Coverage under the *Plan* will become effective as shown within the timeframe shown in the Qualifying Events Chart subsection.

K. Qualifying Events Chart

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

Qualifying Event	Effective Date	Forms and Notification must be Received Within:	You May Make the Following Changes(s)
Marriage	Date of event	thirty-one (31) days of marriage	Enroll yourself, if applicable Enroll your new spouse and other eligible *dependents*
Divorce or annulment	Date of 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 and all other eligible dependents
Adoption, placement for adoption, *foster child*, or legal guardianship of a child	Date of event	thirty-one (31) days of adoption	Enroll yourself Enroll the newly adopted child and all other eligible dependents
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	thirty-one (31) days of spouse's or *dependent's* death	Coverage will terminate for the *dependent* from your health coverage
A *change in employment status* (including a change from one *employment* classification to another or you or your spouse taking a qualified unpaid *leave of absence*. This excludes strike or lockout, or a change in worksite)	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

Significant change in or cost of your, or your spouse's, health coverage due to spouse'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*
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*

L. 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 at midnight on the last day of the month following the earliest of these dates (except in certain circumstances, a covered *employee* may be eligible for COBRA continuation coverage):

1. the date of termination of his or her employment
2. the date the *employee* ceases to be in a class of *employees* eligible for coverage
3. the due date the *employee* fails to make any required contributions
4. the date this *Plan* is discontinued with respect to the *employer*
5. the date the Fund or *Plan* terminates
6. the date you (or any person seeking coverage on your behalf) performs an act, practice, or omission that constitutes fraud
7. the date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact
8. the date of termination of employment for school faculty shall mean the date the *employee's* contract ends so long as the *employee* continues to make required contributions for coverage

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 at midnight on the last day of the month following the earliest of these dates (except in certain circumstances, a covered *dependent* may be eligible for COBRA continuation coverage):

1. the date the *employee's* coverage terminates
2. the date ending the period for which the last contribution is made for the *dependent* coverage
3. the date of termination of all or any *dependent* coverage under this *Plan*
4. the date on which he or she ceases to be an eligible *dependent* under this *Plan* to age as listed in the Eligible Classes of Dependents provisions
5. the date your *dependent* (or any person seeking coverage on behalf of your *dependent*) performs an act, practice or omission that constitutes fraud
6. the date your *dependent* (or any person seeking coverage on behalf of your *dependent*) makes an intentional misrepresentation of a material fact

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**.

M. Continuation during Leave of Absence

If a covered *employee* is granted an approved *leave of absence* by either Cochise County, Central Arizona College, or Cochise College, the covered *employee* and his or her *dependents* will be allowed to remain eligible on this *Plan* during the approved leave, provided any required contributions are made on the established due date each month. Eligibility under an approved leave is for a maximum of six (6) months. If the covered *employee's* leave continues beyond six (6) months, coverage can be continued under the COBRA provisions of this *Plan* (reference the section entitled **Continuation Coverage Rights under COBRA**.

N. 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.

Qualified *employees* are entitled to unpaid leave and can continue to maintain coverage under this *Plan* for the duration of the leave. During the leave, the *employer* will continue *Plan* contributions for the *employee* on the same terms as prior to the beginning of the *FMLA leave*. The *employee* is responsible for making the required monthly premium contributions for *dependent* coverage.

If coverage for *dependents* is terminated for failure to make payments while the covered *employee* is on an approved family or medical leave, coverage for the eligible *dependents* can be automatically reinstated on the date the covered *employee* returns to *active employment*. All accumulated maximums will apply.

O. 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.

P. 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 eighteen (18) years of age, or until they turn twenty-three (23) years of age if they are a full time student.

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.

Because an Unmarried Surviving Dependent of a Law Enforcement Officer, although receiving benefits under the *Plan*, is not a dependent of an active *employee*, they are not eligible for benefits under the *Plan* until the age of twenty-six (26), regardless of whether they are a full-time student.

Q. 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.

R. Employees on Military Leave

The Uniformed Services Employment and Reemployment Rights Act (USERRA) may entitle qualified *employees* to continue their coverage. If called to active military service for up to thirty-one (31) days, coverage under this *Plan* will be continued. If called to active military service for a period exceeding thirty-one (31) days, coverage may be continued for up to twenty-four (24) months. *Employees* who return to *active employment* following active duty service as a member of the United States Armed Forces, will be reinstated to coverage under this *Plan* immediately upon returning from military service. Any questions regarding this should be directed to the *employer*.

S. Qualified Medical Child Support Orders (QMCSO)

This *Plan* adheres to the *Qualified Medical Child Support Orders (QMCSO)* rules and regulations. If an *employee's* separated or divorced spouse or any state child support or Medicaid agency has obtained a *QMCSO*, the *employee* will be required to provide coverage for any child(ren) named in the *QMCSO*. If a *QMCSO* requires that the *employee* provide health coverage for his or her child(ren) and the *employee* does not enroll them, the *employer* must enroll the child(ren) upon application from the separated/divorced spouse, the state child

support agency or Medicaid agency and withhold from the *employee's* pay the cost of such coverage. The *employee* may not drop coverage for the child(ren) unless the *employee* submits written evidence that the *QMCSO* is no longer in effect. The *Plan* may make benefit payments for the child(ren) covered by a *QMCSO* directly to the custodial parent or *legal guardian* of such child(ren).

T. 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.

Every year during the annual *open enrollment period*, *employees* and their *dependents* who are *late enrollees* will be able to enroll in the *Plan*.

Benefit choices made during the *open enrollment period* will become effective July 1 and remain in effect until the next July 1 unless there is a Special Enrollment event or change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a spouse's employment. 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*.

Benefit choices for *late enrollees* made during the *open enrollment period* will become effective July 1.

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

A *plan participant of Central Arizona College* who fails to make an election during an active *open enrollment period* will no longer be covered under this *Plan*. A *plan participant* will automatically retain their present coverage during a passive *open enrollment period*. However, if the *employee* is enrolled in an HSA or FSA, they are required to actively elect these benefits during the *open enrollment period* in order to retain their present *coverage*.

A *plan participant* of Cochise County who fails to make an election during an active *open enrollment period* will no longer be covered under this plan. A *plan participant* will automatically retain their present coverage during a passive *open enrollment period*. However, if the *employee* is enrolled in an HSA or FSA, they are required to actively elect these benefits during the *open enrollment period* in order to retain their present *coverage*.

A *plan participant* of Cochise College who fails to make an election during an active *open enrollment period* will no longer be covered under this plan. A *plan participant* will automatically retain their present coverage during a passive *open enrollment period*. However, if the *employee* is enrolled in an HSA or FSA, they are required to actively elect these benefits during the *open enrollment period* in order to retain their present *coverage*.

If a *plan participant's* eligibility ceases due to certain *qualifying events*, the individual may be eligible for continuation of coverage under COBRA as defined in the section entitled **Continuation Coverage Rights under COBRA**.

SECTION IV—MEDICAL NETWORK INFORMATION

A. Network Provider Information

The *Plan* has entered into an agreement 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.

B. Non-Network Provider Information

Non-network providers have no agreements with the *Plan* and are generally free to set their own charges for the services or supplies they provide. The *Plan* will reimburse for the *allowable charges* 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 *balance billing/surprise billing*.

C. 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.

D. Choosing a Physician – Patient Protection Notice

The *Plan* does not require you to select a *Primary Care Physician (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.

E. Special Reimbursement Provisions

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

1. **Medical Emergency.** In an 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 at the *network* benefit level 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 *usual and customary and reasonable amounts*. 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 and/or provider, 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 ambulance, emergency room *physician*, anesthesiologist, assistant surgeon, or a provider for *diagnostic 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 *usual and customary and reasonable amounts*. 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 you believe or have been told there is not a *network specialist* available due to geographic restraints (over 100 miles from work) to render covered services that you need, you may ask your treating provider to request *pre-certification* of *network* cost-share for services from a *non-network specialist*. This *pre-certification* will not be issued if the *Medical Review Administrator* determines that a *network specialist* is available to treat you. The **Medical Review/Pre-Certification Program** section explains how to make this request.

Refer to the **Consolidated Appropriations Act of 2021** section for additional provisions pertaining to *balance billing/surprise billing*.

F. Network Information – HDHP Option

You may obtain more information about the providers in the *network* by visiting the AmeriBen website.

BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross® BlueShield® of Arizona Providers

www.azblue.com/CHSnetwork

Arizona

(BlueCross® BlueShield® of Arizona, an independent licensee of the BlueCross BlueShield 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 Cochise Combined Trust has assumed all liability for *claims* payments. No *network* access is available from BlueCross BlueShield plans outside of Arizona).

G. Network Information

You may obtain more information about the providers in the *network* by visiting the AmeriBen website.

EPO Provider Network

BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross® BlueShield® of Arizona Providers

www.azblue.com/CHSnetwork

Arizona

(BlueCross® BlueShield® of Arizona, an independent licensee of the BlueCross BlueShield 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 Cochise Combined Trust has assumed all liability for *claims* payments. No *network* access is available from BlueCross BlueShield plans outside of Arizona).

Out-of-Area Provider Network

PHCS MultiPlan

PHCS Healthy Directions

www.multiplan.com/search

Outside Arizona

Available to *participants* living or traveling outside the state of Arizona.

SECTION V—SCHEDULE OF BENEFITS

Verification of Eligibility: (855) 258-6455

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 Benefits

All benefits described in this **Schedule 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 *usual and customary and reasonable amounts*; 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 not in accordance with the *maximum allowable charges*.

B. Pre-Certification

If a *plan participant* fails to comply with the *pre-certification* requirements, it will result in a three hundred dollar ($300) penalty. Once a *pre-certification* is received, it is valid for ninety (90) days.

You are required to obtain *pre-certification* for the following:

1. all non-emergency hospital admissions [emergency within forty-eight (48) hours], including:
    a. *inpatient* admissions to hospice, skilled nursing, or *rehabilitation facilities*
    b. maternity admissions that exceed forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean delivery

    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. chemotherapy and radiation therapy
3. 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 for a further description and limitations of this benefit.
4. any single diagnostic test and/or *surgical procedure* over one thousand dollars ($1,000) in billed charges
5. *durable medical equipment (DME)* charges over one thousand dollars ($1,000) in billed charges
6. general anesthesia and related facility services for dental procedures, for *plan participants* over age six (6)
7. genetic/genomic testing (excluding amniocentesis)
8. home health care
9. injectable medications over one thousand dollars ($1,000) in billed charges, administered in a *physician's* office or in conjunction with home health services

10. occupational, speech, and physical therapy treatment programs (penalty applied per condition)
11. outpatient imaging – Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans (excluding services rendered in an emergency room setting)
12. psychological and neuropsychological testing
13. sleep studies
14. *inpatient* mental health/*substance use disorder* treatment (including *residential treatment facility* services)
15. fixed wing air ambulance
16. medical foods
17. specialty infusion/injectable medications over $1,000 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)
18. non-emergent air ambulance
19. non-invasive prenatal testing (NIPT)

Please see the **Medical Review/Pre-certification Program** section in this booklet for details.

C. Deductible Amount

This is an amount of *covered charges* for which no benefits will be paid. Before benefits can be paid in a *plan year* a *plan participant* must meet the *deductible* shown in the applicable Schedule of Medical Benefits.

The *deductible* is applied in the order of the *Plan's* receipt of *covered charges*.

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

Refer to the applicable Schedule of Medical Benefits for further information regarding the *deductible* amount.

Three Month Carryover Deductible – EPO Option and EPO Buy-Up Option Only

Covered charges incurred in, and applied toward, the *deductible* in April, May, and June will be applied toward the *deductible* in the next *plan year*.

D. Benefit Payment

Each *plan year*, benefits will be paid for the *covered charges* of a *plan participant* that are in excess of the *deductible*. Payment will be made at the rate shown under the General Percentage Payment Rule in the applicable Schedule of Medical Benefits. No benefits will be paid in excess of the *maximum benefit* amount or any listed limit of the *Plan*.

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

E. 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 applicable Schedule of Medical Benefits. You are responsible for the difference between the percentage the *Plan* pays and 100% of the negotiated rate. These amounts for which you are responsible are known as *co-insurance*.

HDHP Plans - For *covered charges incurred* with a *non-network* provider, the *Plan* pays a specified percentage of *covered charges* at the *maximum allowable charge*. 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*.

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

F. Out-of-Pocket Limit

Covered charges are payable at the percentages shown each *plan year* until the *out-of-pocket limit* shown in the applicable Schedule of Medical Benefits 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 *plan year*.

The following charges do not apply to the *out-of-pocket limit*:

1. amounts over *usual and customary and reasonable amounts*
2. charges not covered under the *Plan*
3. cost containment penalties

Refer to the applicable Schedule of Medical Benefits for further information regarding the *out-of-pocket limit*.

G. **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 that grouping of diagnoses and procedures. In the case where the *DRG amount* on an eligible *claim* exceeds 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* and will not exceed the *billed charges*
3. the difference in the *network allowed amount* versus the actual *billed charges* will be the responsibility of the *Plan*

Any amount in excess of the *allowed amount* does not count toward the *Plan's* annual *out-of-pocket limit*. *Plan participants* are responsible for amounts that exceed *allowed amounts* by this *Plan*. This is known as *balance billing*.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *balance billing/surprise billing*.

H. 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 *allowable charge*.

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

Non-network providers have no obligation to accept the *allowable charge*. You are responsible to pay a *non-network* provider's billed charges, even though reimbursement is based on the *allowable 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 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 *balance billing/surprise billing*.

I. Exclusive Provider Organization (EPO) Plan – EPO Option and EPO Buy-Up Option Only

The *Plan* has incorporated the BlueCross® BlueShield® of Arizona (BCBSAZ) *Exclusive Provider Organization (EPO)* as part of the benefit design. An *EPO* is a group of *hospitals*, *physicians*, and other health care providers contracted to furnish medical care at negotiated rates. The *EPO* providers are listed as BCBSAZ Preferred Care and Participating Only providers.

Use of *EPO* providers is required to receive the benefits described in this summary plan description. All services received in Arizona must be rendered by a BlueCross BlueShield of Arizona *network* provider or benefits will not be available (except in the case of a *medical emergency*).

When you need medical care, select a provider and/or facility from your BCBSAZ directory online at www.azblue.com/CHSnetwork to verify current status as a *network* provider/facility. Your ID card identifies the BlueCross BlueShield of Arizona *network* and it should always be presented when obtaining services. The BCBSAZ provider will collect the portion of the bill that is your responsibility and will submit your *claim* for payment consideration. The *Third Party Administrator* will process your benefits at the appropriate level and send you an Explanation of Benefits showing the payment calculation and the amount of patient responsibility.

If the need for medical care due to a *medical emergency* occurs outside the *EPO network*, services may be considered under the applicable Schedule of Medical Benefits if it is determined by the *Third Party Administrator* that immediate medical attention was required due to an *accident* or *illness* which is serious enough to constitute a *medical emergency* as defined in this document.

If your *EPO physician* needs to send you to another *physician* or admits you to a *hospital* be sure that you are referred to a provider/facility that participates in the applicable *EPO network*.

Any services rendered or received at a Mayo Clinic or from a Mayo Clinic provider are excluded from the Plan.

J. Out-of-Area Provider Network

If the *plan participant* is traveling or his/her temporary or permanent place of residence is not in the state of Arizona, PHCS Healthy Directions is available to furnish medical care at negotiated rates. Please refer to the PHCS contact information in the Network Information subsection.

K. Schedule of Medical Benefits – EPO Option

The following benefits are provided to *employees* that have elected the Medical *Plan*. This Schedule of Medical Benefits outlines some (but not all) of the common benefits of the *Plan*. Refer to the sections entitled **Medical Benefits** and **Medical Review/Pre-Certification Program** for more information on *covered charges*, *Plan* exclusions, and services needing *pre-certification*.

The benefits listed as EPO Network Providers are available in Arizona only through BlueCross® BlueShield® of Arizona (BCBSAZ) contracted providers. PHCS Healthy Directions is available to *participants* living or traveling outside the state of Arizona.

If a *plan participant* uses a provider within Arizona that is not a contracted BCBSAZ provider, no benefits will be available.

	EPO Network Providers
Deductible, per Plan Year *Co-payments, prescription drugs,* and *co-insurance* do not apply to the *deductible*.	
Per *plan participant*	$500
Per *family unit*	$1,500
Family Unit - Embedded Deductible If you are enrolled in the family 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 $1,500 *family unit* embedded *deductible*, and the individual *deductible* is $500, and your child *incurs* $500 in medical bills, his/her *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 $1,500 has not been met yet.	
Maximum Out-of-Pocket Limit, per Plan Year The *out-of-pocket limit* includes *co-payments, deductibles*, and *co-insurance*. *Prescription drug charges* for a *family unit* apply to the Medical Benefits *out-of-pocket limit* (*family unit* coverage only).	
Per *plan participant*	$9,100
Per *family unit*	$18,200
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 *plan year* unless stated otherwise. **Note:** The following charges do not apply toward the *out-of-pocket limit* amount and are generally not paid by the *Plan* at 100%: 1. amounts over *usual and customary and reasonable amounts* 2. charges not covered under the *Plan* 3. cost containment penalties 4. penalty for failure to obtain *pre-certification* ($300)	

EPO Option

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	EPO NETWORK PROVIDERS	SPECIAL COMMENTS
General Percentage Payment Rule	80% 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.
Advanced Imaging Single test over $500 allowable	80% after *deductible*	Advanced imaging services under $500 allowable (per line) are covered under the Diagnostic Testing benefit. ***Pre-certification* is required for outpatient imaging - Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans (excluding services rendered in an emergency room setting.**
Allergy Injections	100% *deductible* waived	When not part of an office visit.
Ambulance Service	80%, *deductible* waived	*Non-network* emergency transportation is covered at the *network* benefit level. Transportation for *medical non-emergency care* is not covered. ***Pre-certification* is required** for fixed wing ambulance, and non-emergent air ambulance.
Ambulatory Surgical Facility	80% after *deductible*	***Pre-certification* is required for procedures in excess of $1,000 in billed charges.**
Chiropractic Treatment	$30 *co-payment*, *deductible* waived	**Benefit maximum:** Subject to a *maximum benefit* payable of $40 per *visit*. Charges for x-rays do not apply to this maximum. **Plan year maximum:** Twenty (20) *visits* per *plan participant*.
Diagnostic Testing, Labs, and X-Rays		
Single Test Charges Under $500		Services include 3D mammogram. ***Pre-certification* required for any single diagnostic test and/or surgical procedure over $1,000 in billed charges.**
Physician's Office – Primary Care Physician	$30 *co-payment*, *deductible* waived	
Physician's Office – Specialist	$40 *co-payment*, *deductible* waived	
All Other Locations	$30 *co-payment*, *deductible* waived	
Single Test Over $500 Allowable	80% after *deductible*	
Durable Medical Equipment (DME)	80% after *deductible*	The following items will be considered under the *DME* benefit: 1. Continuous Blood Glucose Monitor 2. Insulin Pump and Related Supplies ***Pre-certification* required for any item in excess of $1,000 in billed charges.**

EPO Option

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	EPO NETWORK PROVIDERS	SPECIAL COMMENTS
Emergency Room	$250 *co-payment*, and 80% after *deductible*	Refer to *medical emergency* definition. All emergency room services for a non-emergency are not covered. *Non-network* emergency rooms are covered at the *network* benefit level when due to a *medical emergency*. The *co-payment* is waived if you are admitted to a *hospital* on an emergency basis.
Hearing Aids	50% after *deductible*	**Benefit maximum:** Limited to two (2) aids every three 3) years, per *plan participant*. Subject to a *maximum benefit* payable of $2,000.
Hearing Examinations	$30 *co-payment*, *deductible* waived	This benefit does not apply to the routine hearing screening for newborns which is mandated under *PPACA* and covered under the Preventive Care provision.
Home Health Care	80% after *deductible*	Therapy provided in the home will apply to the home health care *plan year* maximum. **Plan year maximum:** Sixty (60) *visits* per *plan participant*. ***Pre-certification* is required for home health care and injectable medications in excess of $1,000 in billed charges and for health care.**
Hospice Care	80% after *deductible*	**Benefit maximum:** Limited to sixty (60) days per twelve (12) consecutive months, per *plan participant*. ***Pre-certification* is required for inpatient hospice admissions.**
Inpatient Hospital		
Inpatient Physician Visits	80% after *deductible*	
Room and Board	80% after *deductible*	Limited to the *semi-private room rate*. Charges for a private room (that exceed the cost of a semi-private room) are eligible only if prescribed by a *physician* and the private room is *medically necessary*. ***Pre-certification* is required.**
Maternity		
Initial Office Visit	$30 *co-payment*, *deductible* waived	Dependent child *pregnancy* is not covered. Refer to **Medical Benefits**, Covered Medical Charges, Maternity, for additional information. *Co-payment* on first office visit only.
All Other Services	80% after *deductible*	***Pre-certification* is required for inpatient hospital stays that exceed forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean delivery.**

EPO Option

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	EPO NETWORK PROVIDERS	SPECIAL COMMENTS
Medical Supplies	80% after *deductible*	The following items will be considered under the Medical Supplies benefit: 1. **Jobst / Compression Stockings:** Limited to three (3) units per prescribed limb per *plan year*. 2. **Mastectomy Bras and Camisoles:** Limited to two (2) per *plan participant* per *plan year*.
Morbid Obesity	80% after *deductible*	**Lifetime maximum:** The benefits payable for bariatric surgery, gastric bypass, or any other type of surgical weight loss procedure are limited to one (1) time during the life of the *plan participant*. Benefits will not be provided for subsequent procedures. Please refer to the subsection Covered Medical Charges, Morbid Obesity, for a further description and limitations of this benefit. ***Pre-certification* is required for surgical procedures in excess of $1,000 in billed charges.**
Office Visit		
Primary Care Physician	$30 *co-payment*, *deductible* waived	The *co-payment* applies per *visit* regardless of what services are rendered.
Specialist	$40 *co-payment*, *deductible* waived	
Outpatient Surgery		
Office Surgery Charges under $500 allowed – Primary Care Physician	$30 *co-payment*, *deductible* waived	
Office Surgery Charges under $500 allowed – Specialist	$40 *co-payment*, *deductible* waived	
All Other	80% after *deductible*	Services include any *surgery* over $500 allowed as well as surgeries of any dollar amount performed outside of a *physician's* office. ***Pre-certification* is required for any single diagnostic test and/or surgical procedure $1,000 in billed charges.**
Rehabilitation Therapy		
Inpatient Rehabilitation	80% after *deductible*	**Plan year maximum:** Sixty (60) days per condition per *plan participant*. ***Pre-certification* is required.**
Outpatient Rehabilitation Therapy		
Speech Therapy	80% after *deductible*	**Plan year maximum:** Twenty (20) *visits* per *plan participant*. ***Pre-certification* is required for speech, therapy treatment programs (penalty applied per condition).**
Occupational Therapy Physical Therapy	Non-Hospital Facility: $10 *co-payment*, *deductible* waived Hospital Facility: 80% after *deductible*	***Pre-certification* is required for occupational and physical therapy treatment programs (penalty applied per condition).**

EPO Option

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	EPO NETWORK PROVIDERS	SPECIAL COMMENTS
Routine Inpatient Newborn Care Following Delivery	80% after *deductible*	Routine newborn care is subject to the mother's *deductible* and *out-of-pocket limit*. If the mother is not covered under the *Plan,* then these expenses apply to the newborn's *deductible* and *out-of-pocket limit*.
Routine Vision Exam		
Primary Care Physician	$30 *co-payment*, *deductible* waived	**Plan year maximum:** One (1) exam per *plan participant*, except as covered under the Preventive Care provision.
Specialist	$40 *co-payment*, *deductible* waived	
Second Surgical Opinion	100% *deductible* waived	When services are required by the *Medical Review Administrator*. Refer to the **Medical Review/Pre-certification Program** section for details.
Skilled Nursing Facility/ Extended Care	80% after *deductible*	**Plan year maximum:** Ninety (90) days per *plan participant*. ***Pre-certification* is required.**
Sterilization - Male		
Primary Care Physician	$30 *co-payment*, *deductible* waived	Services include sterilization for male *plan participants* when performed in the *physician's* office. Female sterilization is covered under the Preventive Care provision.
Specialist	$40 *co-payment*, *deductible* waived	
Teladoc	$40 *co-payment*, *deductible* waived	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 logon to your Teladoc account or call 1-800-Teladoc (835-2362). The *Plan* is not liable for services provided by Teladoc. Refer to the Covered Medical Charges subsection for more information.
Urgent Care	$35 *co-payment*, *deductible* waived	The urgent care visit *co-payment* will apply to the urgent care visit and all other services, including lab and x-rays, performed and billed by the *physician* for the same date of service.
Wig in conjunction with Chemotherapy or Radiation Therapy	80% after *deductible*	**Plan year maximum:** $300 per *plan participant*.

EPO Option

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	EPO NETWORK PROVIDERS	SPECIAL COMMENTS
MENTAL DISORDERS & SUBSTANCE USE DISORDER		Mental nervous/*substance use disorder* services do not apply to the *out-of-pocket limit*.
Inpatient	80% after *deductible*	***Pre-certification* is required.**
Outpatient		
Primary Care Physician	$30 *co-payment*, *deductible* waived	CCT also offers an Employee Assistance Program through SupportLinc which provides up to five (5) free counseling sessions each *plan* year (July 1-June 30) for each type of problem you may *encounter* along with work-life assistance, financial concerns, and/or legal problems.
Specialist	$40 *co-payment*, *deductible* waived	
Psychological/ Neuropsychological Testing	80% after *deductible*	***Pre-certification* is required.**

EPO Option

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	EPO NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE If a service is listed as A or B rated on the U.S. Preventive Service Task Force 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 Routine Wellness Care visit. For more information about *preventive care* services please refer to the following websites: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.**		
Routine Preventive Care	100% *deductible* waived	Services include, but are not limited to, routine physical exam, related lab, x-ray, gynecological exam, pap smear, colorectal cancer screening, blood work, bone density testing, and immunizations based on CDC guidelines. Services also include 2D and 3D mammograms [3D mammograms performed off-site are limited to one (1) per *plan year*]. Services for Wellness Care (Not Defined by *PPACA*) will be subject to the $750 *plan year* maximum, as listed below. Please refer to the section entitled **Medical Benefits**, Covered Medical Charges, Routine Preventive Care, for a further description and limitations of this benefit.
Contraceptive Services	100% *deductible* waived	Services include FDA-approved contraceptive methods, female sterilization, and patient education and counseling, not including drugs that induce abortion. **Benefit limitations:** Services are available to all female *plan participants*.
WELLNESS CARE (Not Defined by PPACA)		
Wellness Care (not defined by PPACA)	100% *deductible* waived, up to the *plan year* maximum	Services include Wellness Care, related labs and services not defined by *PPACA*, and biometrics on-site screenings. **Plan year maximum**: $750 per *plan participant*. Up to $100 is allowed for non-mandated off-site *preventive care* and is not subject to *plan participant* cost share. Biometrics on-site screenings are not deducted from the *Plan year* maximum.
TRANSPLANTS		
Organ Transplants	80% after *deductible*	***Pre-certification* is required.**

L. Schedule of Prescription Drug Benefits – EPO Option

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

Prescription drug charges do not apply to the medical *deductible*.

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

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

	PREFERRED PHARMACY	NON-PREFERRED PHARMACY	NON-NETWORK PHARMACY
Retail Pharmacy Option (30 Day Supply)			
Tier 1: Most formulary generics and certain low-cost brand	$10 *co-payment*	$15 *co-payment*	There is no coverage under the *Plan* if you use a *non-network pharmacy*, unless due to a *medical emergency*.
Tier 2: Most formulary brands and certain high-cost generics	$30 *co-payment*	$35 *co-payment*	
Tier 3: Non-formulary brands and generics	$60 *co-payment*	$65 *co-payment*	
Specialty Drugs	20% *co-payment* up to $150	Not Covered	
Specialty drugs are only available through the Navitus SpecialtyRx Program Pharmacy, denoted with MSP on your *formulary drug* list.			
Retail 90 or Mail Order Option (90 Day Supply)			
Tier 1: Most formulary generics and certain low-cost brand	$20 *co-payment*	$25 *co-payment*	There is no coverage under the *Plan* if you use a *non-network pharmacy*, unless due to a *medical emergency*.
Tier 2: Most formulary brands and certain high-cost generics	$60 *co-payment*	$65 *co-payment*	
Tier 3: Non-formulary brands and generics	$120 *co-payment*	$125 *co-payment*	
Certain *preventive care prescription drugs* mandated under *PPACA* (including preferred generic and brand contraceptives) received by a *network pharmacy* are covered at 100% and the *deductible*/*co-payment*/*co-insurance* (if applicable) is waived. Please refer to the following websites for information on the types of payable *preventive care* medications: **https://www.healthcare.gov/coverage/preventive-care-benefits/**			

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 along with the receipt to:

Navitus Health Solutions, LLC
Attn: Manual Claims
PO Box 999
Appleton, WI 54912-0999
(866) 333-2757

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

M. Schedule of Medical Benefits – Buy-Up EPO Option

The following benefits are provided to *employees* that have elected the Medical *Plan*. This Schedule of Medical Benefits outlines some (but not all) of the common benefits of the *Plan*. Refer to the sections entitled **Medical Benefits** and **Medical Review/Pre-Certification Program** for more information on *covered charges*, *Plan* exclusions, and services needing *pre-certification*.

The benefits listed as EPO Network Providers are available in Arizona only through BlueCross® BlueShield® of Arizona (BCBSAZ) contracted providers. PHCS Healthy Directions is available to *participants* living or traveling outside the state of Arizona.

If a *plan participant* uses a provider within Arizona that is not a contracted BCBSAZ provider, no benefits will be available.

	EPO Network Providers
Deductible, per Plan Year *Co-payments, prescription drugs,* and *co-insurance* do not apply to the *deductible*.	
Per *plan participant*	$250
Per *family unit*	$750
Family Unit - Embedded Deductible If you are enrolled in the family 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 $750 *family unit* embedded *deductible*, and the individual *deductible* is $250, and your child *incurs* $250 in medical bills, his/her *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 $750 has not been met yet.	
Maximum Out-of-Pocket Limit, per Plan Year The *out-of-pocket limit* includes *co-payments, deductibles*, and *co-insurance*.	
Per *plan participant*	$5,500
Per *family unit*	$11,000
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 *plan year* unless stated otherwise. **Note:** The following charges do not apply toward the *out-of-pocket limit* amount and are generally not paid at 100%: 1. amounts over *usual and customary and reasonable amounts* 2. charges not covered under the *Plan* 3. cost containment penalties 4. penalty for failure to obtain *pre-certification* ($300)	

Buy-Up EPO Option

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	EPO NETWORK PROVIDERS	SPECIAL COMMENTS
General Percentage Payment Rule	80% 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.
Advanced Imaging Single test over $500 allowable	80% after *deductible*	Advanced imaging services under $500 allowable (per line) are covered under the Diagnostic Testing benefit. ***Pre-certification* is required for outpatient imaging - Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans (excluding services rendered in an emergency room setting.**
Allergy Injections	100% *deductible* waived	When not part of an office visit.
Ambulance Service	80%, *deductible* waived	*Non-network* emergency transportation is covered at the *network* benefit level. Transportation for *medical non-emergency care* is not covered. ***Pre-certification* is required** for fixed wing ambulance, and non-emergent air ambulance.
Ambulatory Surgical Facility	80% after *deductible*	***Pre-certification* is required for procedures in excess of $1,000 in billed charges.**
Chiropractic Treatment	$30 *co-payment*, *deductible* waived	**Benefit maximum:** Subject to a *maximum benefit* payable of $40 per *visit*. Charges for x-rays do not apply to this maximum. **Plan year maximum:** Twenty (20) *visits* per *plan participant*.
Diagnostic Testing, Labs, and X-Rays		
Single Test Charges Under $500		Services include 3D mammogram. ***Pre-certification* required for any single diagnostic test and/or surgical procedure over $1,000 in billed charges.**
Physician's Office – Primary Care Physician	$30 *co-payment*, *deductible* waived	
Physician's Office – Specialist	$40 *co-payment*, *deductible* waived	
All Other Locations	$30 *co-payment*, *deductible* waived	
Single Test Over $500 Allowable	80% after *deductible*	
Durable Medical Equipment (DME)	80% after *deductible*	The following items will be considered under the *DME* benefit: 1. Continuous Blood Glucose Monitor 2. Insulin Pump and Related Supplies ***Pre-certification* required for any item in excess of $1,000 in billed charges.**

Buy-Up EPO Option

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	EPO NETWORK PROVIDERS	SPECIAL COMMENTS
Emergency Room	$250 *co-payment*, and 80% after *deductible*	Refer to *medical emergency* definition. All emergency room services for a non-emergency are not covered. *Non-network* emergency rooms are covered at the *network* benefit level when due to a *medical emergency*. The *co-payment* is waived if you are admitted to a *hospital* on an emergency basis.
Hearing Aids	50% after *deductible*	**Benefit maximum:** Limited to two (2) aids every three (3) years, per *plan participant*. Subject to a *maximum benefit* payable of $2,000.
Hearing Examinations	$30 *co-payment*, *deductible* waived	This benefit does not apply to the routine hearing screening for newborns which is mandated under *PPACA* and covered under the Preventive Care provision.
Home Health Care	80% after *deductible*	Therapy provided in the home will apply to the home health care *plan year* maximum. **Plan year maximum:** Sixty (60) *visits* per *plan participant*. ***Pre-certification* is required for home health care and injectable medications in excess of $1,000 in billed charges.**
Hospice Care	80% after *deductible*	**Benefit maximum:** Limited to sixty (60) days per twelve (12) consecutive months, per *plan participant*. ***Pre-certification* is required for inpatient hospice admissions.**
Inpatient Hospital		
Inpatient Physician Visits	80% after *deductible*	
Room and Board	80% after *deductible*	Limited to the *semi-private room rate*. Charges for a private room (that exceed the cost of a semi-private room) are eligible only if prescribed by a *physician* and the private room is *medically necessary*. ***Pre-certification* is required.**
Maternity		
Initial Office Visit	$30 *co-payment*, *deductible* waived	Dependent child *pregnancy* is not covered. Refer to **Medical Benefits**, Covered Medical Charges, Maternity, for additional information. *Co-payment* on first office visit only.
All Other Services	80% after *deductible*	***Pre-certification* is required for inpatient hospital stays that exceed forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean delivery.**

Buy-Up EPO Option

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	EPO NETWORK PROVIDERS	SPECIAL COMMENTS
Medical Supplies	80% after *deductible*	The following items will be considered under the Medical Supplies benefit: 1. **Jobst / Compression Stockings:** Limited to three (3) units per prescribed limb per *plan year*. 2. **Mastectomy Bras and Camisoles:** Limited to two (2) per *plan participant* per *plan year*.
Morbid Obesity	80% after *deductible*	**Lifetime maximum:** The benefits payable for bariatric surgery, gastric bypass, or any other type of surgical weight loss procedure are limited to one (1) time during the life of the *plan participant*. Benefits will not be provided for subsequent procedures. Please refer to the subsection Covered Medical Charges, Morbid Obesity, for a further description and limitations of this benefit. ***Pre-certification* is required for surgical procedures in excess of $1,000 in billed charges.**
Office Visit		
Primary Care Physician	$30 *co-payment*, *deductible* waived	The *co-payment* applies per *visit* regardless of what services are rendered.
Specialist	$40 *co-payment*, *deductible* waived	
Outpatient Surgery		
Office Surgery Charges under $500 allowed – Primary Care Physician	$30 *co-payment*, *deductible* waived	
Office Surgery Charges under $500 allowed – Specialist	$40 *co-payment*, *deductible* waived	
All Other	80% after *deductible*	Services include any *surgery* over $500 as well as surgeries of any dollar amount performed outside of a *physician's* office. ***Pre-certification* is required for any single diagnostic test and/or surgical procedure $1,000 in billed charges.**
Rehabilitation Therapy		
Inpatient Rehabilitation	80% after *deductible*	**Plan year maximum:** Sixty (60) days per condition per *plan participant*. ***Pre-certification* is required.**
Outpatient Rehabilitation Therapy		
Speech Therapy	80% after *deductible*	**Plan year maximum:** Twenty (20) *visits* per *plan participant*. ***Pre-certification* is required for speech, therapy treatment programs (penalty applied per condition).**
Occupational Therapy Physical Therapy	Non-Hospital Facility: $10 *co-payment*, *deductible* waived Hospital Facility: 80% after *deductible*	***Pre-certification* is required for occupational and physical therapy treatment programs (penalty applied per condition).**

Buy-Up EPO Option

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	EPO NETWORK PROVIDERS	SPECIAL COMMENTS
Routine Inpatient Newborn Care Following Delivery	80% after *deductible*	Routine newborn care is subject to the mother's *deductible* and *out-of-pocket limit*. If the mother is not covered under the *Plan,* then these expenses apply to the newborn's *deductible* and *out-of-pocket limit*.
Routine Vision Exam		
Primary Care Physician	$30 *co-payment*, *deductible* waived	**Plan year maximum:** One (1) exam per *plan participant*, except as covered under the Preventive Care provision.
Specialist	$40 *co-payment*, *deductible* waived	
Second Surgical Opinion	100% *deductible* waived	When services are required by the *Medical Review Administrator*. Refer to the **Medical Review/Pre-certification Program** section for details.
Skilled Nursing Facility/ Extended Care	80% after *deductible*	**Plan year maximum:** Ninety (90) days per *plan participant*. ***Pre-certification* is required.**
Sterilization - Male		
Primary Care Physician	$30 *co-payment*, *deductible* waived	Services include sterilization for male *plan participants* when performed in the *physician's* office. Female sterilization is covered under the Preventive Care provision.
Specialist	$40 *co-payment*, *deductible* waived	
Teladoc	$40 *co-payment*, *deductible* waived	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 logon to your Teladoc account or call 1-800-Teladoc (835-2362). The *Plan* is not liable for services provided by Teladoc. Refer to the Covered Medical Charges subsection for more information.
Urgent Care	$35 *co-payment*, *deductible* waived	The urgent care visit *co-payment* will apply to the urgent care visit and all other services, including lab and x-rays, performed and billed by the *physician* for the same date of service.
Wig in conjunction with Chemotherapy or Radiation Therapy	80% after *deductible*	**Plan year maximum:** $300 per *plan participant*.

Buy-Up EPO Option

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	EPO NETWORK PROVIDERS	SPECIAL COMMENTS
MENTAL DISORDERS & SUBSTANCE USE DISORDER		Mental nervous/*substance use disorder* services do not apply to the *out-of-pocket limit*.
Inpatient	80% after *deductible*	***Pre-certification* is required.**
Outpatient		
Primary Care Physician	$30 *co-payment*, *deductible* waived	CCT also offers an Employee Assistance Program through SupportLinc which provides up to five (5) free counseling sessions each *plan* year (July 1-June 30) for each type of problem you may *encounter* along with work-life assistance, financial concerns, and/or legal problems.
Specialist	$40 *co-payment*, *deductible* waived	
Psychological/ Neuropsychological Testing	80% after *deductible*	***Pre-certification* is required.**

Buy-Up EPO Option

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	EPO NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE If a service is listed as A or B rated on the U.S. Preventive Service Task Force 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 Routine Wellness Care visit. For more information about *preventive care* services please refer to the following websites: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.**		
Routine Preventive Care	100% *deductible* waived	Services include, but not limited to, routine physical exam, related lab, x-ray, gynecological exam, pap smear, colorectal cancer screening, blood work, bone density testing, and immunizations based on CDC guidelines. Services also include 2D and 3D mammograms [3D mammograms performed off-site are limited to one (1) per *plan year*]. Services for Wellness Care (Not Defined by *PPACA*) will be subject to the $750 *plan year* maximum, as listed below. Please refer to the section entitled **Medical Benefits**, Covered Medical Charges, Routine Preventive Care, for a further description and limitations of this benefit.
Contraceptive Services	100% *deductible* waived	Services include FDA-approved contraceptive methods, female sterilization, and patient education and counseling, not including drugs that induce abortion. **Benefit limitations:** Services are available to all female *plan participants*.
WELLNESS CARE (Not Defined by PPACA)		
Wellness Care (not defined by PPACA)	100% *deductible* waived, up to the *plan year* maximum	Services include Wellness Care, related labs and services not defined by *PPACA*, and biometrics on-site screenings. **Plan year maximum**: $750 per *plan participant*. Up to $100 is allowed for non-mandated off-site *preventive care* and is not subject to *plan participant* cost share. Biometrics on-site screenings are not deducted from the *Plan year* maximum.
TRANSPLANTS		
Organ Transplants	80% after *deductible*	***Pre-certification* is required.**

N. Schedule of Prescription Drug Benefits – Buy-up EPO Option

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

Prescription drug charges do not apply to the medical *deductible*.

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

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

	PREFERRED PHARMACY	NON-PREFERRED PHARMACY	NON-NETWORK PHARMACY
Retail Pharmacy Option (30 Day Supply)			
Tier 1: Most formulary generics and certain low-cost brand	$10 *co-payment*	$15 *co-payment*	There is no coverage under the *Plan* if you use a *non-network pharmacy*, unless due to a *medical emergency*.
Tier 2: Most formulary brands and certain high-cost generics	$30 *co-payment*	$35 *co-payment*	
Tier 3: Non-formulary brands and generics	$60 *co-payment*	$65 *co-payment*	
Specialty Drugs	20% *co-payment* up to $150	Not Covered	
Specialty drugs are only available through the Navitus SpecialtyRx Program Pharmacy, denoted with MSP on your *formulary drug* list.			
Retail 90 or Mail Order Option (90 Day Supply)			
Tier 1: Most formulary generics and certain low-cost brand	$20 *co-payment*	$25 *co-payment*	There is no coverage under the *Plan* if you use a *non-network pharmacy*, unless due to a *medical emergency*.
Tier 2: Most formulary brands and certain high-cost generics	$60 *co-payment*	$65 *co-payment*	
Tier 3: Non-formulary brands and generics	$120 *co-payment*	$125 *co-payment*	
Certain *preventive care prescription drugs* mandated under *PPACA* (including preferred generic and brand contraceptives) received by a *network pharmacy* are covered at 100% and the *deductible*/*co-payment*/*co-insurance* (if applicable) is waived. Please refer to the following websites for information on the types of payable *preventive care* medications: **https://www.healthcare.gov/coverage/preventive-care-benefits/**			

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 along with the receipt to:

Navitus Health Solutions, LLC
Attn: Manual Claims
PO Box 999
Appleton, WI 54912-0999
(866) 333-2757

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

O. High Deductible Health Plan (HDHP)

A qualified *high deductible health plan (HDHP)* with a *health savings account (HSA)* provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help build savings for future medical expenses. The *Plan* gives you greater control over how health care benefits are used. An *HDHP* satisfies certain statutory requirements with respect to minimum *deductibles* and *out-of-pocket limits* for both individual and

family coverage. These minimum *deductibles* and maximum *out-of-pocket limits* are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

P. How this Plan Works

This *Plan* features higher annual *deductibles* and *out-of-pocket limits* than other traditional health plans. With the exception *of preventive care*, you must meet the annual *deductible* before the *Plan* pays benefits. It is called a *high deductible health plan* or *HDHP*.

It is paired with a *health savings account (HSA)*. You may elect to make pre-tax contributions from your paycheck to your *HSA* each pay period. The *HDHP* provides medical and *prescription drug* coverage, and the *HSA* provides a tax-free way to help you save for health expenses in retirement. The *HDHP* gives you flexibility and discretion to determine how to use your health care benefits.

You can pay your *deductible* with funds from your *HSA*, or you can choose to pay your *deductible* out-of-pocket, allowing your *health savings account* to grow.

Preventive care services, performed by a network provider, are not subject to the deductible and are paid at 100%. In addition, this Plan includes coverage for Wellness Care not mandated by the Patient Protection and Affordable Care Act (PPACA). Benefits are not subject to the deductible and are paid at 100% up to a maximum benefit of five hundred dollars ($500) per plan year.

Note: There is no coverage under the Plan for preventive care services received from a non-network provider.

Q. How the Administrator Knows When I've satisfied the Deductible

If you have not met your *deductible*, you will be responsible for 100% of the *allowed amount* for your health care expenses. If you use a *network* provider, the provider will submit the *claim* to the *Third Party Administrator* on your behalf. If you use a *non-network* provider, your *physician* may ask you to pay for the services provided before you leave the office. In that case, you must submit your *claim* to the *Third Party Administrator* to ensure your expenses are applied to the separate *non-network deductible*. You will subsequently receive an *Explanation of Benefits* from the *Third Party Administrator* stating how much the negotiated payment amount is and the amount you are responsible for.

R. Requirements for a Health Savings Account (HSA)

To be eligible for enrollment in a *health saving account*, you must:

1. be enrolled in a qualified *HDHP*
2. in general, you cannot have any other non-HDHP medical coverage including coverage under a health flexible spending account or health reimbursement account

   You are allowed to have auto, dental, vision, disability, and long-term care insurance at the same time as an *HDHP*.
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

S. Schedule of Medical Benefits – HDHP Option

The following benefits are provided to *employees* that have elected the Medical *Plan*. This Schedule of Medical Benefits outlines some (but not all) of the common benefits of the *Plan*. Refer to the sections entitled **Medical Benefits** and **Medical Review/Pre-Certification Program** for more information on *covered charges*, *Plan* exclusions, and services requiring *pre-certification*.

The benefits listed as Network Providers are available in Arizona only through BlueCross® BlueShield® of Arizona (BCBSAZ) contracted providers.

	Network Providers	Non-Network Providers
Deductible, per Plan Year The *network* and *non-network deductible* amounts do not accumulate towards each other.		
Per *plan participant*	$3,000	$7,500
Per *family unit*	$6,000	$15,000
Embedded Deductible If you are enrolled in the family option on the *high deductible health plan*, your *Plan* contains two (2) components, an individual *deductible* and a *family unit deductible*. Having two (2) components to the *deductible* allows 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 $6,000 *family unit* embedded *deductible*, and the individual *deductible* is $3,000: If your child *incurs* $3,000 in medical bills, his/her *deductible* is met, and your *Plan* will help pay subsequent medical bills for that child during the remainder of the *plan year*, even though the *family unit deductible* of $6,000 has not been met yet.		
Maximum Out-of-Pocket Limit, per Plan Year The *out-of-pocket limit* includes *deductibles* and *co-insurance*. The *network* and *non-network out-of-pocket limits* do not accumulate towards each other.		
Per *plan participant*	$3,000	$200,000
Per *family unit*	$6,000	$400,000
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 *plan year* unless stated otherwise. **Note:** The following charges do not apply toward the *out-of-pocket limit* amount and are never paid at 100%: 1. amounts over *usual and customary and reasonable amounts* 2. charges not covered under the *Plan* 3. cost containment penalties 4. penalty for failure to obtain *pre-certification* ($300)		

HDHP Option

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.
Advanced Imaging	100% after *deductible*	50% after *deductible*	***Pre-certification* is required for outpatient imaging – Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans (excluding services rendered in an emergency room setting.**
Allergy Injections	100% after *deductible*	50% after *deductible*	When not part of an office visit.
Ambulance Service	100% after *deductible*		*Non-network* emergency transportation is covered at the *network* benefit level. Transportation for *medical non-emergency care* is not covered. ***Pre-certification* is required** for fixed wing ambulance, and non-emergent air ambulance.
Ambulatory Surgical Facility	100% after *deductible*	50% after *deductible*	***Pre-certification* is required for procedures in excess of $1,000 in billed charges.**
Chiropractic Treatment	100% after *deductible*	50% after *deductible*	**Benefit maximum:** Subject to a *maximum benefit* payable of $40 per *visit*. Charges for x-rays do not apply to this maximum. **Plan year maximum:** Twenty (20) *visits* per *plan participant*.
Diagnostic Testing, Labs, and X-Rays	100% after *deductible*	50% after *deductible*	Services include 3D mammogram. ***Pre-certification* required for any single diagnostic test and/or surgical procedure over $1,000 in billed charges.**
Durable Medical Equipment (DME)	100% after *deductible*	50% after *deductible*	The following items will be considered under the *DME* benefit: 1. Continuous Blood Glucose Monitor 2. Insulin Pump and Related Supplies ***Pre-certification* required for any item in excess of $1,000 in billed charges.**
Emergency Room	100% after *deductible*		Refer to *medical emergency* definition. All emergency room services for a non-emergency are not covered. *Non-network* emergency rooms are covered at the *network* benefit level when due to a *medical emergency*.

HDHP Option

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
Hearing Aids	100% after *deductible*	50% after *deductible*	**Benefit maximum:** Limited to two (2) aids every three (3) years, per *plan participant*. Subject to a *maximum benefit* payable of $2,000.
Hearing Examinations	100% after *deductible*	50% after *deductible*	This benefit does not apply to the routine hearing screening for newborns which is mandated under *PPACA* and covered under the Preventive Care provision.
Home Health Care	100% after *deductible*	50% after *deductible*	Therapy provided in the home will apply to the home health care *plan year* maximum. **Plan year maximum:** Sixty (60) *visits* per *plan participant*. ***Pre-certification* is required for injectable medications in excess of $1,000 in billed charges and for home health care.**
Hospice Care	100% after *deductible*	50% after *deductible*	**Benefit maximum:** Limited to sixty (60) days per twelve (12) consecutive months, per *plan participant*. ***Pre-certification* is required for inpatient hospice admissions.**
Inpatient Hospital			
Inpatient Physician Visits	100% after *deductible*	50% after *deductible*	
Room and Board	100% after *deductible*	50% after *deductible*	Limited to the *semi-private room rate*. Charges for a private room (that exceed the cost of a semi-private room) are eligible only if prescribed by a *physician* and the private room is *medically necessary*. ***Pre-certification* is required.**
Maternity			
Initial Office Visit	100% after *deductible*	50% after *deductible*	Dependent child *pregnancy* is not covered. Refer to **Medical Benefits**, Covered Medical Charges, Maternity, for additional information.
All Other Services	100% after *deductible*	50% after *deductible*	***Pre-certification* is required for inpatient hospital stays that exceed forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean delivery.**

HDHP Option

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
Medical Supplies	100% after *deductible*	50% after *deductible*	The following items will be considered under the Medical Supplies benefit: 1. **Jobst / Compression Stockings:** Limited to three (3) units per prescribed limb per *plan year*. 2. **Mastectomy Bras and Camisoles:** Limited to two (2) per *plan participant* per *plan year*.
Morbid Obesity	100% after *deductible*	50% after *deductible*	**Lifetime maximum:** The benefits payable for bariatric surgery, gastric bypass, or any other type of surgical weight loss procedure are limited to one (1) time during the life of the *plan participant*. Benefits will not be provided for subsequent procedures. Please refer to the subsection Covered Medical Charges, Morbid Obesity, for a further description and limitations of this benefit. ***Pre-certification* is required for surgical procedures in excess of $1,000 in billed charges.**
Office Visit	100% after *deductible*	50% after *deductible*	
Outpatient Surgery	100% after *deductible*	50% after *deductible*	***Pre-certification* is required for any single diagnostic test and/or surgical procedure $1,000 in billed charges.**

Rehabilitation Therapy			
Inpatient Rehabilitation	100% after *deductible*	50% after *deductible*	**Plan year maximum:** Sixty (60) days per *plan participant*. ***Pre-certification* is required.**
Outpatient Rehabilitation Therapy			
Speech Therapy	100% after *deductible*	50% after *deductible*	**Plan year maximum:** Twenty (20) *visits* per *plan participant*. ***Pre-certification* is required for speech therapy treatment programs (penalty applied per condition).**
Occupational Therapy Physical Therapy	100% after *deductible*	50% after *deductible*	***Pre-certification* is required for occupational and physical therapy treatment programs (penalty applied per condition).**
Routine Inpatient Newborn Care Following Delivery	100% after *deductible*	50% after *deductible*	

HDHP Option

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
Routine Vision Exam	100% after *deductible*	50% after *deductible*	**Plan year maximum:** One (1) exam per *plan participant*, except as covered under the Preventive Care provision.
Second Surgical Opinion	100% after *deductible*	50% after *deductible*	When services are required by the *Medical Review Administrator*. Refer to the **Medical Review/Pre-certification Program** section for details.
Skilled Nursing Facility/ Extended Care	100% after *deductible*	50% after *deductible*	**Plan year maximum:** Ninety (90) days per *plan participant*. ***Pre-certification* is required.**
Sterilization - Male	100% after *deductible*	50% after *deductible*	Services include sterilization for male *plan participants* when performed in the *physician's* office. Female sterilization is covered under the Preventive Care provision.
Teladoc	100%, *deductible* waived		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 logon to your Teladoc account or call 1-800-Teladoc (835-2362). The *Plan* is not liable for services provided by Teladoc. Refer to the Covered Medical Charges subsection for more information.
Urgent Care	100% after *deductible*	50% after *deductible*	
Wig in conjunction with Chemotherapy or Radiation Therapy	100% after *deductible*	50% after *deductible*	**Plan year maximum:** $300 per *plan participant*.

MENTAL DISORDERS & SUBSTANCE USE DISORDER			Mental nervous/*substance use disorder* services do not apply to the *out-of-pocket limit*.
Inpatient	100% after *deductible*	50% after *deductible*	***Pre-certification* is required.**
Outpatient	100% after *deductible*	50% after *deductible*	CCT also offers an Employee Assistance Program through SupportLinc which provides up to five (5) free counseling sessions each *plan year* (July 1-June 30) for each type of problem you may encounter along with work-life assistance, financial concerns, and/or legal problems.
Psychological/ Neuropsychological Testing	50% after *deductible*		***Pre-certification* is required.**

HDHP Option

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
PREVENTIVE CARE If a service is listed as A or B rated on the U.S. Preventive Service Task Force 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 Routine Wellness Care visit. For more information about *preventive care* services please refer to the following websites: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.**			
Routine Preventive Care	100% *deductible* waived	Not Covered	Includes the office visit and any other eligible item or service billed and received at the same time as any *preventive care* service) Services include, but are not limited to, routine physical exam, related lab, x-ray, gynecological exam, pap smear, colorectal cancer screening, blood work, bone density testing, and immunizations based on CDC guidelines. Services also include 2D and 3D mammograms [3D mammograms performed off-site are limited to one (1) per *plan year*]. Services for Wellness Care (Not Defined by *PPACA*) will be subject to the $750 *plan year* maximum, as listed below. Please refer to the section entitled **Medical Benefits**, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.
Contraceptive Services	100% *deductible* waived	Not Covered	Services include FDA-approved contraceptive methods, female sterilization, and patient education and counseling, not including drugs that induce abortion. **Benefit limitations:** Services are available to all female *plan participants*.

WELLNESS CARE (Not Defined by PPACA)			
Wellness Care (not defined by PPACA)	100% *deductible* waived, up to the *plan year* maximum	Not Covered	Services include Wellness Care, related labs and services not defined by *PPACA*, and biometric on-site screenings. **Plan year maximum:** $750 per *plan participant*. Up to $100 is allowed for non-mandated off-site *preventive care* and is not subject to *plan participant* cost share. Biometric on-site screenings are not deducted from the *Plan year* maximum.
TRANSPLANTS			
Organ Transplants	100% after *deductible*	50% after *deductible*	***Pre-certification* is required.**

T. Schedule of Prescription Drug Benefits – HDHP Option

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

Prescription drug charges apply to the medical *deductible*.

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

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

<table>
<tr><th></th><th>PREFERRED PHARMACY</th><th>NON-PREFERRED PHARMACY</th><th>NON-NETWORK PHARMACY</th></tr>
<tr><td colspan="4">Retail Pharmacy Option (30 Day Supply)</td></tr>
<tr><td>Tier 1: Most formulary generics and certain low-cost brand</td><td colspan="2" rowspan="3">After you meet the Medical Plan deductible, the Plan pays 100%.</td><td rowspan="2">After you meet the Medical Plan deductible, the Plan pays 50%.</td></tr>
<tr><td>Tier 2: Most formulary brands and certain high-cost generics</td></tr>
<tr><td>Tier 3: Non-formulary brands and generics</td><td>Specialty Drugs</td><td>Not Covered</td></tr>
<tr><td colspan="4">Specialty Drugs are only available through the Navitus SpecialtyRx Program Pharmacy, denoted with MSP on your formulary drug list.</td></tr>
<tr><td colspan="4">Retail 90 or Mail Order Option (90 Day Supply)</td></tr>
<tr><td>Tier 1: Most formulary generics and certain low-cost brand</td><td colspan="2" rowspan="3">After you meet the Medical Plan deductible, the Plan pays 100%.</td><td rowspan="3">After you meet the Medical Plan deductible, the Plan pays 50%.</td></tr>
<tr><td>Tier 2: Most formulary brands and certain high-cost generics</td></tr>
<tr><td>Tier 3: Non-formulary brands and generics</td></tr>
<tr><td colspan="4">Prescriptions filled by non-network pharmacy must be a covered medication on the Navitus formulary.</td></tr>
<tr><td colspan="4">Certain preventive care prescription drugs mandated under PPACA (including preferred generic and brand 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 medications: https://www.healthcare.gov/coverage/preventive-care-benefits/ or http://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.
The Plan also covers certain Safe Harbor medications at the preventive rate. For a complete list of preventive and Safe Harbor medications, refer to Navitus list at www.navitus.com.</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 along with the receipt to:

Navitus Health Solutions, LLC
Attn: Manual Claims
PO Box 999
Appleton, WI 54912-0999
(866) 333-2757

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

SECTION VII—MEDICAL BENEFITS

Medical Benefits apply when *covered charges* are *incurred* by a *plan participant* for care of an *injury* or *illness* and while the person is covered for these benefits under the *Plan*. For the purpose of these benefits, for a charge to be considered eligible the charge must be:

1. administered or ordered by a covered *physician*
2. *medically necessary*
3. not of an *experimental* and/or *investigational* nature
4. not of a custodial nature
5. reasonable and customary treatment relative to the diagnosis
6. *usual and customary and reasonable amounts* for the service that is rendered or the item that is purchased as determined by the *Plan* or its designee

Any amounts charged that are in excess of what the *Plan* determines to be the *usual and customary and reasonable amount* will not be eligible under this *Plan*.

All *covered charges* are subject to the exclusions, limitations, and conditions elsewhere stated in this *Plan*. The Medical Benefits payable will be subject to the applicable Schedule of Medical Benefits, are subject to the specified *deductible* provisions, and shall not exceed the maximums specified. Unless otherwise stated, all benefits are calculated on a per *plan participant* per *plan year* basis.

Covered charges may be subject to the annual *deductible* as listed on the applicable Schedule of Medical Benefits, and the applicable *co-insurance* level.

A. Covered Medical Charges

Covered charges are the *usual and customary and reasonable amounts* that are *incurred* for the following items of service and supply. These charges are subject to the benefit limits, exclusions, and other provisions of this *Plan*. A charge is *incurred* on the date that the service or supply is performed or furnished. A charge for a *prescription drug* is *incurred* on the date it is administered by the *physician* or furnished to the *participant*.

1. **Abortion.** Charges *incurred* for a medically required abortion for a covered *employee* or covered *dependent* spouse when the continuation of the *pregnancy* would be *life threatening* to the mother. Expenses related to complications of an abortion (including non-covered abortions) will be considered eligible.
2. **Advanced Imaging.** Charges for advanced imaging including, Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear medicine, or PET scans Charges include the readings of these medical tests/scans. ***Pre-certification* is required for outpatient 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.** Please also see the applicable Schedule of Medical Benefits.
3. **Allergy Services.** Charges for allergy testing, and the cost of the resultant serum preparation and its administration, when rendered by a *physician*, or in the *physician's* office. Injections of food allergy antigens, sublingual immunotherapy and the like are not considered eligible medical expenses. The allowance for antigens will be based on a three (3) month supply and a per vial cost.

4. **Ambulance.** Charges by a licensed professional ambulance service as follows:
    a. ground ambulance to the nearest appropriate *hospital* within twenty-four (24) hours of an *accident* or the sudden onset of severe symptoms of an *illness*
    b. transfer by ground ambulance to the nearest *hospital* with the necessary equipment, staff and facilities to treat the patient's condition, if treatment cannot be performed at the initial *hospital*
    c. ground ambulance service from the *hospital* to the *plan participant's* permanent place of residence will be covered, if *medically necessary*, as determined by the *Plan* or its designee
    d. transport by air or water ambulance will be considered a *covered charge* as described in a & b above, but only when *medically necessary* due to a *medical emergency*

    Charges for services requested for a licensed ground or air ambulance services, when the patient refuses to be transported, will be covered by the *Plan*. ***Pre-certification*** **is required** for fixed wing ambulance and non-emergent air ambulance.
5. **Anesthetics.** Includes anesthetic, oxygen, intravenous injections, solutions, and administration of these items.
6. **Bereavement Counseling.** Only in connection with the *Plan's* Hospice Care provision.

    Note: Bereavement counseling in connection with the *Plan's* Hospice Care provision does not require *pre-certification*.
7. **Birthing Center.** Charges by a hospital-based or freestanding licensed *birthing center*.
8. **Blood.** Non-replaced blood, blood plasma, blood derivatives, and their administration and processing.
9. **Cardiac Rehabilitation.** Cardiac *rehabilitation* Phase I and Phase II as deemed *medically necessary* in accordance with the type and frequency as ordered by a physician, provided services are rendered:
    a. initiated within twelve (12) weeks after other treatment for the medical condition ends
    b. rendered in a *medical care facility* as defined by this *Plan*
10. **Chemotherapy/Radiation.** Radiation or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included.
11. **Chiropractic.** Charges for *chiropractic care/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 (hot/cold therapy, etc.).
12. **Circumcision.** Circumcision for newborns from birth to six (6) months. After six (6) months, only medically necessary circumcisions will be covered.
13. **Clinical Trials.** This *Plan* will cover routine patient costs for a *qualified individual* participating in an *approved clinical trial* 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.**
14. **Contraceptives.** Refer to the Routine Preventive Care provision of this *Plan*.
15. **Diabetic Supplies.** The following diabetic supplies will be covered when *medically necessary*, under the Durable Medical Equipment (DME) provision of this *Plan*:
    a. Continuous Blood Glucose Monitor
    b. Insulin Pump and Related Supplies

    Pre-certification **is required for durable medical equipment (DME) charges over one thousand dollars ($1,000) in billed charges.**

    For all other diabetic supplies coverage, refer to the **Prescription Drugs Benefits** section.
16. **Diagnostic Testing.** Services include the Oncotype DX (ONCA) breast cancer testing. Services also include diagnostic 3D mammograms. ***Pre-certification*** **is required for any single diagnostic test and/or surgical procedure over one thousand dollars ($1,000) in billed charges.**

17. **Dialysis.** Charges for dialysis will be considered *covered charges*.

18. **Durable Medical Equipment (DME).** Charges for *medically necessary durable medical equipment (DME)* as prescribed by a *physician*. **DME charges over one thousand dollars ($1,000) in billed charges require *pre-certification* by the Medical Review Administrator prior to the purchase or rental.** Charges will only be allowed for the standard model of the particular piece of equipment.

    The rental or purchase of *DME* is at the option of the *Plan*, and rental is only payable up to the allowed purchase price (this does not apply to oxygen and its administration).

    Benefits for repair or replacement are eligible but do not apply to damage due to misuse, malicious breakage or gross neglect. Benefits are not available to replace lost or stolen items. Delivery or set-up charges are not a benefit of the *Plan*. Oxygen and its administration are covered under the *DME* benefit.

19. **Emergency Services:** The *Plan* will pay the greater of the following amounts for *emergency services* received from *non- network* providers:

    a. The amount for the *emergency services* is calculated using the same method the *Plan* generally uses to determine payments for services provided by a *non-network* provider (such as *usual and customary and reasonable amounts*), excluding any *co-insurance* that would be imposed if the service had been received from a *network* provider.

    b. The amount that would be paid under *Medicare* (Part A or Part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the *emergency services*, excluding any *co-insurance* that would be imposed if the service had been received from a *network* provider.

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

    a. bunions, when an open cutting/surgical operation is performed

    b. non-routine treatment of corns or calluses

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

    d. any *medically necessary surgical procedure* required for a foot condition that is not otherwise excluded

    Charges for *medically necessary* orthopedic shoes and other related supportive appliances, including their replacement once in each twelve (12)-month period, or, if under nineteen (19) years of age, once in each six (6) month period if necessitated by the child's growth. Orthotics will only be covered when ordered by a M.D. or D.P.M. and dispensed by a certified orthotics laboratory.

21. **Genetic/Genomic Testing and Counseling.** Genetic and genomic testing to identify the potential for, or existence of, a medical condition and/or abnormalities in groups of genes to aid in designing specific treatment options for an individual's condition, such as cancer. Refer to the **Federal Notices** section for the statement of rights under the Genetic Information Nondiscrimination Act of 2008 (GINA). ***Pre-certification* is required (except for amniocentesis).**

    Covered genetic/genomic testing includes:

    a. state-mandated newborn screening tests for genetic disorders

    b. fluid or tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis in covered pregnant *plan participants*, and only if the procedure is *medically necessary* as determined by the *Plan Administrator* or its designee

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

    d. genetic testing (e.g. BRCA) and genetic counseling required as a preventive service, in accordance with *PPACA* regulations

    e. noninvasive Prenatal Testing (NIPT)

22. **Hearing Aids.** The charge for two (2) hearing aids will be subject to the hearing aid limits shown in the applicable Schedule of Medical Benefits. Also covered under this benefit are hearing implants in lieu of a hearing aid. Batteries for related hearing devices are also covered.

23. **Hearing Examinations.** One (1) hearing test per *plan year* will be considered a *covered charge* (except pediatric exams considered preventive according to the U.S. Preventive Service Task Force.)

24. **Home Health Care.** Charges for home health care/home infusion services rendered by a licensed *home health care agency* which a *physician* has prescribed and which is determined by the *Plan* or its designee to be *medically necessary* and the most appropriate care. Mileage charges may be eligible if the *plan participant* resides in a remote area that does not have a local *home health care agency*. Benefits are payable as shown in the applicable Schedule of Medical Benefits. A *visit* by a representative of a *home health agency* of four (4) hours or less shall be considered as one (1) home health care visit. Charges for *custodial care*, mental health care, or *substance use disorder* or chemical dependency treatment would not be eligible under this provision. ***Precertification* is required for home health care and injectable medication over one thousand dollars ($1,000) in billed charges, administered in conjunction with home health care services** (refer to the Medications provision listed below). Please also see the applicable Schedule of Medical Benefits.
25. **Hospice Care.** Charges *incurred* for *hospice care services and supplies* provided by an *institution* or agency licensed as a hospice and certified to receive payment under *Medicare*, when it has been determined that the *plan participant* has less than six (6) months to live. The care must be certified by the attending *physician*, documenting the necessity of such care when traditional medical treatment and cure-oriented services are no longer medically appropriate due to the *plan participant's* terminal condition. The *hospice care plan* must be renewed in writing by the attending *physician* every thirty (30) days. *Hospice care services and supplies* cease if the terminal *illness* enters remission. ***Pre-certification* is required for inpatient admissions**. Please also see the applicable Schedule of Medical Benefits.
26. **Hospital Care.** Charges for semi-private *room and board*, intensive care and miscellaneous *hospital* services directly related to the treatment of the *injury* or *illness* that necessitated the confinement.
    a. Charges for a private room (that exceed the cost of a semi -private room) are eligible only if prescribed by a *physician* and the private room is *medically necessary*.
    b. Services for general anesthesia and related *hospital* or *ambulatory surgical center* services if *medically necessary* for dental procedures if either of the below apply:
        i. the *plan participant* is under age six (6)
        ii. the *plan participant* is over age six (6) and the service has been *pre-certified*

        This benefit does not cover the dentist's services.
27. **Infertility.** Charges to diagnose the condition of *infertility* will be considered a *covered charge*.
28. **Laboratory Studies.** Charges by a laboratory, a pathologist, or a radiologist for diagnostic or curative services related to an *illness* or *injury*, when ordered by a *physician*.
29. **Lenses.** The initial purchase of eyeglasses, contact lenses, or intraocular lenses for the following conditions:
    a. following cataract surgery
    b. damaged lens due to eye trauma
    c. congenital cataract
    d. congenital aphakia
    e. lens subluxation/displacement
    f. anisometropia of two (2) diopters or greater, and uncorrectable vision with the use of glasses or contacts
    g. replacement of a previously implanted, *medically necessary* intraocular lens due to anatomical change, inflammatory response, or mechanical failure

    A clear lens extraction intraocular lens implant for the correction of refractive error is not considered *medically necessary*. Intraocular lenses used to correct presbyopia and astigmatism are not considered *medically necessary*.
30. **Maternity.** Charges *incurred* as a result of *pregnancy* for pre- and post-natal care and delivery for a covered *employee* or covered *dependent* spouse, provided coverage is in effect at the time the actual charges are *incurred* (i.e. at the time of delivery). *Covered charges* include routine lab work and one (1) routine ultrasound during the course of a covered *pregnancy*.

Note: Breastfeeding support, counseling, maintenance, breast milk storage supplies, pump parts, and other supplies are also available without cost sharing when services are received from a *network* provider.

The care and treatment of *pregnancy* for a *dependent* 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/BrowseRec/Index/browse-recommendations** for a current listing of required pregnancy-related *preventive care* benefits.

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.

31. **Medical Foods**. Medical foods and applicable supplies will be covered only when *pre-certified*.

32. **Medical Supplies.** Charges for the following *non-durable* (disposable) supplies are eligible:

    a. cervical collars

    b. **Jobst / compression stockings**
    Limited to three (3) units per prescribed limb per *plan year*.

    c. **mastectomy bras and camisoles**
    Limited to two (2) per *plan participant* per *plan year*.

    d. ostomy supplies

    e. orthopedic braces

    f. sterile surgical supplies required following a covered *surgery*

    g. supplies required to operate/use *durable medical equipment* or corrective appliances

    h. supplies required for use by skilled home health or home infusion personnel, only for the duration of their services

33. **Medications.** Charges for covered *prescription drugs* and medicines, obtainable only upon a *physician's* written prescription, and prescribed for treatment of a covered *illness* or *injury*. Most prescriptions are purchased with the prescription card issued by the *Plan*. *Plan participants* present their prescription card to the pharmacist and pay the *co-insurance* amount indicated in the applicable Schedule of Medical Benefits. Medications that can be purchased over-the-counter are not eligible (including those that can be purchased at a lesser strength).

    Injectable medications over one thousand dollars ($1,000) in billed charges, administered in a physician's office or in conjunction with home health services require *pre-certification* from the Medical Review Administrator. If approved, these injectables may be required to be dispensed through the Prescription Drug Program when it is in the best interest of the *Plan* to do so. In the event the *Plan* determines that an injectable must be dispensed through the Prescription Drug Program, the *physician* or *home health care agency* and patient will be notified. A charge for a *prescription drug* is *incurred* on the date it is administered by the *physician* or furnished to the *participant*.

34. **Mental Disorders and Substance Use Disorder.** Coverage for mental health treatments are considered the same as benefits provided for other medical conditions. Charges for mental health treatment, including charges for *substance use disorder* and chemical dependency are considered *covered charges*.

    a. **Inpatient Treatment.** Alternative *outpatient* facility/day programs/intensive *outpatient* programs may be eligible under the *inpatient* benefit when provided in lieu of *inpatient* care and approved by the *Medical Review Administrator*. ***Pre-certification* is required for inpatient admissions and services.**

    b. **Outpatient Treatment.** *Outpatient* treatment for mental health care, treatment of chemical dependency or *substance* use disorder or family counseling. Expenses for the diagnostic testing to determine the diagnosis, treatment and medication management for attention deficit disorders (ADD and ADHD) will be covered under the mental health services provision of the *Plan*.

        Family counseling services are covered when all of the following criteria are met:

        i. when performed by a covered *mental health/substance use disorder provider*

        ii. when the counseling is provided for a covered diagnosis

c. **Psychological testing and neuropsychological testing are covered only if it is mandated by the condition and is pre-certified by the Medical Review Administrator.** If approved, testing is paid as shown in the applicable Schedule of Medical Benefits. ***Pre-certification* is required.**

35. **Midwife Services.** Benefits for midwife services performed by a certified nurse midwife (CNM) who is 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.

36. **Morbid Obesity.** Bariatric surgery may be considered eligible if the *plan participant* meets all of the following criteria and the procedure is performed by *in-network* providers (surgeons, assistant surgeons, anesthesiologists, etc.) at an *in-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 this *Plan* or their *employer's* plan [for an *employer* that has been a part of Cochise Combined Trust for less than two (2) years] 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, 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

    Note: 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 applicable Schedule of Medical Benefits.

    The term *morbid obesity*, for purposes of this exclusion and this *Plan*, means the *plan participant* meets one (1) or more of the following:

    a. Has a diagnosed condition in which the body weight exceeds the medically recommended weight by either one hundred (100) pounds or twice the medically recommended weight for a person of the same height, age and mobility as the *plan participant*.

    b. The *plan participant* has a Body Mass Index (BMI) of forty (40) or more.

    c. The *plan participant* has a Body Mass Index (BMI) of thirty-five (35) or more and the *plan participant* also, at the same time, suffers from two or more co-morbid medical conditions such as *life-threatening* pulmonary problems, severe diabetes, or severe joint disease surgically treatable except for the obesity, but such conditions may be improved by the performance of the bariatric surgery.

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 one (1) time during the life of the *plan participant*.

37. **Oral Surgery.** Charges for oral surgery for the removal of tumors or cysts, tissue biopsies or for the restoration of sound natural teeth or the alveolar processes due to an *injury* (restoration made to a functional level). If treatment is delayed, charges will only be payable if coverage is still in force at the time the treatment is rendered.

    Facility charges and charges for general anesthesia related to covered oral surgery will only be covered if prescribed by a *physician* and determined to be necessary for a medical reason.

38. **Orthopedic Shoes / Orthotic Appliances.** Charges for *medically necessary* orthopedic shoes and other related supportive appliances, including their replacement once in each twelve (12) month period; or, if under nineteen (19) years of age, once in each six (6) month period if necessitated by the child's growth. Orthotics will only be covered when ordered by a M.D. or D.P.M. and dispensed by a certified orthotics laboratory.

39. **Outpatient Observation Stays.** Services for *outpatient* observation stays will be considered at the applicable benefit level.

40. **Physician Care.** Charges by a *physician* for medical care in the *hospital*, emergency room, office, clinic, or other health care facility. The services of a Physician's Assistant (PA) or of a Nurse Practitioner will be eligible provided they are operating under the direct supervision of a *physician*.

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

    a. If bilateral or multiple *surgical procedures* are performed by one (1) surgeon, benefits will be determined based on the Blue Cross Blue Shield of Arizona allowable amount that is allowed for the primary procedures; 50% of the Blue Cross Blue Shield of Arizona allowable amount 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.

    b. If multiple unrelated *surgical procedures* are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Blue Cross Blue Shield of Arizona allowable amount 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 Blue Cross Blue Shield of Arizona allowable amount percentage allowed for that procedure.

    c. 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 allowed amount, 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*.

    d. If an assistant surgeon is required, the assistant surgeon's *covered charge* will not exceed 20% of the surgeon's Blue Cross Blue Shield of Arizona allowable amount.

41. **Preventive Care.** Charges *incurred* by a *plan participant* for routine *preventive care* such as routine physicals, routine laboratory tests and x-rays, routine gynecological exams, 2D and 3D mammograms [3D mammograms performed off-site are limited to one (1) per *plan year* for female *plan participants* ages thirty-five (35) and up, 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 care* service as defined by the U.S. Preventive Service Task Force. The *Plan* covers these items as stated in the applicable Schedule of Medical Benefits:

    a. **Evidence-Based Preventive Care 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 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, sterilization, and contraceptives. Pap smears are limited to one (1) per *plan year* for female *plan participants* between the ages of twenty-one (21) and sixty-five (65).

e. **Contraceptives.** Contraceptive coverage under the Medical Benefits of this *Plan* includes injections, implants, devices, and associated *physician* charges. Self-administered contraceptives are covered under the **Prescription Drug Benefits** program.

f. **Prevention for Men.** For men, one (1) prostate specific antigen (PSA) test and one (1) digital rectal exam (DRE) will be covered per *plan year* when performed on a preventive basis and performed in a provider's office.

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.

The *Plan* contributes to at least one (1) state-funded vaccination program, which covers the provider's costs associated with immunization serum for eligible, minor children up to the age of nineteen (19). Should a provider bill a vaccine charge for a child who is covered by that state's immunization program, regardless of their eligibility under the *Plan*, the *Plan* will consider its financial obligation of that *claim* satisfied through its contribution to the state funded immunization program and will not remit payment for that *claim*, except as may be required by applicable federal law. The administration of immunizations is covered.

Note: For a detailed listing of *preventive care* services, please visit the U.S. Department of Health and Human Services website at: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations**. For a paper copy, please contact the *Plan Administrator*.

42. **Prosthetic Devices / Corrective Appliances.** Charges for corrective appliances including the original fitting are eligible when ordered by a *physician* and necessary due to an *illness* or *injury*. Charges will only be allowed for the standard model of the corrective appliance. The rental or purchase of a corrective appliance is at the option of the *Plan*; rental is payable only up to the allowed purchase price. Charges will be allowed for replacement, adjustment and servicing of the appliance/prosthesis when necessary due to the growth of a covered child, or when the appliance has exceeded its maximum life expectancy.

43. **Reconstructive Surgery.** Reconstructive surgery expenses are covered in only the following circumstances:

    a. When needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part.

    b. To correct damage caused by an accidental *injury*.

    c. For breast reconstruction following a total or partial *mastectomy*, as follows:

        i. reconstruction of the breast on which the *mastectomy* has been performed

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

        iii. prosthesis and treatment of physical complications of all stages of *mastectomy*, including lymphedemas

    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).

44. **Routine Newborn Care.** Charges *incurred* at a *hospital* for routine newborn care, including charges for a routine in-hospital exam by a pediatrician and routine circumcisions will be covered as part of the mother's maternity *claim*. Any charges *incurred* by the newborn for other than routine care or for any routine care after discharge will only be covered if *dependent* coverage is in effect or is added within

thirty-one (31) days of the date of birth. These charges are subject to the newborn's own maximums and *deductibles*.

Charges *incurred* for well-baby care after birth while the newborn child is hospital confined as a result of the child's birth, including charges for a routine in-hospital exam by a pediatrician and routine circumcisions will be covered as part of the mother's maternity *claim*.

Any charges *incurred* by the newborn for other than routine care or for any routine care after discharge will be payable only if the newborn is enrolled on a timely basis as an eligible *dependent* under this *Plan* (as outlined in the Enrollment Requirements for Newborn Children subsection).

45. **Second Surgical Opinion.** Second surgical opinions will be covered when required and authorized by the *Medical Review Administrator*. The *Medical Review Administrator* will direct the *plan participant* to a surgeon that is not associated with the original *physician* and who specializes in treating the specific surgical problem.

46. **Skilled Nursing Facility.** Charges made by a *skilled nursing facility* or extended care facility are *covered charges* provided the confinement is certified as *medically necessary* by the attending *physician* and the care is not of a custodial nature. Benefits are payable as shown in the applicable Schedule of Medical Benefits. ***Pre-certification* is required for *inpatient* admissions.**

47. **Sleep Apnea/Sleep Studies.** Care and treatment for sleep apnea when *medically necessary*. **Sleep studies require *pre-certification*.**

48. **Sterilization**. Services for vasectomy or other voluntary sterilization procedures for male *participants*. When a vasectomy is elected, only the *physician's* charge for the *surgery* in his or her office will be payable as shown in the applicable Schedule of Medical Benefits. Facility charges for vasectomies will not be eligible.

    Female sterilization and family planning counseling is covered under the Contraceptive Service portion of the Preventive Care provision of this *Plan*.

    The *Plan* does not cover the reversal of voluntary sterilization procedures, including related follow-up care.

49. **Surgery.** Charges by a *physician* for *surgery* performed at a *hospital*, a licensed surgical center, or in the office. 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 any single surgical procedure over one thousand dollars ($1,000) in billed charges.**

50. **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-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.

    c. EPO and EPO Buy-up *plan participants* receive two (2) visits without cost sharing per *plan year*.

51. **Therapy Services.**

    a. **Rehabilitation Services.** Charges for *rehabilitation* services, including physical therapy, speech therapy, physiotherapy, and occupational therapy (for short term progressive *rehabilitation therapy*), provided it is mandated by the disability and is not of a maintenance nature.

    b. **Physical Therapy, Physiotherapy, and Occupational Therapy.** The *rehabilitation therapy* must be ordered by and under the supervision of a *physician* for the area of the body that is within the scope of his or her license and rendered by a *physician* or a Licensed/Registered Therapist. If, at any time, treatment becomes of a maintenance or custodial nature, benefits will cease. ***Pre-certification* is required for occupational and physical therapy treatment programs (penalty applied per condition).**

    c. **Speech Therapy.** Charges made for restoration of normal speech or to correct dysphasic or swallowing disorders, when the loss or impairment is due to a physical *injury*, *illness* or *surgery* will be payable as shown in the applicable Schedule of Medical Benefits. The therapy must be prescribed by a qualified *physician*. Speech therapy is not covered for the correction of stuttering, stammering, myofunctional or conditions of psychoneurotic origin. ***Pre-***

***certification* is required for speech therapy treatment programs (penalty applied per condition).** Please also see the applicable Schedule of Medical Benefits for plan year maximums associated with speech therapy.

Inpatient and *outpatient rehabilitation* treatment will be payable as shown in the applicable Schedule of Medical Benefits. *Inpatient rehabilitation* is limited as shown in the applicable Schedule of Medical Benefits. ***Pre-certification* is required for *inpatient* admissions.** If the condition mandates *inpatient* treatment that exceeds these limitations, the proposed additional treatment must be reviewed and approved in advance by the *Medical Review Administrator* in order for it to be considered for possible additional coverage under this *Plan*.

52. **Transplants.** Charges *incurred* for non-experimental human to human organ or tissue transplants such as: heart; lung; heart/lung; kidney; pancreas; liver; bone marrow; cornea, stem cell (stem cell transplants for breast cancer are considered *experimental/investigational* by this *Plan*).These transplants will only be covered if:
    a. The *plan participant* is a likely candidate for a successful outcome of the procedure; and
    b. The *plan participant* properly pre-certifies and maintains case management services throughout the course of the transplantation and post transplantation period as directed and coordinated by the *Plan's Medical Review Administrator*; and
    c. The procedure is performed at an *in-network* BlueCross of Arizona facility known to have an effective program for doing such procedure. If there is not an *in-network* facility that is equipped to perform the transplant, other facilities may be approved provided the facility is approved in advance by the *Medical Review Administrator* and the re-insurance carrier.

    Charges associated with the donor or the removal of the organ, and/or the procurement/acquisition/ transportation of the organ will also be considered as *covered charges*, subject to the recipient's individual benefit levels and plan maximums. Charges related to the donor for screening and testing and travel expenses (donor or recipient) are not covered under this *Plan*. ***Pre-certification* is required.**
53. **Virtual Visits.** Services rendered telephonically or electronically, performed by providers other than the *Plan's* telemedicine vendor, when performed for otherwise covered services.
54. **Urgent Care.** Services rendered at an *urgent care facility* when immediate medical attention is necessary.
55. **Vision Exams (Routine).** Routine eye exams will be payable as shown in the applicable Schedule of Medical Benefits. This provision only applies to the extent such services are not otherwise eligible under the Routine Preventive Care provision of the *Plan*.
56. **Wellness Care (Not Defined by PPACA).** Charges for routine wellness care not defined/mandated by *PPACA* such as routine physicals and routine laboratory tests and x-rays. Benefits payable are subject to a maximum benefit of five hundred dollars ($500) per *plan year*. Biometrics on-site screenings are not deducted from the *maximum benefit*.
57. **Wigs.** Charges associated with the purchase of a wig in conjunction with chemotherapy or radiation therapy. Subject to the limits as stated in the applicable Schedule of Medical Benefits.
58. **X-Rays.** Diagnostic x-rays.

B. Medical Plan Exclusions

Benefits are not payable under this *Plan* for any charges or treatment related to, or in connection with the following services and/or conditions, regardless of *medical necessity* or recommendation by a *physician*.

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

2. **Abortion.** Services, supplies, care, treatment, or drugs in connection with an abortion unless the life of the mother is endangered by the continued *pregnancy*.
3. **Acupuncture or Acupressure.** Expenses *incurred* for acupuncture or acupressure. Includes acupuncture administered by a *physician*, licensed for this treatment, provided in lieu of anesthetic.
4. **Adoption Charges.**
5. **Adoptive Cell Therapy.**
6. **Alternative Medicine.** Charges for the following, including related drugs, are excluded under this *Plan*: holistic or homeopathic treatment, naturopathic services, thermography, acupressure, aromatherapy, hypnotism, massage therapy, rolfing (holistic tissue massage), art therapy, music therapy, dance therapy, horseback therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.
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. **Assistant Surgeon.** Assistant surgeon when the need for an assistant is not documented.
9. **Assistive/Self-Help Devices.** Assistive/self-help devices which do not serve a primary medical purpose and instead ease the performance of activities of daily living, including but not limited to feeding utensils, reaching tools, or devices to assist with dressing and undressing, etc.
10. **Auditory Therapy.**
11. **Autopsies.** Autopsies (unless required by the *Plan*).
12. **Behavioral.** Diagnosis and treatment of behavioral problems and learning disabilities. Biofeedback, behavior modification, sensitivity training, hypnosis, or electro-hypnosis. Special education, counseling and therapy, or care for learning deficiencies or behavioral problems whether or not associated with a manifest *mental disorder* or other disturbances. This provision only applies to the extent such services are not covered as a *preventive care* service under the Preventive Care provision.
13. **Biofeedback.**
14. **Bone Marrow.** Benefits in connection with harvesting and reinfusion of bone marrow for the treatment of an *illness*, except as otherwise specifically provided herein. Autologous blood donations are not covered unless the blood is actually used during a scheduled *surgery*.
15. **Breast Reconstruction.** Breast reconstruction (except as covered under the Covered Medical Charges subsection), or charges for breast augmentation, breast reduction, or prophylactic breast removal. Charges related to the removal of breast implants inserted for *cosmetic* purposes are not eligible regardless of the reason for removal.
16. **Chelation Therapy.** Chelation therapy, except when necessary for treatment of heavy metal poisoning.
17. **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*.

18. **Complications from a Non-Covered Service.** Care, services, or treatment required as a result of complications from a treatment not covered under the *Plan*. Complications from a non-covered abortion are covered.

19. **Cosmetic.** *Cosmetic* or reconstructive procedures and attendant hospitalization, except for trauma or *disease*, done for aesthetic purposes and not to restore an impaired function of the body. *Cosmetic* procedures will not be covered regardless of the fact that the lack of correction causes emotional or psychological effects, including but not limited to, collagen injections, Botox injections, sclerotherapy, liposuction, tattoos, or tattoo removal.

    Complications or subsequent *surgery* related in any way to any previous *cosmetic* procedure shall not be covered, regardless of *medical necessity*.

20. **Counseling.** Benefits for counseling in the absence of *illness* or *injury*, including, but not limited to, premarital or marital counseling; counseling; education, social, behavioral, or recreational therapy; sex or interpersonal relationship counseling; or counseling provided by a *plan participant's* friends, employer, school counselor, or schoolteacher.

21. **Court Ordered Treatment.** Any treatment of a *plan participant* in a public or private *institution* as the result of a court order or commitment. This exclusion does not apply to *mental health or substance use disorder holds*, as they are not court-ordered treatments.

22. **Covered Charge.** Medical care, services, or supplies which do not come within the definition of *covered charges* and/or are not rendered by an eligible provider of service as defined by this *Plan*.

23. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, or *custodial care*.

24. **Dental Care.** Normal dental care benefits, including any dental, gum treatment, or oral surgery except as otherwise specifically provided herein.

25. **Developmental Delay.** Special education: charges made by a special education facility, tutor, behavior *specialist*, or provider of any kind for testing or treatment of learning disabilities, or developmental disorders. This provision does not apply to ADD or ADHD. This provision only applies to the extent such services are not covered as a *preventive care* service under the Preventive Care provision.

26. **Diabetic Education.** Services and supplies used in diabetes self-management programs are not covered under this *Plan*.

27. **Disposable Supplies.** Disposable (non-durable) supplies, including but not limited to diapers, incontinence pads, and bandages, except as covered under the Covered Medical Charges subsection.

28. **Educational or Vocational Testing.** Services for educational or vocational testing or training. Educational services such as nutrition therapy, asthma self-management education, *durable medical equipment* education, and Lamaze, except as otherwise listed herein.

29. **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.

30. **Examinations.** Examinations, vaccinations, inoculations, or immunizations related to employment, premarital or pre-adoptive requirements, issuance of insurance, obtaining a license, judicial or administrative procedures, medical research, or travel to foreign countries. Examinations or tests (including sports physicals) not incidental to or necessary to diagnose an *injury* or *illness*, except the coverage for the *preventive care* specifically allowed under the Covered Medical Charges subsection.

31. **Excess Charges.** Any charge for care, supplies, treatment, and/or services that are not payable under the *Plan* because the charges are in excess of:

    a. the negotiated rate agreed upon between BCBSAZ and the *network* provider for services and supplies

    b. the *usual and customary and reasonable amount* for services and supplies

    c. any *Plan* benefit limitation or maximum allowable benefit, whether the *Plan* is a primary or secondary payer

32. **Exercise Programs.** Charges *incurred* or related to health club/exercise/gym memberships, except as may be authorized through Cochise College and/or the Cochise Cares Wellness Program, aerobic and strength conditioning, back schools or back strengthening programs, massage therapy, rolfing, exercise equipment rental or purchase, health spas, or fitness resorts or similar i*nstitutions*. Exercise programs for treatment of any condition, except for physician-supervised cardiac *rehabilitation*, occupational, or physical therapy if covered by this *Plan*.
33. **Experimental/Investigational.** Care and treatment that is *experimental* and/or *investigational*. This exclusion shall not apply if the charge is for routine patient care for costs *incurred* by a *qualified individual* who is participating in an *approved clinical trial*. Charges will be covered to the extent specifically set forth in this plan document.
34. **Eye Care.** Services for all types of refractive keratoplasties; any other procedures, treatments, and devices for refractive correction. Charges *incurred* for diagnosis or treatment relating to eye refractive error, orthoptic or visual training, vision therapy, testing for visual acuity, field charting or for eyeglasses or contact lenses or for the fitting of such items. This provision only applies to the extent such services are not covered as a *preventive care* service under the Preventive Care provision.
35. **Foot Care.** Expenses for routine foot care, treatment of weak, unstable or flat feet will not be considered eligible.
36. **Foreign Travel**. Expenses for planned and/or routine services received or supplies purchased outside the United States, including those rendered on a cruise ship are excluded under the *Plan*. Services in the case of a *medical emergency* are a *covered charge*.
37. **Genetic Counseling.** Genetic counseling services are excluded under this *Plan*, except as required under applicable federal law.
38. **Genetic/Genomic Testing/Screening.** This benefit is excluded, except as specifically outlined in the Covered Medical Charges sub-section.
39. **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 or when otherwise prohibited by applicable law. Services received in a U.S. Department of Veterans Affairs (VA) *hospital* or VA facility on account of a military service-related *illness* or *injury* are not payable 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*.
40. **Growth Hormones.** Charges for growth hormones may be covered under the Prescription Drug Program. Refer to the **Prescription Drug Benefits** section for further information.
41. **Habilitation Services.**
42. **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 in conjunction with chemotherapy or radiation therapy.
43. **Health Maintenance Organization (HMO) Providers.** Health Maintenance Organization (HMO) providers when services are rendered to a covered HMO plan member.
44. **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
45. **Hospice Care.** Services for 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; respite care; and services or supplies not included in the *hospice care plan* or not specifically set forth as a hospice benefit.
46. **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.
47. **Hospital Services.** *Hospital* services when hospitalization is primarily for diagnostic testing/studies or physical therapy when such procedures could have been done adequately and safely on an *outpatient* basis.
48. **Illegal Acts.** Treatment received, including the use of ambulance services as described in the Covered Medical Charges subsection, for an *illness* or *injury* sustained as a result of being engaged in an illegal

occupation, or while incarcerated, or sustained during the commission of, or the attempted commission of a crime, an assault or a felony, whether or not there is a criminal charge or a conviction of a crime, if the offense is defined as a criminal act by the state in which the incident occurred, including *injuries* received while operating a motor vehicle in an illegal manner, driving while under the influence of alcohol or illegal drugs, negligent driving or driving at excessive speeds. Treatment of an *illness* or *injury* caused by participating in a civil insurrection or a riot.

49. **Immediate Family Member.** Any charge for care, supplies, treatment, and/or services that are rendered by a provider who is related to the *plan participant* by blood or marriage or who ordinarily dwells in the *plan participant's* household.
50. **Infertility.** Care, supplies, services and treatment for *infertility*, including, but not limited to, artificial insemination, in vitro fertilization, or any assisted reproductive technology (ART) procedure, except for *diagnostic services* rendered for *infertility* evaluation.
51. **Learning Disabilities.** Charges (including mental health care) related to treatment or testing of learning disabilities, developmental disorders, dyslexia, autism or mental retardation or any similar conditions. This provision does not apply to ADD or ADHD. Medications and office visits to monitor medications for these conditions will be eligible. This provision only applies to the extent such services are not covered as a *preventive care* service under the Preventive Care provision.
52. **Magnet Therapy.**
53. **Maintenance Rehabilitation Therapy.** Maintenance *rehabilitation therapy* or therapy for coma stimulation, either *inpatient* or *outpatient*.
54. **Massage Therapy.** Massage therapy or rolfing unless it is performed in conjunction with physical therapy and is performed by an eligible practitioner.
55. **Maternity.** Care and treatment of *pregnancy* and complications of *pregnancy* for a *dependent* daughter, except as stated in the Covered Medical Charges, Maternity provision.
56. **Medical Marijuana.**
57. **Medical Students, Interns, or Residents.**
58. **Modifications to Home.** Elevators, chairlifts, or other modifications to home, stairs, or vehicles.
59. **Music Therapy.**
60. **Myofunctional Therapy.** Myofunctional therapy or the treatment of tongue thrusts.
61. **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force. Charges, or a portion of a charge, for services or supplies that are discounted or reimbursed by a refund or rebate.
62. **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.
63. **No Physician Recommendation.** *Hospital* or other health care expenses if you leave against the medical advice of the attending *physician*.
64. **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.
65. **Non-Emergency Hospital Admissions.** Care and treatment billed by a *hospital* for *medical non-emergency care* admissions on a Friday or a Saturday. This does not apply if *surgery* is performed within twenty-four (24) hours of admission.
66. **Non-Medical Expenses.** Expenses, including but not limited to, 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 or internet consultations (not including services provided by Teladoc), and 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.

67. **Non-Prescription Medication.** Vitamins, nutritional supplements, minerals, diets, foods, infant formula, and naturopathic or homeopathic services and/or substances whether prescribed by a *physician* or purchased over-the-counter. This provision only applies to the extent such services are not covered as a *preventive care* service under the Preventive Care provision.
68. **Not Actually Rendered.** Any charge for care, supplies, treatment, and/or services that are not actually rendered.
69. **Not Medically Necessary.** Any charge for care, supplies, treatment, and/or services that are not *medically necessary*, as determined by the *Plan* or its designee, or are not necessitated as the result of existing symptoms of an *illness* or *injury* or are not considered the standard medical treatment for the diagnosed condition, except as covered under the Covered Medical Charges subsection, unless specifically stated as covered herein.
70. **Nutritional Counseling.** Expenses for nutritional counseling or classes. This provision only applies to the extent such services are not covered as a *preventive care* service under the Preventive Care provision,
71. **Obesity/Morbid 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*, including any type or variation of bariatric surgery (except when considered eligible and criteria is met, as shown under Morbid Obesity under the Covered Medical Charges subsection). This exclusion only applies to the extent such services are not covered as a *preventive care* service under applicable federal law,
72. **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.
73. **Occupational Therapy.** Occupational therapy and supplies, except during an *inpatient hospital* confinement or except as covered under the Covered Medical Charges subsection.
74. **Orthotics**. Charges in connection with orthotics, except as eligible under the Covered Medical Charges subsection.
75. **Other than Attending Physician.** Any charge for care, supplies, treatment, and/or services by a provider who did not render an actual service to the *plan participant*. *Covered charges* are limited to those certified by a *physician* who is attending the *plan participant* as being required for the treatment of *injury* or *disease* and performed by an appropriate provider. This exclusion does not apply to interdisciplinary team conferences to coordinate patient care.
76. **Personal Comfort Items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-prescription drugs and medicines, first-aid supplies, seat risers, and non-hospital adjustable beds.
77. **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 automobile 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.
78. **Personal Service Items.** Personal service items while confined in a *hospital* or health care facility (i.e. guest meals, television, telephone, etc.).
79. **Plan Design Excludes.** Charges excluded by the *Plan* design as mentioned in this document.
80. **Prescription Drugs.** Prescription drugs charges covered under the Prescription Drug Benefits, other than those covered in a *physician's* office or *inpatient* admission.

81. **Prior to Coverage.** Any charge for care, supplies, treatment, and/or services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.
82. **Private Duty Nursing.** Charges in connection with care, treatment or services of a private duty nurse while hospital confined.
83. **Prohibited by Law.** Any charge for care, supplies, treatment, and/or services to the extent that payment under this *Plan* is prohibited by law.
84. **Prosthesis Replacement.** Prosthesis replacement, unless necessitated by the growth of a child or the prosthesis has exceeded its maximum life expectancy.
85. **Repair or Replacement of Durable Medical Equipment (DME).** The following services or charges are not covered:
    a. charges for continued rental of a *DME* item after the allowed purchase price is reached
    b. repair or replacement of *DME* items lost, stolen, or damaged due to neglect; or use that is not in accordance with the manufacturer's instructions or specifications
86. **Reversal Surgery of Any Kind.**
87. School Setting. *Services performed in a school setting. This exclusion also applies to 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.*
88. **Sexual Dysfunction.** Sexual dysfunction or sexual inadequacy, including but not limited to sex change operations, medications, penile prosthetic implants, or similar devices.
89. **Sleep Disorders/Sleep Studies.** Care and treatment for sleep disorders, except in the case of sleep apnea.
90. **Smoking/Vaping Cessation.** Smoking cessation programs, aids, devices, or drugs (i.e. Nicorette and Nicoderm). This provision only applies to the extent such services are not covered as a *preventive care* service under applicable law. Refer to the **Prescription Drug Benefits** section for details on coverage.
91. **Standby Pediatrician.** Pediatrician charges for services as a standby pediatrician during childbirth unless a high-risk factor was indicated during the covered *pregnancy*.
92. **Sublingual Immunotherapy.**
93. **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* subrogation, reimbursement, and/or third party responsibility provisions. Refer to the **Reimbursement and Recovery Provisions** section.
94. **Surrogate Mothers.** Any and all costs for and relating to surrogate motherhood, or charges *incurred* by a *plan participant* acting as a surrogate mother.
95. **Temporomandibular Joint Syndrome**. Charges for surgical or non-surgical care or treatment related to *Temporomandibular Joint Dysfunction or Syndrome (TMJ)*, craniomandibular disorders, reconstruction of the maxilla or mandible for micrognathism, retrognathism, or orthognathic surgery/LeFort procedures, and related oral appliances.
96. **Transplants.** Organ or tissue transplants (except as covered under the Covered Medical Charges subsection), including insertion or maintenance of an artificial heart or organ and charges for artificial, *experimental*, or non-human body organs or tissue transplants. Travel and lodging expenses for *plan participants*, donors, or caregivers.
97. **Transportation.** Transportation charges except for ambulance provided in the Covered Medical Charges subsection.
98. **Travel or Accommodations.** Charges for travel accommodations, whether or not recommended by a *physician*, except for ambulance charges as defined as a *covered charge*.
99. **Vision Care Exclusions.** Expenses for the following:
    a. surgical correction of refractive errors and refractive keratoplasty procedures, including, but not limited to, Radial Keratotomy (RK), Automated Lamellar Keratoplasty (ALK), or Laser In-Situ Keratomileusis (LASIK)

b. diagnosis and treatment of refractive errors, including eye examinations (even when in conjunction with a medical diagnosis), purchase, fitting, and repair of eyeglasses or lenses (including, but not limited to polarized lenses, transition lenses, coating, or tints) and associated supplies, except one (1) pair of eyeglasses or contact lenses is payable as following ocular *surgery* when the lens of the eye has been removed such as with a cataract extraction

c. vision therapy orthoptics (eye muscle exercises) and supplies

d. orthokeratology lenses for reshaping the cornea of the eye to improve vision

100. **War.** Any loss that is due to a declared or undeclared act of war.

SECTION VIII—MEDICAL REVIEW/PRE-CERTIFICATION 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 ensure all *plan participants* receive necessary and appropriate health care while avoiding unnecessary expenses.

The purpose of the program is to determine what charges may be 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 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.

Your *employer* has contracted with the *Medical Review Administrator* 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 and 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

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

The provider, patient, or family member must call the *Medical Review 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*.

IMPORTANT: *Pre-certification* of a procedure does not guarantee benefits. All benefit payments are determined by the *Plan Sponsor* in accordance with the provisions of this Plan.

If a *plan participant* fails to comply with the *pre-certification* requirements, it will result in a three hundred dollar ($300) penalty.

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

1. all non-emergency hospital admissions [emergency within forty-eight (48) hours], including:
    a. *inpatient* admissions to hospice, skilled nursing, or *rehabilitation facilities*

   b. maternity admissions that exceed forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean delivery*

   *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. chemotherapy and radiation therapy
3. clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition
4. This Plan does not cover clinical trials related to other diseases or conditions. Refer to the Clinical Trials section for a further description and limitations of this benefit.
5. any single diagnostic test and/or surgical procedure over one thousand dollars ($1,000) in billed charges
6. durable medical equipment (DME) charges over one thousand dollars ($1,000) in billed charges
7. general anesthesia and related facility services for dental procedures, for plan participants over age six (6)
8. genetic/genomic testing (excluding amniocentesis)
9. home health care
10. injectable medications over one thousand dollars ($1,000) in billed charges, administered in a physician's office or in conjunction with home health services
11. occupational, speech, and physical therapy treatment programs (penalty applied per condition)
12. outpatient imaging – Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans (excluding services rendered in an emergency room setting)
13. psychological and neuropsychological testing
14. sleep studies
15. inpatient *mental health/substance use disorder* treatment (including residential treatment facility services)
16. fixed wing air ambulance
17. medical foods
18. specialty infusion/injectable medications over $1,000 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
19. non-emergency air ambulance
20. non-invasive prenatal testing (NIPT)

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 Review 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 medical management program is set in motion by a telephone call from, or on behalf of, the *plan participant*. Contact the *Medical Review Administrator* **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
7. the proposed rendering of listed medical services

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

The *Medical Review 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 may 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* will be informed of any denial or non-certification in writing.

Penalty for Failure to Pre-Certify

When the required *pre-certification* procedures are followed, your benefits will be unaffected. **However, if you do not follow the *pre-certification* requirements outlined above, you will be subject to a $300 penalty.** Amounts assessed under this penalty will not go towards satisfaction of your *out-of-pocket limit*.

Appeals of a Denial of Pre-Certification Request from the Medical Review Administrator

Pre-certification decisions are considered *claims* decisions that are subject to *appeal*. Refer to the **Claims and Appeals** section for details on how to *appeal* and the timeframes for *appealing* a *pre-service claim* decision.

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 part of the medical management program. The *Medical Review Administrator* will monitor the *plan participant's medical care facility* stay or use of other medical services and coordinate with the attending *physician*, *medical care facilities*, and *plan participant* either the scheduled release or an extension of the *medical care facility* stay or 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 Review Administrator*.

C. Case Management

Case Management is designed to help manage the care of patients who have special or extended care *illnesses* or *injuries*. Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a *plan participant's* health needs, using communication and available resources to promote quality, cost-effective outcomes. The primary objective of Case Management is to identify and coordinate cost-effective medical care which meets accepted standards of medical practice. Case Management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients, and others.

Cases are identified for possible Case Management involvement based on a request for review or the presence of a number of parameters, such as, but not limited to:

1. admissions that exceed the recommended or approved length of stay
2. utilization of health care services that generates ongoing and/or excessively high costs
3. conditions that are known to require extensive and/or long-term follow-up care and/or treatment

The *Plan* may elect, at its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the *Plan*. The alternative benefits, called Case Management, shall be determined on a case-by-case basis, and the *Plan's* determination to provide the benefits in one (1) instance shall not obligate the *Plan* to provide the same or similar alternative benefits for the same or any other *plan participant*, nor shall it be deemed to waive the right of the *Plan* to strictly enforce the provisions of the *Plan*.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The *Plan Administrator*, attending *physician*, patient, and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the *Plan Administrator* will direct the *Plan* to reimburse for *medically necessary* expenses as stated in the treatment plan, even if these expenses normally would not be paid by the *Plan*. Unless specifically provided to the contrary in the *Plan Administrator's* instructions, reimbursement for expenses *incurred* in connection with the treatment plan shall be subject to all *Plan* limits and cost sharing provisions.

Benefits under Case Management may be provided if the *Medical Review Administrator* determines that the services are *medically necessary*, appropriate, cost-effective, and feasible. All decisions made by Case Management are based on the individual circumstances of that *plan participant's* case. Each case is reviewed on its own merits, and any benefits provided are under individual consideration.

All Case Management is a voluntary service. There are no reductions of benefits or penalties assessed if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one (1) with the same diagnosis.

D. Courtesy Reviews

The *Medical Review 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 Review 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 *network pharmacies* to purchase your prescriptions.

If a drug is purchased from a *non-network pharmacy* or a *network pharmacy* when the *plan participant's* ID card is not used, the amount payable is shown in the Schedule of Prescription Drug Benefits.

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

Navitus Health Solutions
Attn: Manual Claims
PO Box 999
Appleton, WI 54912

B. Co-Insurance

Once you have met the Medical *plan year deductible*, your *co-insurance* is applied to each covered *pharmacy* drug or mail order drug charge and is shown in the applicable Schedule of Prescription Drug Benefits.

C. Manufacturer Coupons

Any amounts in the form of manufacturer coupons or drug savings discount cards used for brand name drugs when there is a generic equivalent available, unless the brand name is *medically necessary*, do not apply to the *deductible* or *out-of-pocket limit*.

D. Mail Order Drug Benefit Option

The Mail Order Drug Benefit Option is available for maintenance medications (those 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 Pharmacy Mail Order, the mail order *pharmacy*, is able to offer *plan participants* significant savings on their prescriptions.

E. Specialty Pharmacy Program

The Navitus Specialty Pharmacy Program (SpecialtyRx) is a specialty pharmacy program which covers some limited expensive drugs, such as specialty injectables, cancer drugs, and certain respiratory therapies used to treat various chronic conditions. 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 SpecialtyRx, call toll free at (800) 218-1488 or visit **www.navitus.com**.

F. Co-pay Max Plus Program- EPO and EPO Buy-up Only

The Plan works with the Co-pay Max Plus Program to obtain *co-payment* assistance on your behalf. This program applies to certain drugs that have manufacturer-funded *co-payment* assistance programs available. Under the Co-pay Max Plus Program, if the drugs have *co-payment* assistance available, the amount you pay for select medications may be set to the maximum of the current benefit design, $0, or the amount determined by the manufacturer-funded *co-payment* assistance programs. To take advantage of this pricing, you will be required to remain enrolled in Navitus' program for obtaining manufacturer assistance, including *co-payment* assistance. Amounts paid by manufacturers on your behalf (along with other payments from manufacturers, such as manufacturer coupons) will not count toward your annual *out-of-pocket limit* or *deductible*. Instead, only those payments made directly by you will count toward your *out-of-pocket limit* or *deductible*. Once manufacturer-funded *co-payment* assistance is exhausted, the amount you pay will be no more than your benefit design. Your *co-payment* will default to the formulary's current tiered *co-insurance/co-payment* if a drug does not qualify or is removed from the program.

G. Covered Prescription Drug Charges

1. **Compound Medications.** All compounded prescriptions containing at least one (1) prescription ingredient in a therapeutic quantity.
2. **Diabetic Supplies.** Insulin and other diabetic supplies (excluding diabetic 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.
3. **Injectables.** Injectable drugs or any prescription directing administration by injection.
4. **Over-the-Counter and Prescription Drug Tobacco Cessation Products**, such as nicotine gum or smoking deterrent patches. These drugs are payable without cost sharing up to two (2), ninety (90)-day courses of treatment per *plan year*, which applies to all products. Thereafter, the applicable *co-insurance* applies.
5. **Prescription Drugs Mandated Under PPACA.** Certain *preventive care* medications (including preferred generic and brand name contraceptives) received by a *network pharmacy* are covered and subject to the following limitations:
   a. generic preventive *prescription drugs* are covered at 100% and the *deductible*/*co-payment*/co-insurance (if applicable) is waived
   b. if no *generic drug* is available, then the *preferred brand* will be covered at 100%, and the *deductible*/*co-payment*/*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.):
      i. **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.
      ii. **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.
      iii. **Tobacco Cessation Products**. Such as nicotine gum, smoking deterrent patches, or generic tobacco cessation medications. Certain limitations apply.
      iv. **Preparation 'Prep' Products for a Colon Cancer Screening Test.** The *Plan* covers the over-the-counter or prescription strength products prescribed as preparation for a payable preventive colon cancer screening test, such as a colonoscopy.
      v. **Vaccinations.** Coverage for certain vaccinations at participating *pharmacies* based on Centers for Disease Control (CDC) guidelines including, but not limited to: Influenza, Pneumonia, Tetanus, Hepatitis, Meningitis, Shingles, MMR, HPV, and Varicella.

   Please refer to the following websites for information on the types of payable *preventive care* medications **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**.

H. 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. a thirty (30) day supply for retail prescriptions
4. a ninety (90) day supply for mail order prescriptions

I. Dispense As Written (DAW) Program

The *Plan* requires that retail *pharmacies* dispense *generic drugs* when available. If you or your *physician* specifies that a *brand name drug* should be dispensed when a *generic drug* is available, you will pay the appropriate brand *co-insurance* plus the difference in cost between the brand name and *generic drugs*.

The *plan participant's* share of this *prescription drug* cost difference does not apply toward the *Plan's out-of-pocket limit*.

J. 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 under the *Plan* is considered *creditable coverage* and is generally better than the standard *Medicare* Part D Prescription Drug benefits. This means that the *prescription drug* coverage for this *Plan* is as valuable as the standard *Medicare prescription drug* coverage. If you are a *Medicare* eligible person, you may want to enroll in *Medicare* Part D or another *Plan* Option (if applicable) instead of this *Plan* Option. For further information on this *Plan's prescription drug* coverage and *Medicare* Part D Prescription Drug benefits, refer to the section entitled **Federal Notices**.

K. Prescription Drug Plan Exclusions

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

1. **Abortion.** Drugs that induce abortion such as Mifepristone (RU-486) abortion unless in the case of rape, incest, or the life of the mother is endangered by the continued *pregnancy*. Pre-authorization would be required.
2. **Administration.** Any charge for the administration of a covered *prescription drug*.
3. **Appetite Suppressants/Dietary Supplements.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
4. **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
5. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, insulin pumps, or any similar device.
6. **Drugs Used for Cosmetic Purposes.** Charges for drugs used for *cosmetic* purposes, such as anabolic steroids, Retin A, or medications for hair growth or removal.
7. **Experimental/Investigational.** *Experimental/investigational* drugs and medicines, even though a charge is made to the *plan participant*. A drug or medicine labeled: "Caution: Federal law prohibits dispensing without prescription."
8. **FDA.** Any drug not approved by the Food and Drug Administration.
9. **Growth Hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance, unless approved prior authorization through Navitus Health Solutions is obtained.
10. **Impotence.** A charge for impotence medication.
11. **Infertility.** A charge for *infertility* medication.
12. **Inpatient Medication.** A drug or medicine that is to be taken by the *plan participant*, in whole or in part, while hospital confined. This includes being confined in any *institution* that has a facility for the dispensing of drugs and medicines on its premises.
13. **Medical Exclusions.** A charge excluded under the Medical Plan Exclusions subsection, unless specifically covered in this **Prescription Drug Benefits** section.
14. **No Charge.** A charge for *prescription drugs* which may be properly received without charge under local, state or federal programs.

15. **Non-Legend Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
16. **Refills.** Any refill that is requested more than one (1) year after the prescription was written or any refill that is more than the number of refills ordered by the *physician*.

SECTION X—SHORT-TERM DISABILITY BENEFIT

(Only available if elected during the enrollment period)

A. Schedules of Short Term Disability Benefits

Schedule of Short-Term Disability Benefits (Cochise County Employees)	
Waiting Period	Thirty (30) calendar days of *total disability** *30 days and after all accrued paid leave has been exhausted
Benefits Payable	
Percentage Payable	66 2/3% of salary (*weekly earnings*)
Minimum Payable	$100 per week
Maximum Days Payable	One hundred and eighty (180) calendar days
Survivor Benefit	Thirty (30) calendar days
Benefit Offsets	Other Group Short Term Disability, No Fault Auto Insurance, Social Security Disability, or Rehabilitation Income

Schedule of Short-Term Disability Benefits (Cochise College Employees)	
Waiting Period	Sixty (60) calendar days of *total disability** **Employees* are required to use available leave during the 60-day *waiting period*
Benefits Payable	
Percentage Payable	$66^{2}/_{3}$% of salary (*weekly earnings*) rounded to next higher multiple of $1.00, if not already an exact multiple, subject to a *maximum amount* of $1,385 per week
Minimum Payable	$25 per week
Qualifying Period - Maximum Days Payable	Fifty-nine (59) calendar days
Maximum Interruption During Qualifying Period	Ten (10) calendar days
Daily Limit	One-seventh ($^{1}/_{7}$) weekly amount
Maximum Benefit Period	Eighteen (18) weeks
Benefit Offsets	Other Group Short Term Disability, No Fault Auto Insurance, Social Security Disability, or Rehabilitation Income

Schedule of Short-Term Disability Benefits (Central Arizona College Employees)	
Waiting Period	Thirty (30) calendar days of *total disability***30 days and after all accrued paid leave has been exhausted
Benefits Payable	
Percentage Payable	66 2/3% of salary (*weekly earnings*)
Minimum Payable	$25 per week
Maximum Days Payable	One hundred and eighty (180) calendar days
Benefit Offsets	Other Group Short Term Disability, No Fault Auto Insurance, Social Security Disability, or Rehabilitation Income

If a *covered employee* becomes disabled and is unable to perform all of the duties of his or her job, the *covered employee* will be eligible for Short-Term Disability benefits provided he or she is under the regular care of a *physician* and all terms and conditions of this program have been met.

B. Short-Term Disability Terms

The following Short Term Disability terms appear italicized when used throughout this section.

Benefit Period

The length of time (number of days) during which disability benefits are payable.

Covered Employee

Includes County *employees* that have been employed for a minimum of six (6) months, and Cochise College and Central Arizona College *employees* that have been employed for a minimum of thirty (30) days.

Regular Physician Care

The *covered employee* is being seen by his or her his or her *physician* on a regular basis, at a frequency deemed appropriate for the disabling condition, and at intervals necessary for the *physician* to verify the continuing state of disability. For the purpose of this benefit, the *covered employee* must be seen by his or her *physician* a minimum of once every thirty (30) days.

Total Disability and Totally Disabled

A condition present whereby a person is unable to engage in duties of their regular occupation at their normal place of employment for their regularly scheduled amount of hours, or is unable to perform the normal activities of a person of like age and sex who is in good health, as a result of a covered *injury* or *illness*, and is under the regular care and attendance of a *physician* who certifies the person's disability, and the person is not performing work of any kind for compensation or profit.

Waiting Period

The number of consecutive days a *covered employee* must be *totally disabled* before benefit payments begin.

Weekly Earnings

The basic weekly compensation averaged over the most recent twelve (12) week period, exclusive of overtime, bonuses or commissions, or any other compensation outside of their employment through the *employer*. Disability benefit payments will not be paid during any period when an *employee* would not have normally received a paycheck.

C. Requirements to Establish a Short-Term Disability Claim

The disabled *employee* must submit a disability *claim* form to the *Third Party Administrator*, completed by the *employee*, the *employer,* and the attending *physician*. All three sections must be completed and signed by the persons indicated. The initial *claim* form must be submitted within ninety (90) days of the date the disability began.

In order for benefit eligibility to be established, the *employee* may be required to furnish copies of their medical records.

Any *employee* claiming disability may be subject to medical review at the *Third Party Administrator's* request. Case review may be made by the *Medical Review Administrator* and the *employee* may be required to submit to a medical evaluation for the purpose of a second opinion.

During the course of the disability *benefit period*, periodic requests will be made for updated medical information and/or a medical evaluation to establish continued disability status.

Disability benefits will begin after the *waiting period* has been met and any required accrued paid leave has been exhausted. Please reference the Schedule of Short Term Disability Benefits for the *waiting period*.

If a disabled *employee* returns to full-time work for ten (10) days or less during his or her *waiting period*, and then becomes disabled for the same condition, the *waiting period* will be extended by the number of days the *employee* returned to work (plus any weekends in between).

If a disabled *employee* returns to full-time work for more than ten (10) days during his or her *waiting period*, and then becomes disabled for the same condition, the *employee* will be required to satisfy a new *waiting period* in its entirety.

If an *employee* returns to work for at least one (1) full day and becomes disabled for a new and totally unrelated condition, a new *waiting period* must be satisfied and a new *benefit period* may be payable.

D. Benefit Calculations

1. The disability benefit will be calculated at the percentage referenced in the Schedule of Short-Term Disability Benefits of the *covered employee's weekly earnings*. The *weekly earnings* will be the amount the *covered employee* was earning at the time the disability began. Disability benefit payments will not be affected by statutory or cost of living increases. Benefits payable are subject to the minimum stated in the Schedule of Short-Term Disability Benefits.
2. Disability benefits will be payable through time period referenced in the Schedule of Short-Term Disability Benefits or until the *employee* returns to work, or the *covered employee* is eligible for the Arizona State Long Term Disability benefits, or until the *covered employee* is no longer disabled, whichever occurs first.
3. Disability benefits shall be reduced by income received from any of the following sources:
    a. disability benefits provided by no-fault auto insurance
    b. Social Security disability benefits
    c. rehabilitation income
    d. any salary, wages, commission or similar compensation payments
    e. loss of time benefits provided by any other group insurance contract

    If any of the above sources of income is received in a lump sum, the offset amount will be prorated over the number of weeks it represented. In no event will the benefits payable under this *Plan* be less than:

    For County Employees: One hundred ($100) dollars per week after the above offsets are applied.

    For Cochise College Employees: Twenty-five ($25) dollars per week after the above offsets are applied.

    For Central Arizona College: Twenty-five ($25) dollars per week after the above offsets are applied.

Disability benefit payments will not be paid during any period when an *employee* would not have normally received a paycheck.

Benefits will not be payable concurrently with Retirement Benefits.

E. Short-Term Disability Continuation of Benefits

1. Disability benefits will continue to be paid for up to the maximum number of days indicated in the Schedule of Short-Term Disability Benefits, provided the *covered employee* is continuously and *totally disabled* and meets all the eligibility requirements of this *Plan*.
2. If, during the course of a disability *benefit period*, the *employee* returns to active full-time or part-time work for thirty (30) days or less and then becomes disabled for the same or related condition, the reoccurrence will be considered a continuation of the original disability and therefore part of the same *benefit period*. A new *waiting period* will not be required and the benefits payable will be the remaining balance of the total allowable benefit days.
3. If the disabled *employee* returns to *active employment* for more than thirty (30) days and becomes disabled due to the same or related condition, benefits will only be payable if the recurrence of the disability is separated by six (6) months or more. Benefits will be subject to a new *waiting period* and a new benefit may be payable.

F. Short Term Disability Termination of Benefits

Benefits under this *Plan* will terminate at the time any of the following occurs:

1. the date the *covered employee* is no longer disabled
2. the date the *covered employee* fails to furnish the proper documentation that he or she continues to be disabled
3. the date the *covered employee* is no longer under the care of a *physician*
4. the date the maximum number of benefit days has been paid
5. the date the *covered employee* is eligible for the Arizona State Long Term Disability Plan
6. the date the *covered employee* becomes eligible for retirement benefits

NOTE: If an *employee* terminates coverage under the medical plan while on an approved Short-Term Disability claim, they are still qualified for coverage under the Short Term Disability Plan.

G. Short Term Disability Limitations and Exclusions

Short Term Disability benefits will not be payable if the disability was caused by any of the following:

1. *Injury* or *illness* which arises out of or occurs in the course of any occupation or while working for wage or profit, or for which the *employee* is entitled to benefits under the Workers Compensation Act or similar legislation.
2. War, whether declared or undeclared.
3. Civil disorder or riot.
4. An *injury* or *illness* sustained while incarcerated or sustained during the commission of, or the attempted commission of, an assault, a felony or other criminal act whether or not there is a criminal charge or a conviction of a crime, if the offense is defined as a criminal act by the state in which the incident occurred, including *injuries* received while operating a motor vehicle in an illegal manner, driving while under the influence of alcohol or illegal drugs, negligent driving, or driving at excessive speeds.
5. Service in the armed forces of any country.

SECTION XI—CLAIMS AND APPEALS

This section contains the *claims* and *appeals* procedures and requirements for the Cochise Combined Trust.

TIME LIMIT FOR FILING CLAIMS

All *claims* must be received by the *Plan* within twelve (12) months from the date of *incurring* the expense. 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*.

The following 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. The terms used in this section are defined below.

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* may have the right to request an independent *external review*. The *external review* procedures are described further in this section.

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 when the *appeal* is eligible for an external *appeal*, before a lawsuit may be filed. If a lawsuit is brought, the Plaintiff must comply with the Arizona Notice of Claim requirements set forth in ARS Section 12-821.01 and the one year or other applicable statute of limitations for *claims* against public entities, after the final determination of an *appeal*.

Any of the authority and responsibilities of the *Plan Administrator* under the *claims* and *appeals* 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

	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:	by the next regularly scheduled Trust meeting	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. Types of Claims Managed by the Medical Management Administrator

The following types of *claims* are managed by the *Medical Review 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.

C. 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 *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 will be completed between the *participant* and the provider.

D. Filing Non-Urgent Pre-Service Claims

Procedures for filing *pre-service claims* are discussed in the **Medical Review/Pre-Certification Program** section of the plan document. Under certain circumstances provided by federal law, if you or your *authorized representative* fails to follow the *Plan's* procedures for filing a *pre-service claim*, 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.

E. Urgent Care Claims

In order to file an *urgent care claim*, you or your *authorized representative* must call the *Medical Review Administrator* and provide the *Plan* with 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* fails to provide the *Plan* with the above information, the *Plan* will provide *notice* as soon as reasonably possible after receipt of *claim*, but not later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection after receipt of your *claim*. 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 not 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 not less than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. The *Plan* will then provide you with the *notice* of *benefit determination* within forty-eight (48) hours after the earlier of: receipt of the specified information or 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*, *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, 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 *Medical Review Administrator* shall provide oral *notification* of the *adverse benefit determination* 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 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. If an *urgent care claim* was denied, 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* or its designee 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 be given, upon request and free of charge, 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* or its designee 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* or its designee 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 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* or its designee issues its *final internal adverse benefit determination* based on 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* or its designee 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 Review Administrator* at (800) 388-3193. All necessary information, including the *Medical Review Administrator's benefit determination* on review, will be transmitted between the *Medical Review 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 not 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

If your *appeal* is denied, the *Plan Administrator* or its designee will provide written *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 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 statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures.
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.

F. 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 Review 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.

G. 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*.

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 Review 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 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 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 *Medical Review Administrator* or its designee 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.
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* or its designee 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 be given, upon request and free of charge, 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* or its designee 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* or its designee 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 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* or its designee issues its *final internal adverse benefit determination* based on 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* or its designee 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 Review Administrator* to review in conjunction with your *appeal*. Send all information to the *Medical Review Administrator* as listed in the Quick Reference Information Chart.

Time Period for Deciding Appeals of Other Pre-Service Claims

Appeals of *pre-service claims* will be decided by the *Medical Review 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* or its designee's decision will be provided to you in writing.

Notification of Appeal Denials of Other Pre-Service Claims

If your *appeal* is denied, 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 statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures.
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.

H. 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* or its designee. 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. For *claims*, this second-level review is mandatory, i.e., you are required to undertake this second-level *appeal*, prior to proceeding with civil action.

The *Plan Administrator* or its designee 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 subsection entitled General Procedures 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* or its designee 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* or its designee 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* or its designee'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.

I. 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*.

J. Incomplete Claims

Incomplete *pre-service claims* and/or *post-service claims* can be addressed through the extension of time described herein. (Refer to the *clean claim* definition in the **Defined Terms** section.) 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, or
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*.

K. 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 and must include the following information:

1. the *plan participant's* name, Social Security Number and address
2. *employee'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

Any exceptions to these filing requirements are subject to approval by the *Plan Administrator*.

Notification of Benefit Determinations of Post-Service Claims

Notice of *adverse benefit determinations* will be provided no later than the timeframe shown in the Timeframes for Claim and Appeal Processes 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*.

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*.

Notification of Adverse Benefit Determination of a Post-Service Claim

If a *post-service claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Claims Administrator* or its designee 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.
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 be given, upon request and free of charge, 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 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* or its designee issues its *final internal adverse benefit determination* based on 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* or its designee 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 *Claims Administrator* or its designee 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* or its designee 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* or its designee's decision will be provided to you in writing.

Notification of Appeal Denials of Post-Service Claims

If your *appeal* is denied, the *Claims 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 statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures.
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.

L. Second Level Appeal Process of Post-Service Claims

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

The *Plan Administrator* or its 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* or its designee. 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. For *claims*, this second-level review is mandatory, i.e., you are required to undertake this second-level *appeal*, prior to proceeding with civil action.

The *Plan Administrator* or its designee 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 subsection 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* or its designee 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* or its designee at the next regularly scheduled Trust meeting following receipt of the appeal by the *Plan Administrator* or its designee. The *Plan Administrator* or its designee'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.

M. External Review Rights

If your final *appeal* for a *claim* is denied, you will be notified in writing that your *claim* may be 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* procedure before you can request a voluntary *external review*.

If you decide to seek *external review*, an *Independent Review Organization (IRO)* will be randomly 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*.

N. External Review of Claims

The *external review* process is available only where the *final internal adverse benefit determination* is denied on the basis of:

1. a medical judgment (which includes but is not limited to *Plan* requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of a covered benefit)
2. a determination that a treatment is *experimental* or *investigational*
3. a rescission of coverage

If your *appeal* is denied, you or your *authorized representative* may request further review by an Independent Review Organization. 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 a *final internal adverse benefit determination*.

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 internal 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 *Claims Administrator* or its designee will randomly assign the request to an *IRO*. Once that assignment is made, the following procedure will apply:

1. The randomly assigned *IRO* will utilize legal experts where appropriate to make coverage determinations under the *Plan*.
2. The randomly 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 randomly 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 days after the date of assignment of the *IRO*, the *Plan* must provide to the randomly 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 randomly 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 randomly 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* may be 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 randomly assigned *IRO* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. The randomly 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 randomly 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* process. In addition to the documents and information provided, the randomly assigned *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, will consider any or all of 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 randomly 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 randomly assigned *IRO's* decision *notice* will contain all of 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:

a. 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

b. 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 randomly 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 within to both the *claimant* and the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection.

O. 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.

P. Interpretation of Plan Provisions

The *Plan*, together with the *Medical Review Administrator* and the *Claims Administrator*, shall have the discretion to interpret and apply the provisions of this *Plan*, subject to review by the *Plan Administrator*. Trustees shall have sole discretion to maintain and/or amend the *Plan* as well as in *appeal* and/or other review processes.

Q. Preferred Provider Arrangement

The Board shall have the right to contract with providers or existing *networks* of providers in order to establish a Provider Network. All other *Plan* restrictions and limitations will remain the same.

R. Independent 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.

S. Managed Care Recommendations

The *Plan*, together with the *Medical Review Administrator* and the *Claims 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 a *non-network* provider at the *network* provider level.

T. 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.

U. 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*.

V. 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.

W. 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 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

X. 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 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 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 XII—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 couples covered *dependents* are covered under two (2) or more plans, the plans will coordinate benefits when a *claim* is received.

Standard Coordination of Benefits (COB)

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*.

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	$200
Patient Responsibility	$0
Total Amount Paid	$1,000

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, school insurance coverage, or other benefit payment

C. Allowable Charge

For a charge to be allowable it must be a *usual and customary and reasonable amount* 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 the balance due up to 100% of the total allowable expenses. 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 this, 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 benefit plan which covers a person as an *employee* who is neither laid off or retired are determined before those of a benefit plan which covers that person as a laid-off or retired *employee*. The benefits of a benefit plan which covers a person as a *dependent* of an *employee* who is neither laid off or retired are determined before those of a benefit plan which covers a person as a *dependent* of a laid off or retired *employee*. If the other benefit 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 benefit 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 benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year.
        ii. If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit 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 benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
        ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the step-

parent that covers the child as a *dependent* will be considered next. The benefit 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 benefit 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 **https://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 previous benefit plan, that benefit 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/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 *plan 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, Recovery of Payments subsection, 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 subsection for more details.

L. Exception to Medicaid

The *Plan* shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the *Plan* or making a determination about the payments for benefits received by a *plan participant* under the *Plan*.

SECTION XIII—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 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 XIV—REIMBURSEMENT 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*, *disease,* 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 said incident, and/or other funds are available, including but not limited to no-fault coverage, uninsured or underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (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 one hundred percent (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. By accepting benefits the *plan participant(s)* agrees 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 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 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 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. 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 payments

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, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the *plan participant(s)* is fully compensated by his/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. 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*.

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*, *disease* 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)* 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* 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*, *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, 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 auto insurance 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

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.

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*, *disease*, 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 or 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

Failure by the *plan participant(s)* and/or his or her attorney to comply with any of these requirements may, at the *Plan's* discretion, result in a forfeiture of payment by the plan of medical benefits and any funds or payments due under this *Plan* on behalf of the *plan participant(s)* may be withheld until the *plan participant(s)* satisfies his or her obligation. 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 subrogation and reimbursement 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. The *Plan Administrator* may amend the *Plan* at any time without notice.

SECTION XV—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 Cochise Combined Trust (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.

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).

COBRA continuation coverage does not run concurrent with the coverage under the terms of the *Plan*.

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, 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, Effective Date, and Termination Provisions** section.

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 nonresident 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.

Each *qualified beneficiary* (including a child who is born to or placed for adoption 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

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 *employee* is made ineligible due to a reduction in work hours which puts him/her below the minimum hour requirements stated in the **Eligibility, Effective Date, and Termination Provisions** section of the *Plan*
4. the divorce or legal separation of a covered *employee* from the *employee's* spouse
5. 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.
6. a covered *employee's* enrollment in any part of the *Medicare* program
7. a *dependent* child's ceasing to satisfy the *Plan's* requirements for a *dependent* child (for example, attainment of the maximum age for dependency under the *Plan*)
8. 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*, or 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 the COBRA are also met. For example, any increase in contribution that must be paid by a covered *employee*, or the spouse, or a *dependent* child of the covered *employee*, for coverage under the *Plan* that results from the occurrence of one of the events listed above is a loss of coverage.

D. COBRA and FMLA

An *FMLA leave* does not make a *plan participant* eligible for COBRA coverage. Whether or not coverage is lost because of nonpayment of premium during an *FMLA leave*, the *plan participant* may be eligible for COBRA on the last day of the *FMLA leave*, which is the earliest to occur of:

1. when the *employee* informs their *employer* that he or she is not returning at the end of the leave
2. at the end of the leave, assuming the *employee* does not return
3. when the *FMLA* entitlement ends

For the purpose of an *FMLA leave*, the *employee* and his/her covered *dependents* will be eligible for COBRA as described above only if all of the following conditions are met:

a. the *employee* and/or his/her *dependents* were covered under this *Plan* on the day before the leave commenced (or became covered during the *FMLA leave*)
b. the *employee* does not return to employment at the end of the *FMLA leave*
c. the *employee* and/or his/her *dependents* lose coverage under this *Plan* before the end of what would be the maximum COBRA continuation period

E. Factors to Consider in Electing COBRA Continuation Coverage

You have special enrollment rights under Federal law (*HIPAA*). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's *employer*) within thirty (30) days after *Plan* coverage ends due to a *qualifying event* listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

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:

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. enrollment of the *employee* in 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 the *Plan Administrator* or its designee 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 to the *Plan Administrator* or its designee 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. You must send this notice to the *Plan Sponsor*.

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 the person, department, or firm listed below, at the following address:

AmeriBen
P.O. Box 7565
Boise, ID 83707
Fax: (208) 424-0595

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 the *Plan Administrator* or its designee 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 the *Plan Administrator* or its designee, 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 (but only after any applicable preexisting condition exclusions of that *other plan* have been exhausted or satisfied).

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 enrolls in the *Medicare* program (either part A or part B, whichever occurs earlier)
5. 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*.

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:
    a. eighteen (18) months after the *qualifying event* if there is not a disability extension
    b. 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*. Said notice shall be provided to the *Plan Administrator*, in writing, and must be sent to the *Plan Sponsor* in accordance with the procedures above.

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 *Plan Sponsor* in accordance with the procedures above.

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 up to 102% of the applicable premium and up to 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. 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. Payment that is made to the *Plan* by a later date is also considered timely payment if either under the terms of the *Plan*, covered *employees* or *qualified beneficiaries* are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the *employer* and the entity that provides *Plan* benefits on the *employer's* behalf, the *employer* is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the 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.

Q. Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage

If a *qualified beneficiary's* COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the *Plan* will, during the one hundred eighty (180) day period that ends on that expiration date, provide the *qualified beneficiary* with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the *Plan*.

R. If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the *Plan Sponsor*. For more including 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**.

S. Keep Your Plan Administrator Informed of Address Changes

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

T. 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 XVI—FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the *Plan* is funded as follows:

A. For Employee 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 *Plan Sponsor*. 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 *Plan Administrator* reserves the right to change the level of *employee* contributions.

Benefits are paid directly from the *Plan* through the *Third Party Administrator*.

B. 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. Women's Health and Cancer Rights Act (WHCRA)

If you have had or are going to have a *mastectomy*, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving *mastectomy*-related benefits, coverage will be provided in a manner determined in consultation with the attending *physician* and the patient for:

1. all stages of reconstruction of the breast on which the *mastectomy* was performed
2. *surgery* and reconstruction of the other breast to produce a symmetrical appearance; prostheses
3. treatment of physical complications of the *mastectomy*, including lymphedema

This coverage is subject to the same *deductibles* and *co-insurance* consistent with those established for other benefits under this *Plan*.

B. 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.

C. Notice of Prescription Drug Coverage and Medicare

Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current *prescription drug* coverage with the Cochise Combined Trust (hereafter CCT) and about your options under *Medicare*'s Prescription Drug coverage. It also tells you where to find more information to help you make decisions about your *prescription drug* coverage. You may ask for another copy of this notice from the CCT at any time.

Key points for you to remember:

1. *Medicare* Prescription Drug coverage (sometimes called *Medicare* Part D) is available to everyone with *Medicare*.
2. The *prescription drug* coverage offered to you by CCT is, on average for all plan participants under the EPO, EPO-Buy Up and HDHP Plan, are expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Creditable Coverage.**
3. If you have questions about this Notice or would like more information about your coverage options, please contact your Personnel Office or Human Resources Department.

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 of the *Plan* for information on how this *Plan* will coordinate benefit payment.

For more information about your current *prescription drug* coverage, please call the Prescription Customer Service number on your health insurance card.

If you have questions about this notice or would like more information about your options, please contact your Personnel Office or Human Resources Department.

More detailed information about *Medicare* plans that offer Prescription Drug coverage is available in the *Medicare* & You handbook, which is published annually by *Medicare*. You will get a copy of the handbook in the mail from *Medicare*. You can also get more information about *Medicare* Prescription Drug plans from:

- Visit **www.medicare.gov** for personalized help.
- Call (800) MEDICARE (800-633-4227). TTY users should call (877) 486-2048.

For people with limited income and resources, extra help paying for *Medicare* Prescription Drug plans is available. Information about this extra help can be obtained from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or call (800) 772-1213 (TTY 800-325-0778).

Keep this notice. If you enroll in a Medicare Prescription Drug plan in the future, you may need to give a copy of this notice to the *Plan* to show that you are not required to pay a higher monthly premium. You may ask for another copy of this notice from CCT at any time.

Date:	July 1, 2023
Name of Entity/Sender: Address:	Cochise Combined Trust c/o Gallagher Benefit Services 333 E. Osborn Rd., Suite 270 Phoenix, AZ 85012
Phone Number:	(928) 391-2296

D. Newborns' And Mothers' Health Protection Act Statement of Rights

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 if the attending provider (e.g., the *participant's physician*, nurse midwife, or physician's assistant), after consultation with the mother, discharges the mother and/or newborn earlier. Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48)-hour [or ninety-six (96)-hour] stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a *physician* or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48)-hour [or ninety-six (96)-hour]. *Pre-certification* is still required for the delivery and for newborn placement in an intensive care nursery. *Pre-certification* is also required for any length of stay period in excess of the minimum [forty-eight (48)-hour or ninety-six (96)-hour], even though not required for the minimum length of stay period.

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 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 persons 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:

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 the Cochise Combined Trust are designated as authorized to receive Protected Health Information from the Cochise Combined Trust (the *Plan*) in order to perform their duties with respect to the *Plan*:

a. Account Manager (brokerage firm)

b. Account Executive (brokerage firm)

c. Vice President for Administration

d. Human Resources Director/Associate Human Resources Director

e. Benefits Manager/Coordinator

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 Authorized Employees and Certification of Employers described above.

SECTION XIX—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.

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 immunotherapy*, and T-cell transfer therapy.

Adverse Benefit Determination

Any of the following:

1. a denial in benefits
2. a reduction in benefits
3. a rescission of coverage
4. a termination of benefits
5. a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a *claimant's* eligibility to participate in the *Plan*

Allowable Charges

The *usual and customary and reasonable amount* for any *medically necessary* 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 **Claims and Appeals** section herein, this *Plan's* allowable charges shall in no event exceed the *other plan's* allowable charges. When any *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 the *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*. An alternate recipient shall have the same status as a *plan participant*.

Ambulatory Surgical Center

A licensed facility that is used mainly for performing *outpatient surgery*, has a staff of *physicians*, has continuous *physician* and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

A licensed facility, with a staff of *physicians*, which meets all of the following:

1. has permanent operating rooms and at least one (1) recovery room, and all necessary equipment for use before, during and after *surgery*
2. is other than a private office or clinic of a *physician*
3. has full-time Registered Nurses available for care in an operating room or recovery room
4. has a contract with at least one (1) nearby *hospital* for immediate acceptance of patients who require *hospital* care following care in the freestanding facility
5. is supervised by an organized staff of medical professionals

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 (1) 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.

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. However, where 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.

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* surprise billing *claims*.

Benefit Determination

The *Plan's* decision regarding the acceptance or denial of a *claim* for benefits under the *Plan*.

Benefit Year

The twelve (12) month period beginning July 1 and ending June 30. All *deductibles* and benefit maximums accumulate during the *calendar 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.

Brand Name Drug

A trade name medication.

Calendar Year

The twelve (12) month period beginning January 1 and ending December 31.

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.

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*. In this document, the words 'you' and 'your' are used interchangeably with 'claimant'.

Claims Administrator

See *Third Party Administrator*.

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. fees under review for *usual and customariness* and *reasonableness*
4. 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 Decision

A decision by the *Plan* regarding coverage of an ongoing course of treatment that has been approved in advance by the *Plan*.

Co-Payment

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*, *deductible* amounts, and *out-of-pocket limits*. Providers may bill you directly or request payment of *co-insurance* 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

Charges for services and supplies described in this *Plan, incurred* as a result of a covered *injury* or *illness* by a covered person. For the purpose of these benefits, for a charge to be considered eligible the charge must meet all of the following:

1. administered or ordered by a covered *physician*
2. *medically necessary*
3. not of an *experimental* or *investigational* nature
4. not of a custodial nature
5. reasonable and customary treatment relative to the diagnosis
6. usual and customary amounts for the service that is rendered or the item that is purchased as determined by the *Plan* or its designee

Charges for routine *preventive care* are also considered as covered under the Covered Medical Charges subsection.

For a charge to be covered the charge must be a *usual and customary and reasonable amount* for services and/or supplies that have been prescribed by a *physician* for an *injury* or *illness* covered under this *Plan*. Covered charges shall not include expenses which are specifically excluded or reduced as a result of specific *Plan* requirements not satisfied. Any amounts charged that are in excess of what the *Plan* determines to be the *usual and customary and reasonable amount* will not be eligible under this *Plan*.

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, be performed by persons who have no medical training. 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.

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 child hood, 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 (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an *illness* or *injury* and (d) is appropriate for use in the home.

Emergency Hospitalization/Confinement

A *hospital* admission which takes place within twenty-four (24) hours of the onset of a sudden and unexpected severe symptom of an *illness* or within twenty-four (24) hours of an accidental *injury* during a *medical emergency*.

Emergency Services

With respect to a *medical emergency*:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a *hospital*, including ancillary services routinely available to the emergency department to evaluate such *medical emergency*.
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the *hospital*, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to *stabilize* the individual.

Employee

A person who is an active, regular employee of the *employer*, regularly scheduled to work for the *employer* in an employee/*employer* relationship.

Employer

As used herein shall mean Cochise County, Cochise College, Central Arizona College or the Cochise Combined Trust member entity, which provides eligibility under this *Plan*.

Enrollment Date

The first day of coverage or, if there is a *waiting period*, the first day of the *waiting period*.

Experimental/Investigational

Services, supplies, care, and treatment which do not constitute accepted and appropriate medical practice considering the circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the *Plan Administrator* as set forth below.

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*. In addition to the above, the *Plan Administrator* will be guided by the following principles to determine whether a proposed treatment is deemed to be experimental and/or investigational, 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 (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be experimental and/or investigational
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, then it is deemed to be experimental and/or investigational
3. if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or investigational arm of ongoing 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, then it is deemed to be experimental and/or investigational

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, then it is deemed to be experimental and/or investigational

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.

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:

a. the named drug is not specifically excluded under the *Plan*
b. the named drug has been approved by the FDA
c. the off-label drug use is appropriate and generally accepted by the medical community for the condition being treated
d. 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 (EOB)

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*.

Fiduciary

A *fiduciary* exercises discretionary authority or control over management of the *Plan* or the disposition of its assets, renders investment advice to the *Plan*, or has discretionary authority or responsibility in the administration of 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*, the second-level *appeal* results in a final internal adverse benefit determination that triggers the right to *external review*.

FMLA Leave

A *leave of absence*, which the *employer* is required to extend to an *employee* under the provisions of the *FMLA*.

Formulary/Formulary Drug

A list of prescription medications compiled by the third party payer of safe or effective therapeutic drugs specifically covered by this *Plan*.

Foster Child

An individual who is placed with the covered *employee* by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

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.

The *Plan* complies with Title I of the Genetic Information Nondiscrimination Act of 2008 (GINA) as it applies to group health plans.

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.

Health Savings Account (HSA)

A tax-exempt or custodial account that you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you *incur*. You must be eligible to qualify for an HSA (refer to the **Schedule of Benefits** section of this document). Both *employer* and *employee* may contribute to an HSA in the

same year. Annual contribution limits are subject to IRS guidelines. Participation in a qualified *high deductible health plan* is required for participation in an HSA program.

High Deductible Health Plan (HDHP)

A medical plan with lower premiums and a minimum *deductible* amount, set forth by federal law, which is higher than a traditional health plan *deductible*.

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 it 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 services and supplies* required for the treatment of the patient.

Home Health Care Services and Supplies

The items and services which are furnished to a *plan participant* who is under the care of a *physician*. Such items and services may be furnished by a licensed *home health care agency* or by others under arrangements made by such an agency, under a plan established and periodically reviewed by such *physician*. Such items and services shall be furnished on a visiting basis in the *plan participant's* home or, if necessary, at the nearest facility equipped to provide such services when not available at the *plan participant's* place of residence, and shall consist of any or all of the following:

1. a *visit* by a representative of a *home health care agency* of four (4) hours or less shall be considered as one (1) home health care visit
2. part-time or intermittent nursing care provided by or under the supervision of a Registered Nurse
3. physical therapy, occupational therapy, speech therapy, and part-time or intermittent services of a home health aide, all of whom must be licensed to perform such services

Such items and services may further consist of any or all of the following:

a. medical social services under the direct supervision of a *physician*
b. medical supplies (other than drugs and biologicals), and the use of medical appliances while under such a plan
c. in the case of a *home health care agency* which is affiliated or under common control with a *hospital*, medical services provided by an intern or resident in-training of such *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 care agency* and supervised by a *physician*.

Hospice Care Services and Supplies

Services rendered for the care of patients who are dying of a terminal condition and have less than six (6) months to live and for whom traditional cure-oriented services are no longer medically appropriate. A hospice care program represents a coordinated, interdisciplinary program that provides services which consist of both:

1. *inpatient* or *outpatient care*, home care, nursing care, counseling and other supportive services and supplies provided to meet the physical, psychological, spiritual and social needs of the dying *plan participant*

2. instructions for care of the patient, counseling and other supportive services for the family of the dying person

Hospice care charges are only eligible when rendered by an organization that is approved by *Medicare* for payment.

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 defects, *disease*, physical illness, or *mental disorder*. Illness includes *pregnancy*, childbirth, miscarriage or complications of *pregnancy*.

For a Covered Dependent other than Spouse: A bodily disorder, congenital defects, *disease*, physical illness, or *mental disorder*, not including *pregnancy* or its complications.

Immediate Family Member

The *plan participant's* mother, father, sister, brother, husband, wife, and/or child whether by birth or by marriage.

Incurred

An expense for a service or supply is incurred on the date the service or supply is furnished. A charge for *prescription drug* is incurred on the date it is administered by the *physician* or furnished to the *participant*. 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 determinations* and *final internal adverse benefit determinations*.

Infertility

Incapable of producing 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.

In-Network

See *Network*.

Inpatient

Treatment in an approved facility during the period when charges are made for *room and board*.

Institution

A facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a hospital, ambulatory surgical center, *psychiatric hospital*, community mental health center, *residential treatment facility*, psychiatric treatment facility, *substance use disorder treatment center*, alternative *birthing center*, home health care center, or any other such facility that the *Plan* approves.

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 per day.

Investigational

See *Experimental/Investigational*.

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

Unexpected, acute, sudden, and serious conditions which require immediate medical treatment.

Life-Threatening Disease or Condition

Any *disease* or condition from which the likelihood

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.
of death is probable unless the course of the *disease* is interrupted.

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. *network* allowed amount
2. *network non-participating provider* rate
3. *the negotiated rate established in a contractual arrangement with a provider*
4. *the usual and customary and/or reasonable amount*
5. *the actual billed charges for the covered services*
6. air ambulance will be considered at 200% of the *Medicare* rate

The *Plan* has the discretionary authority to decide if a charge is *usual and customary and reasonable amount* 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.

Maximum Benefit

Any one (1) of the following, or any combination of the following:

1. The *maximum amount* paid by this *Plan* for any one (1) *plan participant* during the entire time he or she is covered by this *Plan*.
2. The *maximum amount* paid by this *Plan* for any one (1) *plan participant* for a particular *covered charge*. The *maximum amount* can be for either:
    a. the entire time the *plan participant* is covered under this *Plan*
    b. a specified period of time, such as a *plan year*
3. The maximum number as outlined in the *Plan* as a *covered charge*. The maximum number relates to the number of:
    a. treatments during a specified period of time
    b. days of confinement
    c. *visits* by a *home health care agency*

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 either:

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)

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 manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A medical emergency includes such conditions as heart attacks, cardiovascular *accidents*, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care

Care which can safely and adequately be provided other than in a *hospital*.

Medical Review Administrator

A team 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 **Medical Review/Pre-certification Program** section of this document.

Medically Necessary/Medical Necessity

Care and treatment that 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 Disorders and Nervous Disorders/Substance Use 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/Substance Use Disorder Provider

1. a licensed Psychiatrist, a licensed Psychologist, a Licensed Professional Counselor (LPC), a Licensed Clinical Social Worker (LCSW), a Licensed Independent Substance Use Disorder Counselor (LISAC), a Licensed Psychiatric Nurse Practitioner (PSYNP); or
2. when rendered by one (1) of the following counselors, provided the counselor is employed by and working under the direct supervision of a Psychiatrist or Clinical Psychologist:
    a. Master Social Worker (MSW)
    b. Master Science Nurse (MSN)
    c. Master of Arts in Guidance & Counseling (MA)
    d. Master of Education in Guidance & Counseling (MED)
    e. Master in Counseling (MA)

Morbid Obesity

The *plan participant* meets one (1) or more of the following:

1. A diagnosed condition in which the body weight exceeds the medically recommended weight by either one hundred (100) pounds or twice the medically recommended weight for a person of the same height, age and mobility as the *plan participant*.
2. The *plan participant* has a Body Mass Index (BMI) of forty (40) or more.
3. The *plan participant* has a Body Mass Index (BMI) of thirty-five (35) or more and the *plan participant* also, at the same time, suffers from two or more co-morbid medical conditions such as *life-threatening* pulmonary problems, severe diabetes, or severe joint *disease* surgically treatable except for the obesity, but such conditions may be improved by the performance of the bariatric surgery.

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 one (1) time during the life of the *plan participant*.

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-Durable

Goods and supplies which cannot withstand repeated use and/or are considered disposable and limited to a one-person or one-time use, including but not limited to diapers, incontinence pads, soap, etc.

Non-Formulary Drug

A brand-name drug you choose to purchase in spite of available *generic drugs*; or new drugs whose cost is higher than alternative therapies (though these may eventually become *formulary drug*s).

Non-Network

Services rendered by a non-participating provider within the designated *network* area.

Notice/Notify/Notification

The delivery or furnishing of information to a *claimant* as required by federal law.

Open Enrollment Period

The annual period in which *employees* and *dependents* are able to elect or change their benefit options.

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, school insurance coverage, or other benefit payment

Outpatient/Outpatient Care 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, ambulatory surgical center, or the patient's home. This definition also applies to intensive outpatient mental health services.

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 *plan year*. Out-of-pocket limits accumulate on an individual basis. After a *plan participant* reaches the out-of-pocket limit, the *Plan* pays benefits at a higher rate.

Patient Protection and Affordable Care Act (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 duly licensed or certified *practitioner* acting within the scope of his/her license or certification and holding the degree of:

1. Doctor of Medicine (M.D.)
2. Doctor of Osteopathy (D.O.)
3. Physician's Assistant (P.A.)
4. Nurse Practitioner (N.P.)
5. Doctor of Podiatry (D.P.M.)

The services of a Physician's Assistant will be eligible provided they are operating under the direct supervision of an M.D. or D.O. An eligible physician shall not include the *plan participant*, or a physician who is part of the *plan participant's* immediate family.

Plan

The Cochise Combined Trust, which is a benefits *Plan* for certain *employees* of the *employer* and is described in this document.

Plan Administrator

The Cochise Combined Trust which is the named administrator of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and the management and disposition of *Plan* assets.

Plan Participant/Participant

Any *employee* or *dependent* who is covered under this *Plan*.

Plan Sponsor

The Cochise Combined Trust

Plan Year

The twelve (12) month period beginning July 1 and ending June 30. All *deductibles, out-of-pocket limits,* and *benefit maximums* accumulate during the plan year.

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.

Practitioner

A person acting within the scope of applicable state licensure/certification requirements and holding the degree of Certified Nurse Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA), Registered Physical Therapist (RPT), Occupational Therapist, Speech Therapist, Physician's Assistant (PA), Certified Surgical Assistant (CSA), Registered Nurse First Assistant (RNFA), Nurse Practitioner (NP) or Registered Respiratory Therapist. An eligible practitioner shall not include the *plan participant*, or anyone who is a member of the *plan participant's* family or resides with the *plan participant*. Eligible Mental Health/Behavioral Health practitioners are limited to Psychiatrist, Psychologists, Certified Professional Counselors, and social workers with a master's degree in behavioral science (provided they are working under the direct supervision of a *physician*, a Psychiatrist or a Psychologist). Optometrists administering topical pharmaceutical agents or removing superficial foreign bodies from the eye must be appropriately licensed and meet any additional state requirements for such services.

Pre-Admission Tests/Testing

Those *diagnostic services* done prior to scheduled *surgery*, provided that all of the following conditions are met:

1. The tests are approved by both the *hospital* and the *physician*.
2. The tests are performed on an *outpatient* basis prior to *hospital* admission.
3. The tests are performed at the *hospital* into which confinement is scheduled, or at a qualified facility designated by the *physician* who will perform the *surgery*.

Pre-Certification (Pre-Certified)

An evaluation conducted by a *Medical Review Administrator* through the **Medical Review/Pre-certification 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 an *illness* 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* (e.g. a request for *pre-certification* under the Medical Review/Pre-Certification Program).

Preventive Care

Certain preventive services mandated under the *Patient Protection and Affordable Care Act (PPACA)* which are available without cost sharing 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 Physician (PCP)

A Family Practitioner, General Practitioner, Internist, Pediatrician, Obstetrician/Gynecologist (OB/GYN), Nurse Practitioner, or Physician's Assistant who provides basic or general health care.

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*.

Psychiatric Hospital

An *institution* constituted, licensed, and operated as set forth in the laws that apply to *hospitals*, which meets all of the following requirements:

1. it is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a *physician*
2. it maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided
3. it is licensed as a psychiatric hospital
4. it requires that every patient be under the care of a *physician*
5. it provides twenty-four (24) hour per day nursing service

The term psychiatric hospital does not include an *institution*, or that part of an *institution*, used mainly for nursing care, rest care, convalescent care, care of the aged, *custodial care*, or educational care.

Qualified Beneficiary

Used and defined under the section, **Continuation Coverage Rights Under COBRA**.

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*.

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.

Qualifying Event

Used and defined under the section, **Continuation Coverage Rights Under COBRA**.

Rehabilitation/Rehabilitation Therapy

Physical, occupational, and speech therapy prescribed by a *physician* and performed by licensed therapists, to improve body function that has been restricted or diminished as a result of *illness*, *injury,* or *surgery*. The *Plan* covers active rehabilitation which refers to therapy in which the patient actively participates and is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform their normal body function.

Passive rehabilitation refers to therapy in which the patient does not actively participate because of a cognitive deficit, is comatose or otherwise physically or mentally incapable of active participation. Maintenance rehabilitation refers to therapy in which the patient actively participates and has met the functional goals of the active rehabilitation so that no continued improvement is anticipated but where additional therapy may be prescribed to maintain, support and/or preserve the patient's functional level.

Rehabilitation Hospital/Facility

An *institution* which mainly provides therapeutic and restorative services to ill or injured people. It is recognized as such if it meets any of the following criteria:

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

Retiree

For information regarding eligibility for retirees, refer to the section entitled **Eligibility, Effective Date and Termination Provisions**.

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*

State Children's Health Insurance Program (SCHIP)

The State Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

Security Standards

The final rule implementing *HIPAA's* Security Standards for the Protection of Electronic PHI, as amended.

Semi-Private Room Charge/Rate

The charge by a *hospital* for a room containing two (2) or more beds.

Sickness

See *Disease*.

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 convalescing from *injury* or *illness*
2. 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 registered nurse

   Services to help restore patients to self-care in essential daily living activities must be provided.
3. its services are provided for compensation and under the full-time supervision of a *physician*
4. it provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse
5. it maintains a complete medical record on each patient
6. it has an effective utilization review plan
7. 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 care facility, long-term acute care facility, or any other similar nomenclature.

Sound Natural Tooth

A tooth that is stable, functional, free from decay and advanced periodontal disease, and in good repair at the time of the accident.

Specialist

A *physician* whose practice is limited to a specific area of medicine or *surgery* in which they have undergone additional training.

Specialty Drug

High-cost drugs used to treat complex or rare conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia. The drugs are often self-injected or administered in a *physician's* office or through *home health care services*.

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.

Stabilize

With respect to an emergency medical condition: To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

With respect to an emergency medical condition of a pregnant woman who is having contractions: To provide such medical treatment of the condition as may be necessary because (1) there is inadequate time to effect a safe transfer to another *hospital* before delivery, or (2) transfer may pose a threat to the health or safety of the woman or her unborn child, to deliver (including the placenta).

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 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 CARG
3. licensed, certified or approved as an alcohol or *substance use disorder* treatment program or center by a state agency having legal authority to do so

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 Disorder/Syndrome (TMJ)

Temporomandibular Joint Disorder/Syndrome (TMJ) is the treatment of jaw joint disorders including conditions of structures linking the jawbone 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*.

Total Disability (Totally Disabled)

In the case of a *dependent* child, the complete inability as a result of *injury* or *illness* 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 *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*.

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 *plan participant*.

Usual and Customary and Reasonable Amount

The normal charges of the provider for a service or supply, but not more than the prevailing charge in the same geographical area for a like service or supply. A charge is usual when it corresponds to the going charge for a given service by a provider of medical services. The charge is customary when it is within the range of usual charges made by providers of medical services, with similar training and experience, for the same service within the same specific and limited geographical area. The charge is considered reasonable when it meets the foregoing criteria, and, in the opinion of responsible medical authorities, it is justifiable considering the special circumstances of the particular case in question. With respect to *EPO*/PPO providers, the UCR charge is defined as the fee allowance as outlined in the agreements between the *EPO*/PPO providers and the *EPO*/PPO.

Waiting Period

An interval of time during which the *employee* is in the continuous, *active employment* of his or her participating *employer*.

Visit

An in-person interview/consultation between a *physician* or other eligible health care *practitioner* and a *plan participant*.

SECTION XX—PLAN ADOPTION

A. Severability

In the event that any provision of this plan 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 plan document will not in any way be affected or impaired thereby.

B. Adoption

The Cochise Combined Trust hereby adopts the provisions of this Exclusive Provider Organization (EPO) Plan, Buy-Up Exclusive Provider Organization (Buy-Up EPO) Plan, High Deductible Health Plan (HDHP), and its duly authorized officer has executed this Plan Document and Summary Plan Description effective the first day of July 2023.

DocuSigned by:
By: Wendy Davis
DD2917C3BB70444...

Date: 7/3/2023

Title: CCT Chairperson

If you have questions about your *Plan* benefits,
please contact the *Third Party Administrator* at
(855) 258-6455.

AmeriBen

PO Box 7186
Boise ID 83707