
**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

PINAL COUNTY EMPLOYEE BENEFIT TRUST

Effective 1/1/2010

PINAL COUNTY EMPLOYEE BENEFIT TRUST

To All Covered Plan Members

The "PINAL COUNTY EMPLOYEE BENEFIT TRUST" (PCEBT), hereinafter called the Plan, assures the Covered Plan Members during the continuance of this Plan, that all benefits hereinafter described, shall be paid to them or on their behalf in the event the Covered Person incurs Covered Expenses as defined herein.

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

This revised Plan of benefits for the Pinal County Employee Benefit Trust became effective as of 12:01 a.m. Mountain Standard Time on January 1, 2010.

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:

- Receive approval from American Health Group prior to all surgical and diagnostic procedures over \$1,500.
- Receive care from a provider in the EPO network.
- Have surgery and x-ray/laboratory work done on an outpatient basis whenever possible.
- Use hospital emergency rooms only in the event of a serious medical emergency.
- Review all Hospital and Physician billings and your Explanation of Benefits to be sure you and the Plan have only been billed for the services you received.
- **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!

TO YOUR GOOD HEALTH!

QUICK REFERENCE INFORMATION

Group Number	PCE001 or 0110001
Plan Administrator/Plan Sponsor	Pinal County 31 North Pinal Florence, Arizona 85232 (800) 208-6897
Claims Administrator	AmeriBen/IEC Group P.O. Box 7186 Boise, ID 83707 1-877-955-1548 (fax) 208-424-0595 www.ameriben.com Flex fax: 800-723-4703 Flex email: flex@ameriben.com
Medical Review <i>(Pre-certification and Second Opinions)</i>	American Health Group (AHG) 2152 South Vineyard #103 Mesa, Arizona 85210 (602) 265-3800 (800) 847-7605
Exclusive Provider Organization <i>(Names of Physicians & Hospitals in the Network)</i>	BlueCross® BlueShield® of Arizona P O Box 13466 Phoenix Arizona 85002 (800) 232-2345 www.azblue.com
Prescription Drug Program	WHP Health Initiatives, Inc. PO Box 29061 Phoenix, Arizona 85038-9061 (800) 207-2568 www.mywhi.com
Address for mail order	Walgreens Healthcare Plus P.O. Box 29061 Phoenix, Arizona 85038-9061
Employee Assistance Program	Jorgensen/Brooks Group (888) 520-5400

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EXCLUSIVE PROVIDER ORGANIZATION (EPO)

This 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" providers" and the BCBSAZ "Participating Only" providers.

Use of EPO providers is required for the benefits described in this book. All services received in Arizona must be rendered by a BlueCross® Blue Shield® of Arizona network provider or benefits will not be available (except in the case of a life threatening emergency). When a Plan Member receives pre-certified, approved services from an In-Network provider at an In-Network facility and, through no choice of their own, receives ancillary services such as anesthesiology, radiology, hospitalist, etc. from a non-contracted provider, those services may be considered at the In-Network benefit level. This provision will not apply in situations where the provider sends medical work to non-contracted facilities.

When you need medical care select a provider from your BlueCross® BlueShield® of Arizona directory or contact BCBSAZ at (800)-232-2345 or www.azblue.com to verify the doctor's current status as a network provider. Your ID card identifies the BlueCross® BlueShield® of Arizona network and it should always be presented when obtaining services. The BCBSAZ provider will collect your co-payment and will submit your claim to AmeriBen for payment consideration. AmeriBen 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".

A current directory of the BlueCross® BlueShield® of Arizona contracted "Preferred Care" and "Participating Only" hospitals, physicians, and other network providers is available by link on the Pinal County Website.

If the need for emergency medical care occurs while outside of the Plan's Arizona EPO network or if a Plan Member lives in another state, benefits will be payable in accordance with the "Out-of-State" schedule of benefits shown in Article I.

If your EPO physician needs to send you to another physician or admit you to a hospital, be sure that you are referred to a provider that participates in your EPO network.

(BlueCross® BlueShield® of Arizona, an independent licensee of the BlueCross® BlueShield® Association, does not provide administrative or claims payment services for the Plan. The Plan Administrator has assumed all liability for claim payments in accordance with the provisions of this plan document.)

MEDICAL REVIEW / PRE-CERTIFICATION

This Plan has contracted with American Health Group (AHG) to provide medical review, and pre-certification of selected services. AHG will review proposed medical services to determine their medical necessity and appropriateness.

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

This program is designed as a cost containment program to maximize the Plan benefits and reduce unnecessary hospitalizations, surgical procedures and other diagnostic services. Once a pre-certification is received it is valid for ninety (90) days.

Failure to comply with the pre-certification requirements may result in a twenty percent (20%) reduction in benefits or may disqualify the Covered Person for benefits.

1. Pre-certification is required on the following:

Diagnostic tests and surgical procedures over one thousand five hundred dollars (\$1,500)
All non-emergency Hospital or Facility admissions

2. Procedure for obtaining pre-certification:

- a. For non-emergency procedures and Hospital admissions, the Covered Person or his/her Physician must contact AHG prior to the admission or in advance of the procedure. AHG will review the request for services and contact the Physician for any records or additional information necessary for AHG to thoroughly evaluate the need for services. Benefit eligibility for the pre-certified procedures must be verified with AmeriBen prior to completing services.
- b. For emergency procedures or hospital admissions the Covered Person, his/her Physician, the hospital admissions clerk, or anyone associated with the Covered Person's treatment must notify AHG by telephone within forty-eight (48) hours of the procedure or the admission.

3. Second Surgical Opinions

Before approval of a requested surgical procedure, AHG may require the Covered Person to have a second opinion. AHG will provide the Covered Person with the name of one or more Physicians that can provide the second opinion.

4. Case Management

In certain complex medical situations case management may become necessary. A case manager will be assigned to work with the patient, the family, the Physician and the claims payor to coordinate an effective treatment plan.

5. Appeal / Reconsideration Procedures

You may appeal any recommendation made by this medical review program. The appeal must be made in writing directly to American Health Group. You can expect a response within thirty (30) days of your request unless it is necessary to obtain additional medical records.

"AHG" may be reached at: (602) 265-3800 or (800) 847-7605
2152 South Vineyard #103
Mesa, Arizona 85210

Benefit Eligibility information can be obtained on AmeriBen's website at www.ameriben.com

ARTICLE I

SCHEDULE OF MEDICAL BENEFITS

The following benefits are provided to employees that have elected the Medical Plan.

The benefits listed as ***In-Network*** are available in Arizona only through BlueCross® BlueShield® of Arizona (BCBSAZ) contracted providers. **If a Plan member uses a provider within Arizona that is not a contracted BCBSAZ provider, no benefits will be available.** The ***Out-of-State*** benefits are available when a Plan Member is traveling outside Arizona or is living in another state. All Out-of-State benefits are subject to the deductible(s) except when defined by the Plan as a life threatening emergency.

MEDICAL PLAN		
	NETWORK PROVIDERS	OUT OF STATE BENEFITS
MAXIMUM LIFETIME BENEFIT AMOUNT, PER COVERED PERSON	\$2,000,000 (Combined In-Network and Out of State Maximum)	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	\$0	\$250
Per Family Unit	\$0	\$750
CO-INSURANCE MAXIMUM AMOUNT, PER CALENDAR YEAR		
For eligible charges that are payable at 80%, the first \$10,000 per Person, or \$20,000 per Family in a Calendar Year are payable at 80%. Eligible charges over these amounts are payable at 100% for remainder of Calendar Year.		
	NETWORK PROVIDERS	OUT OF STATE BENEFITS
Note: The maximums listed below are the total for Network and Out of State expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Out of State Providers.		
Common Accident Provision		
If more than one person is involved in an accident, then only one deductible must be satisfied for the accident.		
Hospital Services (including Mental Health/Substance Abuse)		
Room and Board	80%	80% after deductible
Intensive Care Unit	80%	80% after deductible
Emergency Room	\$100 copay (copay waived if admitted to hospital)	80% after deductible
The Emergency Room copayment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator must be notified within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.		
Urgent Care (Freestanding and Hospital based)	\$50 copay	80% after deductible
Note: Covered Charges from a Non-Network Provider for a Life Threatening Emergency will be payable at the Network level of benefits.		
Skilled Nursing Facility 60 Day Calendar Year Maximum (Combined In-Network and Out of State Maximum)	80%	80% after deductible
Physician Services (including Mental Health/Substance Abuse)		
Inpatient visits	\$25 copay	80% after deductible
Office visits	\$25 copay	80% after deductible
Outpatient diagnostic x-ray & lab	\$25 copay	80% after deductible
Anesthesiologist	100%	80% after deductible

MEDICAL PLAN		
	NETWORK PROVIDERS	OUT OF STATE BENEFITS
Ancillary Charges Note: When a Plan Member receives pre-certified, approved services from an In-Network provider at an In-Network facility and, through no choice of their own, receives ancillary services, such as anesthesiology, radiology, hospitalist, etc. from a non-contracted provider, those services may be considered at the In-Network benefit level. This provision will not apply in situations where the provider sends medical work to non-contracted facilities.		
Allergy serum, injections and testing	\$25 copay per day of service	80% after deductible
Outpatient Surgery		
Facility Charges	\$100 copay per day	80% after deductible
Physician	100%	80% after deductible
Home Health Care 100 Visits Calendar Year Maximum	100%	80% after deductible
Hospice Care	\$25 copay 100 Day Lifetime Maximum (Combined In-Network and Out of State Maximum)	80% after deductible 100 Day Lifetime Maximum (Combined In-Network and Out of State Maximum)
Ambulance Service	100%	80% after deductible
Jaw Joint/TMJ \$300 Calendar Year Limit	80%	80% after deductible
Wig After Chemotherapy	80%	80% after deductible
Occupational Therapy	80%	80% after deductible
Physical Therapy	\$25 copay Out-Patient Maximum: 3 month treatment plan & a \$1,500 maximum benefit per condition Inpatient Maximum: \$1,000 per day and 60 day Calendar Year Limit (Combined In-Network and Out of State Maximums)	80% after deductible Out-Patient Maximum: 3 month treatment plan & a \$1,500 maximum benefit per condition Inpatient Maximum: \$1,000 per day and 60 day Calendar Year Limit (Combined In-Network and Out of State Maximums)
Physiotherapy	80% Out-Patient Maximum: 3 month treatment plan & a \$1,500 maximum benefit per condition Inpatient Maximum: \$1,000 per day and 60 day Calendar Year Limit (Combined In-Network and Out of State Maximum)	80% after deductible Out-Patient Maximum: 3 month treatment plan & a \$1,500 maximum benefit per condition Inpatient Maximum: \$1,000 per day and 60 day Calendar Year Limit (Combined In-Network and Out of State Maximum)
Speech Therapy	80% Out-Patient Maximum: 3 month treatment plan & a \$1,500 maximum benefit per condition Inpatient Maximum: \$1,000 per day and 60 day Calendar Year Limit (Combined In-Network and Out of State Maximum)	80% after deductible Out-Patient Maximum: 3 month treatment plan & a \$1,500 maximum benefit per condition Inpatient Maximum: \$1,000 per day and 60 day Calendar Year Limit (Combined In-Network and Out of State Maximum)
Durable Medical Equipment	\$25 copay per item per month \$750 Per Item Maximum (Combined In-Network and Out of State Maximum)	80% after deductible \$750 Per Item Maximum (Combined In-Network and Out of State Maximum)
Prosthetics	80%	80% after deductible

MEDICAL PLAN		
	NETWORK PROVIDERS	OUT OF STATE BENEFITS
Orthotics	80% Limited to once in each 12 month period for ages 19 and older and once in each 6 month period for under age 19 if necessitated by growth. (Combined In-Network and Out of State Maximum)	80% after deductible Limited to once in each 12 month period for ages 19 and older and once in each 6 month period for under age 19 if necessitated by growth. (Combined In-Network and Out of State Maximum)
Spinal Manipulation Chiropractic	\$25 copay \$1,000 Calendar year Limit	80% after deductible \$1,000 Calendar year Limit
Skilled Nursing/Rehab Facility	80% 60 day Calendar Year Maximum	80% after deductible 60 day Calendar Year Maximum
Preventive Care		
Routine Well Care	\$25 copay (Age 2 through Adult) \$500 Calendar Year Maximum (Combined In-Network and Out of State Maximum)	80% after deductible (Age 2 through Adult) \$500 Calendar Year Maximum (Combined In-Network and Out of State Maximum)
Includes: mammogram, routine physical examination, x-rays, laboratory blood tests, and immunizations/flu shots.		
Colonoscopy Screening (Frequency Limits Apply)	\$25 copay	80% after deductible
Frequency limits for Colonoscopy Ages 50 and over Colonoscopy once every Ten (10) years		
Routine Well Baby Care (to age 2) \$750 Calendar Year Maximum (Combined In-Network and Out of State Maximum)	\$25 copay	80% after deductible
Includes: office visits, routine physical examination, laboratory blood tests, x-rays, hearing tests and immunizations through age 1.		
Eye Examinations (under age 17)	\$25 copay	Not Covered
Hearing Examinations	80%	80% after deductible
Hearing Aides	50% \$1,500 per Calendar Year Maximum (Combined In-Network and Out of State Maximum)	50% after deductible \$1,500 per Calendar Year Maximum (Combined In-Network and Out of State Maximum)
Pregnancy Dependent daughters not covered.		
Inpatient Hospital Charges	80%	80% after deductible
Pre & Postnatal Care & Delivery	\$25 copay at Initial Visit Only	80% after deductible
Limits: One routine maternity ultrasound per Pregnancy; \$750 maximum per epidural per pregnancy (Combined In-Network and Out of State Maximum)		
All other covered services	80%	80% after deductible

Prescription Drug Program

Network Provider: WHI Health initiatives

Retail Pharmacy Option (Maximum 30 Day Supply)**Copayment, per Prescription:**

	Mandatory Generic (including Diabetic Supplies/Drugs)	\$10 copay
	Brand Name (when Generic not available)	\$25 copay
	Non-Preferred Brand Name or Brand with Generic available	\$50 copay plus cost difference between Generic and Brand Name

Mail Order Option (90 Day Supply)

	Mandatory Generics (including Diabetic Supplies/Drugs)	\$20 copay
	Brand Name (when Generic not available)	\$50 copay
	Non-Preferred Brand Name or Brand with Generic available	\$100 copay plus cost difference between Generic and Brand Name

Retail 90 Advantage 90[®] Pharmacy Option (Maximum 90 Day Supply)

	Mandatory Generics (including Diabetic Supplies/Drugs)	\$20 copay
	Brand Name (when Generic not available)	\$50 copay
	Non-Preferred Brand Name or Brand with Generic available	\$100 copay plus cost difference between Generic and Brand Name

ARTICLE II

ELIGIBILITY / EFFECTIVE DATE

2.01 Eligible Employee: All active full-time Employees scheduled to work 40 hours or more each week and elected officials, are eligible provided they occupy an authorized budgeted position, as defined by the County, and are performing all of the duties of their employment. Correctional Health Nurses (RN/LPN) are considered as full-time employees when they occupy an authorized budgeted position and are scheduled for a minimum of thirty-six (36) hours weekly. Elected officials are also eligible to participate under the Plan under the same requirements as Employees. Selection of this Plan must be in accordance with the Pinal County Flexible Benefits Plan during the annual open enrollment or when a qualified change of status has occurred.

2.02 Leave of Absence: If a Covered Employee is granted an approved leave of absence by the County, the Covered Employee and his/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, or until the Employee is qualified for Long Term Disability with the State of Arizona. If the Covered Employee is not able to return to work after the six (6) month leave, coverage can be continued under the COBRA provisions of this Plan (reference Article IV for additional COBRA information).

2.03 Initial Enrollment: All new employees will be covered based on their date of hire. If the date of hire is within the first twenty-one (21) days of a month, the effective date for coverage will be the first day of the month following the day of hire. If the date of hire is the twenty-second (22nd) day of the month or after the effective date for coverage will be the first day of the second month following the day of hire. Eligibility is contingent on the following:

- a] Proper enrollment has been made; and
- b] Any required contributions have been authorized.

2.04 Eligible Dependent: Eligible dependents shall include a Covered Employee's:

- a] Lawful spouse (not common law) provided they are not legally separated;
- b] Unmarried children, including legally adopted children (from the date of placement in the employee's home for the purpose of adoption), until their nineteenth (19th) birthday. The following children will also be considered as eligible dependents provided their primary residence is with the employee, and the employee or the employee's spouse is legally responsible to provide medical care:
 - 1] Stepchild;
 - 2] Lawfully placed foster child for whom coverage is not available through a state agency;
 - 3] A child who is under the legal guardianship of the employee substantiated by a court order.
- c] Unmarried children nineteen (19) years of age but less than twenty-four (24) years of age, provided they are a full-time student (as defined by the institution they are attending) at an accredited university, college, vocational or other institution of higher learning and they are dependent upon the employee for principal financial support. If a dependent student has completed the spring semester at their school, eligibility will continue through the months of June, July and August, however if a student graduates they are no longer an eligible dependent and coverage ceases at the end of the month in which they graduate. Documentation of student status will be required by the Claims Administrator before benefits will be considered.

Any dependent, who is an eligible dependent because they are a full-time student under this section is entitled to extended coverage, if they are on a "medically necessary leave of absence" and if they were enrolled in the Plan on the basis of being a full-time student immediately before the first day of the leave of absence, until the sooner of: (1) one year from the start of a medically necessary leave of absence, or (2) the date of coverage would otherwise terminate under the terms of the Plan. A "medically necessary leave of absence" means a leave of absence from a postsecondary educational institution or any other change in enrollment at that postsecondary educational institution that: (1) commences while the child is suffering from a serious illness or injury; (2) is medically necessary; and (3) causes the child to lose student status for purposes of coverage under the terms of the Plan. To be eligible, and before being eligible, the dependent's treating physician must provide written certification to the Plan that the dependent is suffering from a serious illness or injury requiring a "medically necessary leave of absence" within thirty-one (31) days of the first date the dependent is unable to maintain full-time student status. The written medical certification will be reviewed and approved by the Plan's pre-certification vendor.

2.05 Eligibility Restrictions: An employee may not be covered under this Plan as both an employee and as a dependent. If both a husband and a wife are Covered Employees, dependent children can be covered under this Plan by either parent, but **not** by both parents. An employee may not enroll their dependents without enrolling themselves in the Plan.

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

- a] Incapable of self-support due to a permanent mental or physical handicap; and
- b] Became handicapped prior to the attainment of age nineteen (19), or age twenty-four (24) if they were a full-time student; and
- c] 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.

The Plan may require the Covered Employee to obtain a Physician's statement certifying the physical or mental handicap prior to approval and at reasonable intervals thereafter.

2.07 Dependents Effective Date: If an employee has eligible dependents when his or her coverage begins, dependent coverage will begin on the same day as the employee's provided proper enrollment has been made and any required contributions have been authorized.

2.08 Newborn Dependents: Newborn children will be covered from the time of birth for necessary medical care **only if:** a) the employee is carrying dependent coverage on the date of the baby's birth, or b) enrollment for dependent coverage is made *prior* to the baby's birth, or c) enrollment is made and required contributions are paid within thirty-one (31) days of the date of birth. When enrolling for the dependent coverage, coverage is effective from the baby's date of birth and contributions for the dependent coverage are required for the entire month in which the baby was born. "Routine" newborn charges incurred at a Hospital at the time of birth will be considered under the mother's coverage and paid as part of the mother's claim, whether or not dependent coverage is in effect.

2.09 OBRA/QMCSO: This Plan adheres to the Federal OBRA and 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/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).

2.10 Late Enrollment: Employees and dependents that do not enroll for coverage within thirty-one (31) days of their eligibility date are called late enrollees and subject to a six (6) month Pre-Existing Condition limitation. Excluded from this provision are certain *family status changes* if enrollment is made within thirty-one (31) days of the event.

2.11 Special Enrollments due to Loss of Other Coverage: 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 within thirty-one (31) days of coverage termination from the other plan. Coverage will become effective on the first of the month following completion of the enrollment with the Plan. Failure to enroll under this Special Enrollment provision means you must follow the Late Enrollment provisions to enroll in this Plan.

2.12 Change of Status: If the Plan Member has any of the following qualifying change of status situations during the year, the Plan Member will be allowed to make a change in their coverage selections and change who is covered under the medical coverage:

- a] Change in legal marital status: Marriage, divorce, legal separation, annulment, death of spouse.
- b] Change in the number of dependents: Birth, adoption, or death of dependent child.
- c] 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.
- d] Change in dependent status under the terms of this Plan: Age, or any other reason provided the definition of an eligible dependent.
- e] Change of residence or worksite: If the change impairs the Plan Member's ability to access the services of In-Network providers.

- f] Change required under the terms of a Qualified Medical Child Support Order (QMCSO).
- g] Eligibility for or cancellation of coverage under Medicare, Medicaid or the Children's Health Insurance Program (Chip).
- h] Increase in the cost of the benefits.
- i] Significant changes in the benefits.
- j] Changes in spouse's, former spouse's or dependent's coverage through their employer.

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.

Except for newborns and newly adopted children, anyone enrolling under this provision will be subject to the pre-existing limitation. If the enrollment is not completed within thirty-one (31) days, they will be considered "late enrollees" and will be subject to the longer pre-existing limitation.

For changes in status related to 2.12.(g) in this Section, the Plan must be notified in writing within sixty (60) days of the qualifying change in status.

2.13 FMLA: In accordance with the "Family and Medical Leave Act of 1993" (FMLA), qualified employees are entitled to twelve (12) weeks of unpaid leave and can continue to maintain coverage under this Plan for the duration of the leave. During the leave, the Plan Administrator will continue Plan contributions for the employee on the same terms as prior to the beginning of the leave. The employee is responsible for making the required monthly premium contributions for dependent coverage and/or any supplemental insurance.

If Employee or Dependent coverage is terminated for failure to make payments, coverage will be automatically reinstated on the date the Covered Employee returns to active employment. Returning Employees and their Dependents will be subject to the pre-existing limitation (Article VI), as a "late enrollee". Any of the Plan's rules or practices or benefit changes that went into effect while on leave or in a non-payment status will apply once the leave is completed, including the completion of any pre-existing limitation. All accumulated annual and lifetime maximums will apply.

2.14 USERRA: 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 eighteen (18) months. If election to continue coverage was made after December 10, 2004, 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 the Plan immediately upon returning from military service.

Any questions regarding USERRA should be directed to the Plan Administrator.

2.15 If a Covered Person's eligibility ceases due to certain Qualifying Events, the individual may be eligible for continuation of coverage under COBRA as defined in Article IV.

ARTICLE III

TERMINATION

3.01 Employee coverage under this Plan shall terminate at midnight on the last day of the month following the earliest of:

- a] The date of termination of his/her employment;
- b] The date the Employee ceases to be in a class of employees eligible for the coverages;
- c] The due date the Covered Employee fails to make any required contributions;
- d] The date this Plan is discontinued with respect to the Employer;
- e] The date this Plan is discontinued with respect to the class of Employee to which such person belongs;
- f] The date the Trust terminates; or
- g] The date the Covered Employee voluntarily elects to be terminated from the Plan. Note: The Employee can only waive coverage if they have proof of other medical insurance.

3.02 A dependent's coverage under this Plan shall terminate at midnight on the last day of the month following the earliest of:

- a] The date the Employee's coverage terminates;
- b] The date ending the period for which the last contribution is made for the dependent coverage;
- c] The date of termination of all or any dependent coverage under this Plan;
- d] The date on which he/she ceases to be an eligible dependent under this Plan; or
- e] The date the dependent becomes eligible for coverage as an Employee with this Plan.

3.03 At the sole discretion of and at the election of the Trustees, termination of this Plan shall automatically occur upon the first day following thirty (30) days written notice of termination of the Plan.

3.04 In addition to the above stated termination provisions, continued coverage under COBRA ceases for a "Qualified Beneficiary" according to the COBRA termination rules in Article IV.

ARTICLE IV

CONTINUATION OF COVERAGE (COBRA)

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that employers provide for the temporary continuation of group health coverage to "Qualified Beneficiaries" enrolled in the Plan, whose coverage ends as a result of a specified "Qualifying Event". A Qualified Beneficiary's coverage under COBRA will generally be identical to the coverage he/she had immediately before the Qualifying Event. Any modification to the Plan that affects active employees will also affect COBRA participants. Qualified Beneficiaries will have the same enrollment and election change rights as active employees. For additional information on COBRA continuation coverage, rights, and obligations, contact the Plan Administrator or AmeriBen the Claims Administrator.

This Article serves as notice to all Plan Members of their rights and obligation under the Federal COBRA continuation of coverage regulations.

4.01 QUALIFIED BENEFICIARY

Active employees and their spouses and dependent children become Qualified Beneficiaries if they were covered under this Plan on the day preceding a "Qualifying Event." A child who is born to or who is placed for adoption with a Qualified Beneficiary during a period of COBRA continuation can be enrolled in this Plan for the time frame remaining for any other dependents covered under COBRA.

4.02 QUALIFYING EVENT

A Qualifying Event occurs for a Covered Employee and his/her Covered Dependents:

- a) If the employee is terminated for any reason other than gross misconduct;
- b) If 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 section of the Plan.

A Qualifying Event also occurs for a Covered Spouse and Covered Dependent Children when it is due to:

- a) Death of the Covered Employee;
- b) Divorce or legal separation from the Covered Employee;
- c) The Covered Employee becomes entitled to Medicare;
- d) The Covered Dependent no longer satisfies the Plan's definition of an eligible dependent.

4.03 NOTIFICATION AND ELECTION

The employer must notify the employee of the right to continued coverage when the employee is first covered under the Plan (which is included in the new employee information packets), and the option must be included in the Summary Plan Description.

The Covered Employee or Qualified Beneficiary must notify the Plan Administrator and the Claims Administrator in writing of a marriage, divorce, legal separation or the addition of a new dependent child within thirty-one (31) days of the event. The Plan must be notified within sixty (60) days of when a child loses their dependent status under this medical plan (according to the Plan's eligibility rules) or when a Qualified Beneficiary becomes eligible for Medicare. Failure to provide timely notification will result in loss of COBRA rights. The Employer/Claims Administrator then must notify the appropriate Qualified Beneficiaries of their right to continue coverage within fourteen (14) days. Notice by first-class mail to the beneficiary's last known address satisfies this requirement.

The Covered Employee or Qualified Beneficiary must make the decision to continue coverage and return a completed election form within sixty (60) days of the Qualifying Event or within sixty (60) days of the date the notification of COBRA rights was provided, whichever occurs later, or else the individual forfeits their right to COBRA coverage.

4.04 DURATION OF COVERAGE

The maximum period of continued coverage will be as follows (subject to modifications and changes in the Federal COBRA regulations):

- a) Employees and Qualified Beneficiaries who lose their coverage due to employment termination (for other than gross misconduct) or reduction of hours worked that makes them ineligible for coverage, are allowed continuation of coverage for a maximum period of eighteen (18) months. If a Covered Employee or Covered Dependent is entitled to the eighteen (18) months of COBRA, that period can be extended for an additional eleven (11) months if a Qualified Beneficiary is determined to be entitled to Social Security disability benefits. The eleven (11) month extension is available to all the Qualified Beneficiaries in the family who have elected COBRA coverage (not just the disabled person).

The following conditions must be satisfied:

- 1) The disability occurred on or before the start of COBRA continuation coverage, or occurs within the first sixty (60) days of COBRA continuation coverage; and
- 2) The disabled person receives a determination from Social Security that they are entitled to disability income benefits, and this determination is received before or during the original eighteen (18) month COBRA period; and
- 3) The disabled person notifies the Plan within sixty (60) days of receiving the determination of disability from Social Security.

This extended period of COBRA continuation coverage will end at the **earlier** of:

- The end of twenty-nine (29) months from the date of the qualifying event; or
 - The date the disabled person becomes entitled to Medicare; or
 - The date Social Security determines the individual is no longer considered disabled under Title II or XVI of the Social Security Act. Note: The disabled person is required by law to notify the Plan Administrator within thirty (30) days of any change in disability status.
- b) Qualified Beneficiaries due to any other Qualifying Event are allowed a continuation of coverage for a maximum period of thirty-six (36) months.
 - c) If the employee's qualifying event is termination of employment or reduction of hours, and it occurred within eighteen (18) months of becoming entitled to Medicare, the COBRA coverage period for the qualified dependents will be either eighteen (18) months from the termination of employment or thirty-six (36) months from the earlier Medicare entitlement date whichever is longer. If Medicare entitlement occurred more than eighteen (18) months before termination of employment, this rule does not apply.
 - d) If an individual was covered under Medicare due to End Stage Renal Disease (ESRD) at the time of the Qualifying Event, the Qualified Beneficiary would be eligible for COBRA for the full time allowed by law, however Medicare would become primary on the thirty-first (31st) month of the Medicare eligibility. If the COBRA participant becomes eligible for Medicare due to ESRD after their COBRA effective date COBRA would terminate on the date Medicare becomes effective.

If an individual experiences more than one Qualifying Event, the maximum period of coverage will be calculated from the date of the earliest Qualifying Event, but will be extended to the full thirty-six (36) months if required by the subsequent Qualifying Event.

4.05 COBRA and FMLA

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

- a) When the employee informs the County that he/she is not returning at the end of the leave; or
- b) At the end of the leave, assuming the employee does not return; or
- c) 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:

- 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); and
- b) The employee does not return to employment at the end of the FMLA leave; and
- c) The employee and/or his/her dependent loses coverage under this Plan before the end of what would be the maximum COBRA continuation period.

4.06 COVERAGE TERMINATION

Coverage under COBRA will cease on:

- a) The last day of the month for which premiums have been paid;
- b) The date the Qualified Beneficiary becomes covered under another group health plan (whether as an employee or otherwise) provided that the other group plan does not contain an exclusion or limitation with respect to any pre-existing condition of such individual. In the event a pre-existing condition limitation applies, all Qualified Beneficiaries can remain on this Plan's continuation of coverage;
- c) The date the Qualified Beneficiary becomes entitled to Medicare benefits;

- d] The last day of the maximum period of continuation the Beneficiary qualified for;
- e] The date the employer ceases to maintain any group health plan for any employee;
- f] The 30th day following the month in which SSA determines the Qualified Beneficiary is no longer disabled, for those on the extended eleven (11) month continuation of coverage.

Once continuation of coverage begins the Employer must be notified in writing if the Qualified Beneficiary is no longer eligible for continuation of coverage or no longer wishes to continue coverage.

4.07 COST OF COBRA CONTINUATION OF COVERAGE

The cost of continuation of coverage under COBRA is determined by the Employer and is paid by the Qualified Beneficiary. If the qualifying individual is not disabled, the applicable premium cannot exceed 102% of the Plan's cost of providing coverage. The cost during a period of extended continuation of coverage due to a disability cannot exceed 150% of the Plan's cost of coverage.

- a] The employee or the Qualified Beneficiary must make the first payment within forty-five (45) days of notifying the Plan Administrator of their election to continue coverage. The initial payment must include all monthly premiums due back to the date coverage terminated.
- b] Future payments must be made within thirty (30) days of the scheduled due date.
- c] The scheduled due date is the first day of each month.
- d] Rates and payment schedules are established by your employer and may change when necessary due to Plan modifications.
- e] The cost to continue coverage is computed from the date coverage would have normally ended due to the Qualifying Event.
- f] Failure to make the first payment within forty-five (45) days or any subsequent payment within thirty (30) days of the established due date will result in the permanent cancellation of continuation coverage. Coverage will terminate retroactively to the last day of the month for which the last premium was paid.
- g] When a premium check is received timely, and that check subsequently is not honored by the bank (i.e.: the check bounces due to insufficient funds), the premium will not be treated as timely paid. The Qualified Beneficiary will be allowed to correct the payment provided it is done within the original thirty (30) day period following the premium due date.
- h] Payment of benefit claims filed during the sixty (60) day COBRA election period and the period before the first COBRA premium payment by an individual eligible to make an election, will be denied by the Plan until the individual both timely elects COBRA continuation coverage and pays the first required COBRA premium. Once a timely election is made and required premium payments are received, previously denied claims will be processed as if coverage had not been terminated. These benefit claims will not be paid if timely COBRA continuation coverage election and premium payments are not made.

ARTICLE V

MEDICAL BENEFITS

If, as a result of a covered injury or illness a Covered Person incurs charges for services and supplies described in this Article, the Plan will pay benefits at the percentage indicated in the Schedule of Benefits. For the purpose of these benefits, for a charge to be considered eligible the charge must be: a) administered or ordered by a Covered Physician; b) medically necessary; c) not of an experimental or investigational nature; d) not of a custodial nature; e) reasonable and customary treatment relative to the diagnosis; and f) a negotiated rate for the service that is rendered or the item that is purchased that is agreed upon between BCBSAZ and the Network Provider.

The Plan requires all care received in the state of Arizona be provided by a BlueCross® BlueShield® of Arizona network provider. If a Covered Person lives outside of Arizona benefits are available under the "Out-of-State" benefit schedule.

Any amounts charged that are in excess of the negotiated amount agreed upon between BCBSAZ and the Network Provider will not be eligible under this Plan. Unless otherwise stated, all benefits are calculated on a per Covered Person per Calendar Year basis. All expenses are subject to the exclusions, limitations and conditions elsewhere stated in this Plan. The Medical benefits payable shall be at the percentages shown in the Schedule of Benefits, are subject to the specified deductible and co-pay provisions, and shall not exceed the maximums specified.

CO-PAYMENTS / CO-INSURANCE / DEDUCTIBLES

5.01 *Co-payment / Co-pay:* The co-payment is the dollar amount (as indicated in the Schedule of Benefits) which a Covered Person must pay in conjunction with the receipt of certain eligible services. Co-payment amounts are not part of the Deductible or Co-insurance maximums.

5.02 *Co-insurance:* Co-insurance is the percentage of a claim that represents the amount the Covered Person is financially responsible for.

5.03 *Co-insurance Maximum:* The co-insurance maximum is the total dollar amount of eligible charges shown in the Schedule of Benefits for which the Covered Person is financially responsible for during the Calendar Year (the 20% co-insurance) after which the Plan will pay eligible charges for the remainder of the Calendar Year at one hundred percent (100%). Expenses for co-payments and penalties for noncompliance with pre-certification requirements do not accumulate toward the co-insurance maximum.

5.04 *Out-of-State Individual Deductible:* The individual deductible represents the dollar amount shown in the Schedule of Benefits which must be accumulated in eligible out-of-state expenses by a Covered Person during each Calendar Year, before out-of-state benefits are payable under this Plan. The Deductible is applied in the order of the Plan's receipt of eligible expenses.

5.05 *Out-of-State Family Deductible:* When the total eligible medical expenses that apply to the satisfaction of the individual deductibles exceeds the family out-of-state Deductible amount shown in the Schedule of Benefits, no further deductibles for any family member will be required for the remainder of the Calendar Year. If both husband and wife are Covered Employees, credit will be given towards the "Family Deductible". One individual cannot satisfy the Family Deductible.

5.06 *Out-of-State Carryover Deductible Provision:* Eligible Expenses incurred during the last three (3) months of the Calendar Year which are actually applied toward satisfaction of the out-of-network deductible may be "carried over" towards satisfying the subsequent Calendar Year's deductible.

5.07 *Out-of-State Common Accident:* If two (2) or more covered family members are injured in the same accident, only one (1) Individual Deductible amount must be met for eligible expenses to be reimbursed for all covered family members as a result of such accident for that Calendar Year.

FOR THE PURPOSE OF THIS PLAN DOCUMENT ELIGIBLE MEDICAL EXPENSES INCLUDE:

HOSPITAL / FACILITIES

5.08 Emergency Room: Charges by the Hospital for the use of the Hospital emergency room for appropriate medical charges necessitated by an acute medical emergency. Charges are subject to a separate Emergency Room co-pay as indicated in the Schedule of Benefits unless the patient is admitted to the Hospital.

5.09 Hospice: Charges incurred for hospice care provided by an institution or agency licensed as a Hospice and certified to receive payment under Medicare, when it has been determined that the Covered Person 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 Covered Person's terminal condition. The plan of Hospice Care must be renewed in writing by the attending Physician every thirty (30) days. Hospice benefits are subject to the per day co-pay shown in the Schedule of Benefits (in-patient or out-patient) and are limited to one hundred (100) days. Hospice care benefits cease if the terminal illness enters remission.

5.10 Inpatient Hospital: Inpatient Hospital 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. 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.

5.11 Licensed Birthing Center: Charges by a Hospital based or freestanding licensed birthing center.

5.12 Skilled Nursing Facility: Charges made by a Skilled Nursing Facility or Extended Care Facility are Eligible Expenses provided the confinement is certified as medically necessary by the attending Physician and the care is not of a custodial nature. Benefits are limited to sixty (60) days per Calendar Year.

5.13 Surgical Facility: Charges by a Hospital based or freestanding ambulatory/surgical facility.

5.14 Urgent Care Facility: Charges incurred at an Urgent Care Facility for appropriate medical charges necessitated by an acute medical condition.

SURGERY / ANESTHESIA

5.15 Anesthesia: Charges by a licensed professional anesthetist or anesthesiologist for the administration of anesthetics, pre- and post-operative visits and the administration of fluids and/or blood incidental to the anesthesia or surgical procedure.

5.16 Assistant Surgeon: Charges for an assistant surgeon will be considered Eligible Expenses when medically required. If the assistant surgeon is a BlueCross® BlueShield® of Arizona provider, the eligible charge amount will be up to 20% of the amount allowed for the BCBSAZ surgeon. If the assistant surgeon is a non-BCBSAZ provider and the assistant surgeon is an MD or DO, the eligible charge amount will up to 25% of the amount allowed for the surgeon. If the assistant surgery is performed by a non-BCBSAZ Registered Nurse First Assistant (RNFA), Certified Surgical Assistant (CSA) or a Physician's Assistant (PA), the eligible charge will be up to 15% of the amount allowed for the surgeon. The services of a standby surgeon will only be covered when: a) a clear medical necessity exists, and b) the standby surgeon is gowned, scrubbed, and physically present in the surgical suite.

5.17 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 accidental injury (restoration made to a functional level). Charges will only be payable if coverage is still in force at the time the treatment is rendered.

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

5.18 Organ Transplants: Charges incurred for the following non-experimental human to human organ or tissue Transplants such as: Bone Marrow; Kidney; Pancreas; Cornea; Liver; Heart; Lung; Heart/lung. These transplants will only be covered if:

- a] The Covered Person is a likely candidate for a successful outcome of the procedure; and
- b] The Covered Person 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 firm; and

- c] The procedure is performed at an In-Network facility known to have an effective program for doing such procedure. If there isn't an In-Network facility that is equipped to perform the transplant, Out-of-Network facilities may be eligible if approved in advance by the Claims Administrator and it is performed at a facility approved by the re-insurance carrier.

Charges associated with the donor for the removal of the organ, and/or the procurement/ acquisition/transportation of the organ will also be considered as Eligible Expenses, subject to the recipient's individual benefit levels and plan maximums. Charges related to the donor for screening and testing are **not** covered expenses under this Plan.

5.19 Reconstructive Surgery: Charges for reconstructive surgery provided:

- a] Reconstructive surgery is required as the direct result of an accidental injury, an infection or disease of the involved part.
- b] Reconstructive surgery is necessary for the correction of congenital abnormalities which resulted in a functional defect.
- c] Reconstructive surgery is necessary post mastectomy.
Eligible charges will include surgery and reconstruction of the other breast to produce a symmetrical appearance and prosthesis and treatment of any physical complications at all stages of mastectomy, including lymphedemas.

5.20 Second Surgical Opinion: Charges for a second surgical opinion will be covered. When it is required and authorized by the medical review company, the charge will be paid at one hundred percent (100%). The medical review company will direct the Covered Person to a surgeon that is not associated with the original Physician and to one who specializes in treating the specific surgical problem.

5.21 Surgery: Charges by a Physician for surgery performed at a Hospital, a licensed surgical center or in the office. In the case of multiple surgeries performed through the same incision the maximum allowable expense shall be equal to the negotiated rate agreed upon between BCBSAZ and the Network Provider for the procedure with the greatest scheduled amount. Additional allowances (modifiers) may be given when the additional surgeries add significant complexity to the surgical session.

If during the same surgical session multiple surgeries are performed through separate incisions, the allowable expense shall be calculated at the full negotiated rate agreed upon between BCBSAZ and the Network Provider of the primary procedure, and at fifty percent (50%) of the negotiated rate agreed upon between BCBSAZ and the Network Provider of each of the lesser procedure(s) that are through their own separate incision(s).

MEDICAL / PHYSICIAN SERVICES

5.22 Acupuncture: Charges incurred for acupuncture administered by an MD or DO licensed for this treatment.

5.23 Allergy Testing/Injections: Charges for initial 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 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.

5.24 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). Benefits payable are limited to one thousand dollars (\$1,000) per Calendar Year.

5.25 Dialysis: Charges for dialysis are considered eligible expenses.

5.26 Hearing: Charges for hearing examinations are payable at eighty percent (80%). Charges for hearing aides are payable at fifty percent (50%) up to a maximum of one thousand five hundred dollars (\$1,500) per Calendar Year.

5.27 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 Covered Person resides in a remote area that does not have a local Home Health Care Agency. Charges are subject to a maximum of one hundred (100) visits per Calendar Year. Charges for custodial care, mental health care, or substance abuse or chemical dependency treatment would not be eligible under this provision

5.28 Nutritional (Diabetic) Counseling/Classes; Charges for diabetic nutritional counseling or classes will be payable up to a Lifetime Maximum of two hundred dollars (\$200).

5.29 Pathology / Radiology: 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. Charges for routine screenings are covered up to the wellness benefits shown in the schedule of benefits.

5.30 Physician: Charges by a Physician for medical care either 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.

5.31 Rehabilitation Services: Charges for rehabilitation services including physical therapy, physiotherapy, speech therapy and occupational therapy (for short term progressive rehabilitation therapy), provided it is mandated by the disability and is not of a maintenance nature. The rehabilitation therapy must be ordered by and under the supervision of a Doctor of Medicine, Doctor of Osteopathy, or by a Doctor of Podiatry for the area of the body that is within the scope of his/her license, and rendered by a Physician or a Licensed/Registered Therapist. At any time if treatment becomes of a maintenance or custodial nature benefits will cease.

Outpatient rehabilitation treatment is limited to a three (3) month treatment plan, and a fifteen hundred dollar (\$1,500) maximum benefit per condition. Inpatient rehabilitation is limited to one thousand dollars (\$1,000) per day up to a maximum of sixty (60) days per condition. If the condition mandates outpatient or inpatient treatment of a longer duration, the proposed additional treatment must be reviewed and approved in advance by the Claims Administrator and/or the Medical Review firm in order for it to be considered for possible additional coverage under this Plan.

5.32 Speech Therapy: Charges made by a qualified speech therapist for restoration of normal speech or to correct dysphasic or swallowing disorders, when the loss or impairment is due to an injury, illness or surgery. 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.

5.33 TMJ: Charges incurred for the treatment of Temporomandibular Joint Dysfunction or Syndrome (TMJ) including splints and appliances, will be limited to a benefit of three hundred dollars (\$300) per Calendar Year.

5.34 Wellness: Charges for routine wellness care such as routine physicals, routine laboratory tests and x-rays, routine mammograms, routine well baby care (up to the age of 2), required routine childhood immunizations, and flu shots. Benefits payable are subject to an maximum benefit of five hundred dollars (\$500) per Calendar Year or seven hundred and fifty dollars (\$750) per Calendar Year for well baby care.

MATERNITY / FAMILY PLANNING

5.35 Abortions: Charges incurred for a *medically required* abortion for a Covered Employee or a Covered Spouse when the continuation of the pregnancy would be life threatening to the mother. Charges related to the complications of any abortion will be considered eligible.

5.36 Contraception: Charges for contraceptive devices, insertion and removal of I.U.D.s, the cost of a fitting of diaphragm, or medication (birth control pills, depo-provera shots, norplant) for birth control purposes.

5.37 Midwife: Charges made by a Certified Nurse Midwife (CNM) for obstetrical or well woman care that is within the scope of his/her license in the state in which he/she is licensed.

5.38 Newborns: Charges incurred at a Hospital for "routine" newborn care (DRG 391), 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.

5.39 Pregnancy: Charges incurred as a result of pregnancy for pre- and post-natal care and delivery for a Covered Employee or a Covered Dependent Spouse, provided coverage is in effect at the time the actual charges are incurred (i.e.: at the time of delivery). Eligible expenses include routine lab work, one (1) routine ultrasound during the course of pregnancy, and seven hundred fifty dollars (\$750) towards the cost of a routine epidural.

5.40 Sterilizations: Charges incurred for elective or medically required sterilizations. When a vasectomy is elected, only the Physician's charge for the surgery in his/her office will be covered. Facility charges for vasectomies will not be eligible.

AMBULANCE

- 5.41** 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 Covered Person's permanent place of residence will be covered, if medically necessary, as determined by the Plan or its designee;
 - d) Transport by air ambulance will be an eligible expense as described in a & b above but **only** when medically necessary due to a life threatening condition.

MEDICATIONS / EQUIPMENT / SUPPLIES

5.42 Blood: Blood Transfusion services, including the cost of blood and blood products, to the extent they are not replaced or donated through the operation of a blood bank or otherwise.

5.43 Bras: Charges for prosthesis bras (up to two per year) and the related postmastectomy prosthetic devices.

5.44 Contact Lenses: Charges made for the initial pair of Contact Lenses as prescribed by a Physician when required immediately following cataract surgery.

5.45 Corrective Appliances / Prosthetics: 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 to the allowed purchase price. Charges will be allowed for replacement, adjustment and servicing of the appliance when necessary due to the growth of a covered child, or when the appliance has exceeded its maximum life expectancy. 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.

5.46 Durable Medical Equipment: Charges for necessary Durable Medical Equipment (DME) as prescribed by a Physician. 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. DME charges are limited to seven hundred and fifty dollars (\$750) payable per item. Charges in excess of the \$750 Plan allowance may be considered eligible, however the item must be reviewed by the Claims Administrator and a determination of necessity made for additional benefits **prior** to the purchase or rental.

5.47 Medications: Charges for prescription drugs and medicines, obtainable only upon a Physician's written prescription, and prescribed for treatment of a covered illness or injury. Medications that can be purchased over-the-counter, including those that can be purchased in lesser strength (i.e. Ibuprofen, Motrin IB, Monistat, Zantac, Pepcid, etc.) are **not** eligible. Prescriptions are purchased with the RX card issued by the Plan. The RX card requires that generic drugs be dispensed when available. If a Brand Name drug is dispensed when a generic is available, the Covered Person will be required to pay the cost difference. Covered Persons present their RX card to the Pharmacist and pay the co-pay amount indicated in the Schedule of Benefits.

5.48 Nutritional Food Supplements: Medically necessary food supplements may be eligible, but they must be authorized in advance by the Claims Administrator. If approved, the supplements will be payable at fifty percent (50%) up to a maximum payment of three thousand (\$3,000) dollars per Calendar Year.

5.49 Supplies: Charges for the following Non-durable (disposable) supplies are eligible: a) sterile surgical supplies required following a covered surgery; b) insulin syringes and test strips for diabetics; c) supplies required to operate/use durable medical equipment or corrective appliances; d) supplies required for use by skilled home health or home infusion personnel, only for the duration of their services; e) anti-embolism garments (e.g., Jobst) up to three (3) per calendar year.

5.50 Orthopedic Shoes / Orthotics: 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. Charges will only be covered when ordered by a M.D. or D.P.M. and dispensed by a certified orthotics laboratory.

5.51 Oxygen: Charges for oxygen and for the equipment to use it. The equipment cost is covered under Durable Medical Equipment, Section 5.46.

MENTAL HEALTH CARE / SUBSTANCE ABUSE

5.52 Charges for Mental Health care and treatment including charges for substance abuse and chemical dependency are considered Eligible Expenses.

Facility charges for inpatient or residential treatment of mental and nervous disorders, chemical dependency or substance abuse, will be eligible when care is received at a licensed Hospital or a licensed treatment facility. Alternative outpatient facility/day programs may be eligible under the inpatient benefit when provided in lieu of inpatient care and approved by the medical review company.

Outpatient treatment for mental health care, treatment of chemical dependency or substance abuse or family counseling will be eligible when rendered by a licensed Psychiatrist, licensed Psychologist, Licensed Professional Counselor (LPC), Licensed Clinical social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Independent Substance Abuse Counselor (LISAC) or when rendered by one 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)
- f] Certified Addiction Counselor (CAC)

Psychological testing and neuropsychological testing are covered only if it is mandated by the condition and is pre-certified by the medical review company.

MAJOR MEDICAL

5.53 Colonoscopy: This Plan covers medically necessary colonoscopies. Preventative Colonoscopies are payable for Covered Persons over the age of fifty (50), once every ten (10) Calendar Years and are only covered when performed by an In-Network provider. (This preventative benefit is not part of the wellness benefit.)

PRESCRIPTION DRUG PROGRAM

Prescription drugs may be obtained through the **Walgreens Health Initiatives (WHI)** system. Your *personalized Healthcare Card* can be used at your local Pharmacy or by mail order.

You may obtain medications from two different sources, depending on your needs:

Retail Pharmacy

The retail network of pharmacies is available for prescriptions you need right away or for a short time (such as antibiotics). You may obtain up to a **30-day supply** of medication. You have over **50,000** retail pharmacies to choose from nationwide. To locate the nearest retail pharmacy, please call 1-800-207-2568 or visit the website at www.whphi.com.

Mail Service Pharmacy

When you need prescriptions for long-term health conditions (such as high blood pressure), you may order up to a **90-day supply** of medication through the Walgreens HealthCare Plus mail service. By using mail service, you can save money and have your prescription delivered right to your home.

90 Day Advantage 90® Drug Benefit Option.

The Advantage 90® Drug Benefit Option is available for maintenance medications (those that are taken for long periods of time for conditions such as high blood pressure, asthma, etc.) This benefit is available at over 37,000 participating chain and independent pharmacies nationwide. These pharmacies allow you to obtain a 90-day supply of maintenance medications for one copayment. Participating pharmacies include but are not limited to: any A&P, Acme, Albertsons, Aurora Pharmacy, Baker's Pharmacy, Brooks Pharmacy, Buehler's, City Market, CVS Pharmacy, Dillons, Dominick's Eckerd, Fred Meyer, Fry's, King Soopers, Kmart, Kroger, Longs Drugs, Meijer, Osco Drug, QFC, Ralphs, Randalls, Safeway, Sam's Club, Sav-On Drugs, ShopKo, Smith's, Target, Thrifty White, Tom Thumb, Vons, Wal-Mart, Walgreens, and Winn-Dixie. This list is subject to change. For the most up-to-date, complete list of participating pharmacies, please visit www.mywhi.com or call the WHI member services number listed on your Healthcare ID card.

Definitions of a Three-Tier Formulary:

Generic – Members pay the *lowest* co-pay for generic drugs (\$7.00 co-pay). Generic medications are FDA approved and are as safe and effective as their brand name equivalents. ALL generic drugs are part of the Formulary.

Preferred Brand – For Preferred brand name drugs (\$20.00 co-pay), members pay a *higher* co-pay than the generic medications. The Formulary is a list of approved drugs that have been selected based on clinical advantage and cost effectiveness. Brand name drugs have been under patent protection for a number of years, during which time a generic equivalent is not available.

Non-Preferred – Members pay the *highest* co-pay for any brand name drugs not listed on the Walgreens Health Initiatives formulary OR for brand name drugs that have a generic equivalent (\$35.00 co-pay + cost difference). If your physician determines that there is a medical reason for you to take a nonformulary medication, you may still obtain the drug, however you will be responsible for the higher co-pay and the difference between the generic and brand drug cost.

ARTICLE VI

PRE-EXISTING CONDITIONS

A pre-existing condition is any medical condition for which the Covered Person received treatment including, but not limited to, diagnosis, consultation, treatment or taking prescribed drugs/medications (including self-administered drugs or biologicals not requiring a Physician's prescription) for an illness or injury, during the six (6) month period immediately preceding the Covered Person's enrollment date under this Plan. The "enrollment date" for the purpose of this Article is the Covered Person's effective date or the first day of the waiting period if earlier.

This pre-existing limitation does not apply to newborns, newly adopted children or pregnancy.

6.01 For new employees and their covered dependents, charges incurred after their enrollment date which are related to a pre-existing condition will not be eligible for benefits until the Covered Person has been continuously covered by this Plan for twelve (12) consecutive months.

6.02 Employees and their dependents who enroll in this Plan more than thirty-one (31) days after their original eligibility date are considered "Late Enrollees". Late Enrollees will not be eligible for benefits related to a pre-existing condition until they have been continuously covered by this Plan for eighteen (18) months.

6.03 When an employee and his/her dependents enroll in this Plan, and they have previously had "creditable coverage" issued by a health plan or a self-insured group health plan, the time covered under the prior plan will be credited towards the pre-existing waiting period under this Plan. The Covered Person must have been continuously covered under the prior plan, with no more than a sixty-three (63) day gap between coverage under the prior plan and their enrollment date under this Plan.

6.04 "Creditable coverage" is defined in the "Health Insurance Portability and Accountability Act of 1996" (HIPAA). Creditable coverage refers to coverage under a group health plan (including a governmental or church plan), individual health insurance coverage, Medicare (other than coverage solely under Section 1928), Medicaid, military-sponsored health care, a program of the Indian Health Services, a State health benefits risk pool, the Federal Employees Health Benefit Program, a public health plan as defined in regulation and any health benefit plan of the Peace Corps Act.

6.05 Covered Persons must submit a written "Certificate of Coverage" from their prior insurance carrier as proof of prior creditable/accountable coverage.

ARTICLE VII

GENERAL LIMITATIONS AND 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.

7.01 Services and supplies which 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 Article V, Section 5.34.

7.02 Medical care, services or supplies which do not come within the definition of Eligible Expenses and/or are not rendered by an eligible provider of service as defined by this Plan.

7.03 Expenses associated with complications of a noncovered condition, illness, procedure or service, (except for complications arising from an elective termination of pregnancy).

7.04 Charges in excess of the negotiated rate agreed upon between BCBSAZ and the Network Provider for services and supplies, or charges which exceed any Plan benefit limitation or maximum allowable benefit.

7.05 Services received or supplies and medication purchased outside the United States unless the charges incurred are a result of a life threatening emergency or accidental injury that occurs while traveling outside the United States.

7.06 Charges incurred for preparing medical reports, itemized bills, or claim forms. Expenses for broken appointments, telephone calls, photocopying fees, mailing, shipping or handling expenses.

7.07 Charges for an illness or injury deemed to have arisen out of or in the course of work for wage or profit whether or not there was Workers' Compensation coverage for such claim, and whether or not it has been reported in accordance with the Workers' Compensation rules. No work related claim shall be payable under this Plan unless the injury or illness has been adjudged as non-occupational by the appropriate Workers' Compensation Board.

7.08 Charges for any illness or injury incurred prior to a Covered Person's eligibility date as defined in Article II, or after the Covered Person's termination date as defined in Article III.

7.09 Treatment received 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.

7.10 Any services for which a charge would not have been made in the absence of this coverage; or portion of a charge that is higher than the amount that would have been charged in absence of this coverage.

7.11 Charges, or a portion of a charge, for services or supplies that are discounted or reimbursed by a refund or rebate.

7.12 Any charges in excess of rates negotiated between any organization and the Physician, Hospital or other provider of services, whether the plan is a Primary or Secondary payor.

7.13 Charges incurred due to a court ordered treatment or hospitalization unless a clear medical necessity also exists.

7.14 Services rendered by an immediate family member, whether relationship is by blood or law, or by any person who regularly resides in the Covered Person's home.

7.15 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.

7.16 Examinations or tests not incidental to or necessary to diagnose an injury or illness except the coverage for the routine care specifically allowed in Article V, Section 5.34.

- 7.17** Charges or treatment provided as a benefit under a program of the United States Government or State agency or political subdivision, including but not limited to active duty in the armed forces, Medicare, Medicaid, TriCare or any treatment paid for by any governmental program unless the Covered Person is legally required to pay.
- 7.18** 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.
- 7.19** Treatment of an illness or injury resulting from an act of war (whether declared or undeclared), invasion or aggression, or any atomic explosion or release of nuclear energy (except when used solely for the purpose of medical treatment).
- 7.20** Treatment of an illness or injury caused by participating in a civil insurrection or a riot.

ADDITIONAL EXCLUSIONS:

The following excluded charges have been arranged in alphabetical order to assist in finding the information. The entire list should be reviewed as the wording of a particular excluded service may place it in a location other than where one might expect to find it.

- 7.21** Abortions / elective termination of pregnancy, unless the mother's life would be endangered if the pregnancy were allowed to continue. Complications arising out of an elective abortion would be considered an eligible medical expense.
- 7.22** Adoption charges.
- 7.23** Assistant surgeon when the need for an assistant is not documented.
- 7.24** 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, devices to assist with dressing and undressing, etc.
- 7.25** Autologous blood donations are not covered unless the blood is actually used during a scheduled surgery.
- 7.26** Autopsies (unless required by the Plan).
- 7.27** Behavior modification type therapy, hypnosis, biofeedback, or charges considered educational (i.e. stress management, weight reduction, etc.).
- 7.28** Breast reconstruction (except as covered under Article V, Section 5.19) 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.
- 7.29** Chelation therapy, except when necessary for treatment of heavy metal poisoning.
- 7.30** Cochlear implants, or any similar implants to improve hearing.
- 7.31** Comfort items: Charges incurred for services, supplies or surgery which are primarily for personal comfort.
- 7.32** Cosmetic: Charges incurred for cosmetic surgery, plastic surgery, or reconstructive surgery or any complications thereof, or other cosmetic procedures including, but not limited, collagen injections, botox injections, sclerotherapy, liposuction, tattoos or tattoo removal, except as covered under Article V, Section 5.19.
- 7.33** Counseling charges incurred for marriage, career, sexual, social adjustment, financial or religious counseling.
- 7.34** Custodial care, charges made by an institution or part thereof which is primarily a place for rest, the aged, a hotel, health spa, fitness or weight reduction resort or similar institution or childcare, homemaker services or maintenance care.
- 7.35** Dental procedures or dental treatment of any kind, except as provided for under Article V, Section 5.17 or under Article VIII, the optional Dental Benefits .
- 7.36** Disposable (non-durable) supplies, including but not limited to diapers, incontinence pads and bandages, except as covered under Article V, Section 5.48.
- 7.37** Elevators, chairlifts or other modifications to home, stairs or vehicles.

- 7.38** Exercise; Charges incurred or related to health club/exercise/gym memberships, aerobic and strength conditioning, back schools or back strengthening programs, massage therapy, rolfing, and exercise equipment rental or purchase.
- 7.39** Experimental / Investigational; Charges for services, procedures, equipment or supplies which are considered experimental or investigational as defined in Article XII, Section 12.30.
- 7.40** Eye surgery (Kerato-refractive surgery) to correct nearsightedness or farsightedness and/or astigmatism, including but not limited to Radial Keratotomy and keratomileusis surgery and refractive keratoplasties and LASIK surgery.
- 7.41** Genetic services rendered during pregnancy (or in anticipation of a pregnancy), including tests and procedures performed for the purpose of detecting, evaluating or treating chromosomal abnormalities or genetically transmitted characteristics, except alphafetoprotein analysis. Genetic testing/screening for rendered only because of family history.
- 7.42** Hair Loss; Services or supplies for the prevention or restoration of natural hair loss (i.e.: Rogaine, Minoxidil), or charges for hair transplants, hair weaving, toupees or wigs.
- 7.43** Health Maintenance Organization (HMO) providers when services are rendered to a covered HMO plan member.
- 7.44** Holistic services, supplies or accommodations provided in connection with holistic or homeopathic treatment or medicine.
- 7.45** Infertility; Charges related to the treatment of infertility, infertility drugs, artificial insemination, in-vitro fertilization, embryonic transfer, sperm banking or any other similar procedure (charges to diagnose the condition of infertility will be considered eligible expenses).
- 7.46** Learning disabilities / Developmental Disorders; Charges (including mental health care) related to treatment or testing of learning disabilities, developmental disorders, dyslexia, autism or mental retardation or any similar conditions. Charges for medications and for medical checkups to monitor medications for these conditions will be eligible.
- 7.47** Maintenance rehabilitation therapy or therapy for coma stimulation Inpatient or Outpatient.
- 7.48** Magnet therapy.
- 7.49** Massage therapy.
- 7.50** Maternity related charges for dependent daughters, or any complications thereof.
- 7.51** Medical students, interns or residents.
- 7.52** Medications; Charges for experimental or non-prescription medications or charges for prescriptions to be used for an application that has not been approved by the FDA. Medications that can be purchased over-the-counter, including those that can be purchased in lesser strength (i.e., Ibuprofen, Motrin, Monistat etc.). Non-smoking aids, drugs for cosmetic purposes, weight control drugs or fertility agents.
- 7.53** Music therapy.
- 7.54** Myofunctional therapy or the treatment of tongue thrusts.
- 7.55** Naturopathic treatment or treatment rendered by a Naturopath.
- 7.56** Nutritional Counseling/Classes except as provided under Article V, Section 5.28.
- 7.57** Occupational therapy, except during an Inpatient Hospital confinement or as included in Article V, Sections 5.27 and 5.31.
- 7.58** Organ or tissue transplants (except as provided in Article V, Section 5.18), including insertion or maintenance of an artificial heart or organ and charges for artificial, experimental or non-human body organs or tissue transplants.
- 7.59** Orthognathic surgery, except in cases where a significant dysfunction exists due to an extreme congenital or developmental anomaly.
- 7.60** Orthotics, except as covered under Article V, Section 5.50.
- 7.61** Pediatrician charges for services as a standby pediatrician during childbirth unless a high risk factor was indicated during the covered pregnancy or during the delivery, and the pediatrician is present during the delivery.

- 7.62** Personal comfort items or devices which do not meet the definition of Durable Medical Equipment or Corrective Appliances including but not limited to air conditioners, air purifiers, dehumidifiers, water purification systems, waterbeds, airbed systems, cervical pillows, whirlpools, spas and the like.
- 7.63** Personal service items while confined in a Hospital or health care facility (i.e. guest meals, television, telephone, etc.).
- 7.64** Private duty nursing services.
- 7.65** Prosthesis replacement unless necessitated by the growth of a child or the prosthesis has exceeded its maximum life expectancy.
- 7.66** Reversal surgery of any kind.
- 7.67** Sexual dysfunction or sexual inadequacy, including but not limited to sex therapy, sex change operations, medications, penile prosthetic implants or similar devices.
- 7.68** Sleep disorders; charges related to the diagnosis and treatment of sleep disorders, except in the case of sleep apnea.
- 7.69** 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.
- 7.70** Smoking cessation programs, aids, devices or drugs (i.e. Nicorette and Nicoderm).
- 7.71** Surrogate Mothers; Any and all costs for and relating to surrogate motherhood, or charges incurred by a Covered Person acting as a surrogate mother.
- 7.72** TMJ; 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, or retrognathism or orthognathic surgery except as listed in Section 5.33.
- 7.73** Transportation charges except for ambulance provided in Article V, Section 5.41.
- 7.74** Travel charges (transportation, lodging, meals and related expenses) by a Covered Person, a Physician or any healthcare provider except as provided in Article V, Section 5.27.
- 7.75** Vision; 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, except as covered under Article I (for children under 17) or as covered under the optional Vision Benefits, Article IX.
- 7.76** Vitamins; (except for pre-natal vitamins covered under the Prescription coverage), 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, except as covered under Article V, Section 5.48.
- 7.77** Virtual Office Visit / Internet; Expenses related to an online internet consultation with a Physician or other health care provider, Physician-Patient web service or e-mail service, including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online provider.
- 7.78** Vocational or educational training services, supplies or materials.
- 7.79** Weight Control / Obesity; Charges incurred for the care and treatment of obesity or primarily for weight control, including weight control drugs, supplies, supplements, substances, weight reduction programs or surgery, including but not limited to bariatric gastric and/or intestinal bypass, gastric stapling or gastric balloon implants.
- Bariatric surgery may be considered eligible if the Covered Person meets all of the following criteria:
- a] Is confirmed to be morbidly obese by two legally qualified Covered Physicians; and
 - b] Has been one hundred (100) pounds over ideal weight for five (5) or more years; and
 - c] Has tried weight reduction diets and/or medications under a Physician's care and failed to maintain weight loss and can provide proof of same; and
 - d] Has underlying medical problems such as arthritis, hypertension, diabetes, or a strong family history of same, which present a life threatening situation.
 - e] Has been on the Plan for a minimum of two (2) years.
 - f] The surgery is performed by an In-Network surgeon at an In-Network facility.

ARTICLE VIII

DENTAL BENEFITS

OPTIONAL DENTAL BENEFITS (Only available if selected through the County's Cafeteria Plan).

"BASIC" DENTAL PLAN SCHEDULE

<u>Covered Services</u>	<u>Maximum Benefit Payable</u>
Exam	\$20.00
X-Rays (1 set bitewings, fullmouth, or panorex)	\$20.00
Cleaning	\$35.00
Fluoride	\$15.00
Extraction (per tooth)	\$25.00
Restorations (Amalgam / Composites)	
one surface	\$20.00
two surface	\$25.00
three surface	\$30.00
Root Canal Treatment (per tooth)	\$45.00
Single Crowns (per crown)	\$80.00

"EXTENDED" DENTAL PLAN SCHEDULE

<u>Covered Services</u>	<u>Benefits Payable*</u>
<u>Initial annual oral exam</u> , x-rays, cleaning, scaling, & fluoride treatment <i>(Not Subject to Deductible)</i>	100%
<u>Deductibles:</u> Individual per Calendar Year	\$50
Family per Calendar Year	\$100
<u>Percentages payable:</u> <i>(after deductible)</i>	
Additional Preventive Services	80%
Restorations (either amalgam or composite)	80%
Endodontics (root canal treatments)	80%
Periodontics	80%
Oral Surgery	80%
Prosthodontics (inlays, crowns, bridges, dentures)	50%
Maximum per person per Calendar Year	\$1,500

Dental Plan

The Dental Benefits are payable in accordance with the above Dental Schedules of Benefits and are subject to the applicable Deductibles (*Extended Dental Plan only*), the Dental Limitations and Exclusions herein, and all other Plan provisions. The "Extended Dental Plan" Calendar Year dental maximum stated in the Schedule of Benefits is the total of benefits payable for all dental services combined.

If as a result of a covered condition, a Covered Person incurs dental expenses, the Plan will pay the Usual, Reasonable and Customary eligible charge at the percentage indicated in the Schedule of Dental Benefits. The Plan allows benefits only for the most cost effective treatment which provides a satisfactory, functional result as determined by the Claims Administrator or its designee.

If a Covered Person needs extensive dental work and would like an estimate of the benefits prior to the work being performed, the dentist can complete a listing of the proposed dental work, and the associated charges, and submit it to the Claims Administrator (AmeriBen) for written pre-treatment estimate.

8.01 DENTAL DEDUCTIBLE (Extended Dental Plan Only)

The Dental Deductible is the amount of eligible Dental charges which must be incurred by each Covered Person each Calendar Year before benefits are payable. The Family Deductible amount applies collectively to all Covered Persons in the same family. When the Family Deductible is satisfied, no further Deductible will be applied for the remainder of the Calendar Year.

8.02 DENTAL SERVICES INCURRED DATE

An eligible dental charge is considered incurred as follows:

- a) A charge is incurred at the time the impression is made for an appliance or modification of an appliance.
- b) A charge is incurred at the time the tooth or teeth are prepared for a crown, bridge or gold restoration, provided the service is completed (the crown or bridge is seated) and provided coverage is still in effect at time the service is completed.
- c) A charge is incurred at the time the pulp chamber is opened for root canal therapy.
- d) All other charges are incurred at the time the dental service is rendered or the supply furnished.

COVERED DENTAL SERVICES

8.03 DIAGNOSTIC AND PREVENTIVE Services means the procedures necessary to evaluate the conditions existing and the procedures or techniques to prevent the occurrence of dental abnormalities or disease. Diagnostic services provide for the necessary examination and x-ray procedures to assist the Dentist in evaluating the conditions existing and the dental care required. Preventive services provide for procedures necessary to clean, scale and polish teeth and apply fluoride.

- a) Routine Oral Examinations
- b) Prophylaxis / Cleanings
- c) Topical fluoride treatments, for children under age sixteen (16).
- d) Full mouth and bitewing x-rays.
- e) Sealants on permanent bicuspids and molars on children under age fourteen (14).
- f) Palliative treatment / emergency care to relieve pain when no other dental treatment is given. (*If other treatment is given, other than x-rays, the amount of benefits paid for the pain relief will be based on the category of that treatment.*)

Diagnostic and Preventive Services – Limitations / Exclusions

- a) Routine oral examinations and cleanings limited to two (2) per Calendar Year.
- b) Bitewing x-rays limited to one (1) set per Calendar Year.
- c) One set of full mouth or panorex x-rays limited to one set in a twenty-four (24) month period.
- d) Topical fluoride treatments limited to one (1) application every Calendar Year.

8.04 RESTORATIVE Services means the necessary procedures to restore teeth to normal contour and function.

- a) Fillings: amalgam, synthetic, porcelain, plastic or composite materials.

8.05 ENDODONTIC Services means the necessary examinations and procedures for diagnosis and treatment of diseases of the tooth pulp and/or infections of the root canal and periapical area.

- a) Pulp therapy and root canal treatment.

8.06 PERIODONTIC Services means the necessary examinations and procedures for diagnosis and treatment of the periodontium. The periodontium is collectively the tissues that surround and support the teeth (including the gingiva, cementum, periodontal membrane, and the supporting alveolar bone).

- a) Treatment for disease of gingival tissue or alveolar supporting structures of the mouth including periodontal surgery.
- b) Occlusal adjustments in connection with periodontal treatment.
- c) Full mouth debridement, once per twelve (12) month period.

Periodontic Services; Limitations / Exclusions

- a) Surgical periodontic services are limited to once every three (3) years per quadrant.
- b) Non-surgical periodontic services are limited to once every two (2) years.
- c) Crown lengthening or single tooth gingivectomy are allowed once in conjunction with crown preparation.
- d) Periodontal Prophylaxis are limited to once every six (6) months.

8.07 ORAL SURGERY means the necessary examinations and procedures for treatment by extraction or other oral surgery not covered under periodontic services.

- a) Provides the necessary procedures for extractions and other oral surgical procedures including impacted teeth and including pre- and postoperative care.
- b) IV Sedation or General Anesthesia in conjunction with a covered oral surgery procedure (not covered for simple extractions).

8.08 PROSTHODONTIC Services means the necessary procedures or techniques concerned with the restoration and replacement of teeth. Dental prostheses may be either fixed or removable.

- a) Crowns: three-quarter, full and stainless steel.
- b) Charges for fixed bridges, Maryland bridges and full or partial dentures.
- c) Porcelain, composite, or gold inlays and onlays.
- d) Charges for adjusting, relining, re-basing or repairing bridges or dentures and re-cementing inlays, onlays, crowns or bridges.
- e) Space maintainers for managing spacing of primary teeth following extraction or permanent tooth loss.

Initial placement of bridges, or full or partial dentures (charges will be considered "initial placement" only if they are not replacing an existing bridge or denture) are Eligible Expenses provided:

1. Placement is due to the extraction of one or more natural, injured or diseased teeth; and
2. Placement of bridge or denture includes replacement of extracted tooth; and
3. Bridge or denture is placed within twelve (12) months after the extraction.

Replacement of an existing fixed bridge or a full or partial denture are Eligible Expenses provided:

1. Prosthetic appliance to be replaced was placed more than five (5) years ago and cannot be made satisfactory; or
2. Addition of teeth is needed to replace one (1) or more natural teeth extracted and the addition of teeth is completed within twelve (12) months after the date of the extraction(s); or
3. Replacement of existing fixed bridge or denture is due to an accidental injury requiring oral surgery and the replacement is completed within twelve (12) months after the event.

Prosthodontic Services – Limitations / Exclusions

- a) Temporary full or partial dentures are not covered.
- b) Charges for replacement due to loss or theft of denture or fixed bridge is **not** covered.
- c) Implants are only payable up to the benefit that would be allowed for a bridge or partial denture.
- e) Anterior space maintainers are not covered.
- f) Replacement of an existing bridge or denture which can be made satisfactory.
- g) Replacement of a denture for which benefits were paid under this Plan, if such replacement occurs in a period which is less than five (5) years from date of initial placement unless:
 1. Such replacement is necessary due to the initial placement of an opposing full denture or extractions of natural teeth; or
 2. The denture is a stayplate or a similar temporary partial denture, and is being replaced by a permanent denture; or
 3. The denture, while in the oral cavity, has been damaged beyond repair as a result of injury while the individual is a Covered Person.

8.09 GENERAL DENTAL LIMITATIONS AND EXCLUSIONS

In addition to the General Limitations in Article VII and the Pre-Existing Conditions Limitation in Article VI, the Plan does not cover Dental Expenses for the following charges:

1. **Analgesia** sedation or hypnosis for relief of anxiety or apprehension.
2. **Anesthesia**, unless it is administered in conjunction with a covered oral surgery (not covered for simple extractions).
3. **Appliances** to increase vertical dimension or to restore or alter occlusion for cosmetic or non-cosmetic purposes.
4. **Assignment** of dental benefits to a provider outside of the United States.
5. **Charges** incurred for any procedure which commenced **before** the Covered Person's effective date under this Plan, or any supplies furnished in connection with such procedure, except that for the purpose of this Dental Limitation, x-rays, or prophylaxis treatment shall not be deemed to commence a dental procedure.
6. **Charges** in excess of the Usual, Customary and Reasonable charge.
7. **Complications** resulting from a non-covered service.
8. **Congenital** or developmental malformations.
9. **Cosmetic** dental procedures performed for reasons, including, but not limited to, bleaching, whitening, altering or extracting and replacing sound natural teeth to change appearance.
10. **Dental procedures** covered under the medical expense provisions of this Plan.
11. **Dental services** not rendered by a dentist (D.D.S. or D.M.D.) or by a dental hygienist or x-ray technician under the supervision of a dentist, except in emergency situations, charges by an MD or DO would be eligible.
12. **Duplicate** or spare prosthetic devices or appliances.
13. **Extra oral grafts** (grafting of tissue from outside the mouth to oral tissues).
14. **Fluoride** treatments on persons age sixteen (16) or older.
15. **Hospital** or a surgical facility charges incurred for to dental services.
16. **Myofunctional** therapy.
17. **Nightguards**, athletic mouthguards, splints, or harmful habit appliances.
18. **Oral hygiene** instructions or supplies, dietary or plaque programs, or other educational programs.
19. **Orthodontia** related charges.
20. **Orthognathic** or **TMJ** treatment or surgery.
21. **Precision attachments**, semi-precision attachments or stress-breakers.
22. **Preparation of dental reports**, itemized bills or claim forms, or charges for broken appointments, telephone calls, photocopying fees, or mailing.
23. **Prescription drugs**, unless available through the Prescription Program.
24. **Replacement** of lost or stolen appliances (i.e.: denture, bridges etc.).
25. **Sealants** on persons age fourteen (14) and older.
26. **Services or supplies** not recognized or recommended by the American Dental Association.
27. **Veneers**

ARTICLE IX

VISION BENEFITS

OPTIONAL VISION BENEFITS

Only available if selected through the County's Cafeteria Plan

SCHEDULE OF BENEFITS

Deductible:

Individual Deductible Per Calendar Year	\$ 50
Family Deductible Per Calendar Year	\$150

Limitations / Maximums Payable:

Exam (<i>one per calendar year</i>)	\$ 50
Lenses* (<i>one set per calendar year</i>)	\$100
Frames* (<i>one per calendar year</i>)	\$ 50
Contacts* (<i>one set per calendar year</i>)	\$125

**Lenses and frames, or contacts (not both)*

9.01 ELIGIBLE EXPENSES

Benefits are available for the following eligible services and supplies required for routine vision care.

A complete examination of the eyes and related structures (once per calendar year) to determine the presence of vision problems or other abnormalities rendered by a licensed optometrist or ophthalmologist, including prescribing and ordering proper lenses and verifying the accuracy of finished lenses.

The purchase of appropriate lenses, frames or contacts, once per calendar year.

Lenses and frames which are lost or broken will not be replaced except at normal intervals when the benefits would have otherwise available.

9.02 LIMITATIONS ON VISION EXPENSES

1. Any charge the Participant is either not legally obligated to pay or any charge not customarily made in the absence of this coverage;
2. Cosmetic supplies;
3. Duplicate service rendered prior to end of any specified time interval;
4. Examination required as a condition of employment, except at the intervals specified;
5. Expenses arising out of, or in the course of, any work for wage or profit for which benefits are available under Worker's Compensation statute or similar statutes whether or not a claim is actually submitted or such benefits are actually paid;
6. Extra cost associated with blended lenses, coating of lenses, laminating of lenses, double segment bifocals, oversize lenses, and progressive multifocal lenses;
7. Medical or surgical treatment of the eye;
8. Orthotics or vision training;
9. Photochromatic lenses or sunglasses;
10. Plano (non-prescription lenses);
11. Second pair of glasses in lieu of bifocals;
12. Services and supplies furnished by or through a government agency; or
13. Tinted lenses, except Pink #1 and Pink #2.

ARTICLE X

SHORT TERM DISABILITY BENEFIT

OPTIONAL SHORT TERM DISABILITY BENEFITS
Only available if selected through the County's Cafeteria Plan

Schedule of STD Benefits

<i>Benefit Eligibility Period:</i>	1st day of disability following the end of the 30 day waiting period through the 180th day of disability
<i>Waiting Period:</i>	Thirty (30) calendar days of total disability.
<i>Benefit Payable:</i>	60 % of Weekly Earnings
<i>Minimum Payable:</i>	\$15 per week
<i>Benefit Offsets:</i>	State of Arizona Disability No Fault Auto Insurance Social Security Disability

If a Covered Employee becomes "*Totally Disabled*" and is unable to perform all of the duties of his/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.

10.01 *SHORT TERM DISABILITY TERMS*

Benefit Period shall mean the length of time (number of days) during which disability benefits are payable. The eligible time-frame is from the first day of disability following the end of the 30 day waiting period through the one hundred and eightieth (180th) day of disability.

Eligible Employee is any employee that has met all probation requirements and has been employed on a full-time permanent basis for one hundred and eighty (180) days.

Covered Employee shall only include benefit eligible employees that have selected the STD benefit during the open enrollment period and are in active full-time status at the onset of a disability.

Received Medical Treatment shall mean that the Covered Employee consulted a licensed Physician, or was taking medication for the disabling condition.

Regular Physician Care shall mean the Covered Employee is being seen by his/her physician on a regular basis of 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/her Physician a minimum of once every thirty (30) days.

Total Disability and Totally Disabled shall mean the inability to engage in all of the duties of one's job as a result of an injury or illness. To be considered totally disabled the Covered Employee must be under the regular care of a licensed Physician.

Waiting Period shall mean the number of consecutive days a Covered Employee must be totally disabled before benefit payments begin.

Weekly Earnings shall mean the basic weekly compensation exclusive of overtime, bonuses or commissions, or any other compensation outside of their employment with the County. Disability benefit payments will not be paid during any period when an employee would not have normally received a paycheck.

10.02 *REQUIREMENTS TO ESTABLISH A SHORT TERM DISABILITY CLAIM*

- a] The disabled employee must submit a disability claim form to the Claims 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.
- b] In order for benefit eligibility to be established, the employee may be required to furnish copies of their medical records.
- c] Any employee claiming disability may be subject to medical review at the Claims Administrator's request. Case review may be made by the Administrator's Utilization Review company and the employee may be required to submit to a medical evaluation for the purpose of a second opinion.
- d] During the course of the disability benefit period, periodic requests will be made for updated medical information to establish continued disability status.
- e] Disability benefits will begin after the Waiting Period of thirty (30) days has been met and after all sick leave, comp time, and vacation days have been exhausted unless the Employee elects to maintain 40 hours of vacation time on the books.
- f] If a disabled employee returns to full-time work for ten (10) days or less during his/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).
- g] If a disabled employee returns to full-time work for more than ten (10) days during his/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.
- h] 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.

10.03 *BENEFIT CALCULATIONS*

- a] The disability benefit will be calculated at sixty percent (60%) of the Covered Employee's weekly earnings. The weekly earnings will be the amount the Covered Employee was earning at the beginning of the Plan Year (January 1). Disability benefit payments will not be affected by statutory or cost of living increases. Benefits payable are subject to the minimum and maximum amounts stated in the Schedule of Benefits.
- b] Disability benefits will begin after the thirty (30) day waiting period has been met and/or after all sick leave, donated leave time, vacation days and comp time has been exhausted, whichever is longer.
- c] Disability benefits will be payable through the one hundred and eightieth (180th) day of disability 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).
- d] Disability benefits shall be reduced by income received from any of the following sources:
 - 1. Disability benefits provided by no-fault auto insurance
 - 2. Social Security disability benefits
 - 3. Rehabilitation Income
 - 4. Any salary, wages, commission or similar compensation payments
 - 5. 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 for which it represented. In no event will the benefits payable under this Plan be less than fifteen (\$15) dollars per week after the above offsets are applied. Benefits will not be payable concurrently with Arizona State Retirement Benefits.

10.04 *SHORT TERM DISABILITY CONTINUATION OF BENEFITS*

- a] Disability benefits will continue to be paid for up to the maximum number of days indicated in the Schedule of Benefits, provided the Covered Employee is continuously and totally disabled and meets all the eligibility requirements of this Plan.
- b] Any Employee claiming disability benefits may be subject to medical review at the request of the Claims Administrator. The Employee may be required to a second medical opinion at the direction of and to a Physician of the Administrator's choice.
- c] 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 recurrence 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.
- d] 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.

10.05 *SHORT TERM DISABILITY TERMINATION OF BENEFITS*

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

- a] The date the Covered Employee is no longer disabled; or
- b] The date the Covered Employee fails to furnish the proper documentation that he/she continues to be disabled; or
- c] The date the maximum number of benefit days has been paid; or
- d] The date the Covered Employee is eligible for the Arizona State Long Term Disability Plan; or
- e] The date the Covered Employee becomes eligible for retirement benefits.

10.06 *SHORT TERM DISABILITY LIMITATIONS AND EXCLUSIONS*

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

- a] Injury or illness which arises out of, or occurs in the course of any occupation or employment for wage or profit.
- b] Any injury or illness for which the employee is entitled to benefits under the Workers Compensation Act or similar legislation.
- c] A disability that began prior to the commencement of the Employee's employment contract.
- d] Any disability that is considered to be due to a condition that was pre-existing. A condition will be considered pre-existing if the Employee was diagnosed or received medical treatment during the six (6) month period immediately preceding their employment date.
- e] War, whether declared or undeclared.
- f] Civil disorder or riot.
- g] An illness or injury sustained as a result of being engaged in an illegal occupation or sustained during the commission of, or the attempted commission of a crime, assault, felony, misdemeanor or other illegal act.
- h] Service in the Armed Forces of any Country.

ARTICLE XI

COORDINATION OF BENEFITS

All charges incurred by Covered Persons are subject to "Coordination of Benefits" (COB). This provision allows for coordination of this Plan's benefits with other "Applicable Policies" the Covered Person may also be entitled to benefits under.

Benefits will be coordinated so that the amount received under this Plan along with the benefits received under all other applicable plans will not exceed the total allowable expense.

11.01 GENERAL TERMS / PROVISIONS

APPLICABLE POLICIES means any of the following plans that provide coverage for hospital, surgical, medical, dental or vision care; group plans insured or noninsured; labor-management trustee plans; union welfare plans; employer organization group plans; employee benefit organized plans; school plans; prepaid group practice; automobile first-party medical provision; group blanket or franchise insurance; benefits provided under Title XVIII of the Social Security Act of 1965 as amended (Medicare Parts A and B); any insurance or similar provisions.

ALLOWABLE EXPENSE means any necessary, reasonable and customary item of expense, a part of which is covered under one of the plans of the individual for whom the claim is made. If a Preferred Provider (PPO) discount is made by the Primary carrier, this Plan as secondary will only allow payments up to the PPO contracted allowed amount.

COB BENEFIT DETERMINATION PERIOD shall mean one (1) Calendar Year.

PRIMARY PLAN means the plan which initially pays its regular benefits.

SECONDARY PLAN means the plan which pays the balance of the remaining eligible expenses after the Primary Plan has paid its complete liability. When the Secondary Plan's benefits are added to the Primary Plan's benefits, the total amount paid will not be more than the total allowable expense. In no event will the secondary plan's payment be greater than its normal liability would be had it been the Primary payor, for all claims combined for the Calendar Year (accumulated credit savings can be used when necessary).

11.02 ORDER OF BENEFIT DETERMINATION

This Plan follows the guidelines established by the National Association of Insurance Commissioners (NAIC) when coordinating benefits.

1. The rules for determining primary vs. secondary for the order of benefit payments are as follows:
 - a] A plan which does not have a non duplication of Benefits provision will pay as primary and this Plan will be secondary.
 - b] The plan which covers the claimant as an Employee, member, subscriber or retiree shall be primary.
 - c] The plan which covers the claimant as a Dependent shall be considered secondary.
 - d] If a claimant is covered under one policy in an active status and is also covered under another policy in a retired or laid off status, the policy that covers the claimant in the active status will be primary.
 - e] If a claimant has coverage under COBRA and is also covered under another plan in an active or retiree status, COBRA coverage would be secondary to active or retiree coverage.
 - f] The benefits of a plan which covers the patient as a Dependent child whose parents are not separated or divorced shall have benefits determined according to the "Birthday Rule" as follows:
 - 1) The plan of the parent whose birthday (excluding year of birth) occurs earlier in a Calendar Year is primary over the plan of the parent whose birthday occurs later in a Calendar Year.
 - 2) If both parents have the same birthday, the plan which has covered a parent longer is primary before the plan which has covered the other parent for a shorter period of time.
 - g] If none of the above are applicable, the plan covering the person the longest will be Primary.
2. When Dependent children are covered under more than one plan as a result of a divorce or legal separation, the Primary Plan order of responsibility will be determined as follows:
 - a] First: The plan where the dependent child is covered as a result of a divorce decree or court ordered "Qualified Medical Child Support Orders" (QMCSO) which establishes financial responsibility for the medical or dental expenses.

- b] Second: The plan of the natural or adoptive parent who has custody of the Dependent child.
- c] Third: The plan of the stepparent, provided the child's permanent primary residence is with the stepparent.
- d] Fourth: The plan of the natural or adoptive parent who does not have custody.
- e] Fifth: Joint Custody; When the court decree does not specify which parent is responsible for the child's health care expenses, the "Birthday Rule" as defined above will apply.
- f] If none of the above are applicable, the plan covering the Dependent child the longest will be Primary.

If none of the above rules determine which plan is Primary, each plan shall pay an equal share of the Covered Person's eligible expenses.

11.03 COORDINATION WITH MEDICARE

The term "Medicare" as used herein means the Medicare program including Part A and Part B, established by Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended. A person shall be considered to be entitled to all of the coverage provided by Medicare on or after the earliest date he/she would have become so entitled had he/she promptly submitted all applications and proof required for such coverage, whether or not enrollment for such coverage or benefits has been made. This Plan will adhere to all current regulations as determined by Medicare.

Medicare Order of Benefit Determination:

- a] This Plan will be considered Primary for Active Employees and their Covered Dependents who are eligible for Medicare.
- b] Covered Persons who are totally disabled and under age sixty-five (65) will be considered Primary under this Plan and Secondary under Medicare.
- c] Medicare will be Primary and this Plan will be Secondary for Covered Retirees and their Covered Dependents who are eligible for Medicare.
- d] This Plan will be Primary for Covered Persons entitled to Medicare due to end-stage renal disease (ESRD) for the first thirty (30) months of Medicare coverage, at which time Medicare will become the Primary Payor.
- e] Medicare is primary over COBRA coverage, except in the case of ESRD (refer to [d] above).

11.04 PAYMENT TO THIRD PARTIES

Whenever payments which should have been made under this Plan in accordance with the previous provisions have been made by any other plans, this Plan will have the right to pay to any organizations making these payments the amount it determines to be warranted in order to satisfy the intent of the previous provisions. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, the Plan and the Employer will be fully discharged from liability under this Plan.

ARTICLE XII

DEFINITIONS

For the purpose of this Plan the following terms will have the following definitions when used in this document.

12.01 *ACCIDENT* means nonoccupational bodily injury that is caused by an event that is external, violent, sudden and unforeseen, is not of gradual onset and is independent of all other causes or conditions.

12.02 *ACTIVE* means on a scheduled work day the employee is performing in the customary manner the regular duties of his/her employment on a full-time basis at the Employer's establishment or at some location to which the Employer's business requires him/her to travel.

On a day that is not a scheduled work day, the employee will be considered "Active" only if he/she was performing in the customary manner all of the regular work duties of his/her employment on the preceding scheduled work day.

12.03 *ADMINISTRATOR* or *PLAN ADMINISTRATOR* as defined by Federal Law means the Employer in the case of an employee benefit plan established or maintained by a single employer.

12.04 *BIRTHING CENTER* means a freestanding or hospital based, public or private institution, other than private offices or clinics of Physicians, which is licensed by the State as a Birthing Center or is associated with a licensed Hospital and meets the official requirements of the State Department of Health.

12.05 *CALENDAR YEAR* means the twelve (12) month period of time from January 1 through December 31.

12.06 *CHIROPRACTOR* is a practitioner duly licensed by the state to practice the science of chiropractic medicine, acting within the scope of his/her license.

12.07 *CLAIMS ADMINISTRATOR* means the company employed by the Plan who is responsible for the processing of claims and payment of benefits, administration, accounting and reporting as contracted for by the Plan. The current Claims administrator is AmeriBen.

12.08 *CLAIMS REVIEW COMMITTEE* shall mean two (2) or more persons employed by the Claims Administrator responsible for the determination of all requests for review of a claim denial.

12.09 *CO-INSURANCE* means the percentage of a claim that is the financial responsibility of the Covered Person after this Plan's eligible benefit percentage has been calculated.

12.10 *CO-INSURANCE LIMIT* means the total dollar amount of eligible charges shown in the Schedule of Benefits for which the Covered Person is financially responsible for during the Calendar Year (the 20% co-insurance), after which the Plan will pay eligible charges for the remainder of the Calendar Year at one hundred percent (100%). Expenses for co-payments and penalties for noncompliance with pre-certification requirements do not accumulate toward the co-insurance maximum.

12.11 *CO-PAYMENT / CO-PAY* means the specified dollar amount which a Covered Person must pay in conjunction with the receipt of eligible services under the terms of this Plan.

12.12 *CORRECTIVE APPLIANCE* means items which are prosthetic or orthotic and necessary for the restoration of function or replacement of body parts.

Prosthetic is an item used to replace all or part of a natural body part or the function thereof.

Orthotic is an item used to support a weakened body part or to correct a body defect.

12.13 *COSMETIC* refers to treatment, surgery or service performed which will preserve or improve appearance (i.e.: reshape the structure) and which will not affect the physiological function.

12.14 *COVERED DEPENDENT* shall be those Dependents who are eligible according to the eligibility rules provided herein under Article II, "Eligibility", and are enrolled by a Covered Employee.

12.15 *COVERED EMPLOYEE* shall refer to an elected official, employee or former employee who is eligible hereunder and who has been enrolled in the Plan. To be considered a Covered Employee, the individual must satisfy the requirements in Article II, "Eligibility".

12.16 *COVERED PERSON* shall refer to a Covered Employee, Covered Dependent, or a Qualified Beneficiary under COBRA.

12.17 CUSTODIAL CARE shall mean services which are provided to help a person with personal hygiene, or to perform activities of daily living and which can be safely performed by individuals who are not trained, licensed health care professionals. Services are custodial regardless of who recommends, orders, provides or directs the care or location for the care.

12.18 DENTIST means a duly licensed practitioner acting within the scope of his or her license and holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD).

12.19 DEDUCTIBLE means the total amount of Eligible Expenses for services or supplies which the Covered Person must accumulate in Eligible Expenses prior to receiving benefit payment from this Plan.

12.20 DRUG means any medication or article which may only be lawfully dispensed (as provided under the Federal Food, Drug and Cosmetic Act) upon the written or oral prescription of a Physician duly licensed by law to administer it.

12.21 DURABLE MEDICAL EQUIPMENT means equipment that can withstand repeated use, is not disposable, and is primarily and customarily used for a medical purpose and would not generally be useful in absence of illness or injury.

12.22 ELECTION PERIOD means the period in which each Qualified Beneficiary must elect coverage continuation. The period commences when the Covered Person becomes eligible or receives the notice specified in the Continuation of Coverage provision, whichever is later. The Election period terminates sixty (60) days after the receipt of the notice of rights under termination.

12.23 ELIGIBLE EXPENSES for the purpose of these benefits, for a charge to be considered eligible the charge must be: a) administered or ordered by a Covered Physician; b) medically necessary; c) not of an experimental or investigational nature; d) not of a custodial nature; e) reasonable and customary treatment relative to the diagnosis; and f) a negotiated rate agreed upon between BCBSAZ and the Network Provider for the service that is rendered or the item that is purchased as determined by the Plan or its designee. Eligible charges shall also include charges related to routine wellness care as defined in Article V, Section 5.34. Eligible charges shall not include expenses which are specifically excluded or reduced as a result of specific Plan requirements not satisfied.

12.24 EMERGENCY means a sudden unexpected onset of a medical condition, which manifests itself by such acute symptoms of sufficient severity that requires urgent and immediate medical attention (without regard to the hour of day or night) to prevent significant impairment in bodily functions or serious and/or permanent dysfunction of any bodily organ or part and is not normally treatable in the provider's office.

12.25 EMERGENCY HOSPITALIZATION OR CONFINEMENT means 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 life threatening situation.

12.26 EMERGENCY SURGERY shall mean a surgical procedure performed within twenty-four (24) hours of the sudden and unexpected severe symptom of an illness or within twenty-four (24) hours of an accident, during a life threatening situation.

12.27 EMPLOYER as used herein shall mean Pinal County.

12.28 ENROLL means to make written application for coverage on the prescribed forms, within the stipulated time-frames.

12.29 EXPENSE INCURRED shall mean the date on which the service or supply is actually rendered or obtained. Any agreement as to fees or charges made between the individual and the Physician shall not bind the Plan in determining its liability with respect to the Expense Incurred.

12.30 EXPERIMENTAL / INVESTIGATIONAL TREATMENT, PROCEDURE OR EQUIPMENT means any services, procedures, equipment or supplies which:

- a) Is considered by any governmental agency, such as the Food and Drug Administration (FDA), the National Institute of Health (NIH), or the Centers for Medicare and Medicaid Services (CMS) as noted in the Medicare Coverage Issue Manual, to be experimental or investigational; or
- b) Cannot be lawfully marketed without approval of the Food and Drug Administration and approval for marketing has not been given at the time a drug or device is furnished; or
- c) "Reliable evidence" shows that the drug, device or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; or

- d] "Reliable evidence" shows that the consensus of opinion among experts regarding the drug, device or 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 the standard means of treatment or diagnosis; or
- e] Do not have a documented success ratio of fifty percent (50%) for a period of two (2) years.

"Reliable Evidence" shall mean published reports and articles in the authoritative medical and scientific literature, or the written protocol or written informed consent used by the treating facility or of another facility studying substantially the same drug, device, medical treatment or procedure.

12.31 *GRACE PERIOD* means the period of time in which the Covered Person/Qualified Beneficiary must pay the required contributions for continued coverage to remain in effect. The Grace period will be the longest of:

- a] Thirty (30) days; or
- b] The period the Employer allows Covered Employees to pay late or overdue contributions.

12.32 *HOME HEALTH CARE AGENCY* shall mean a licensed public agency or private nonprofit organization which:

- a] Is primarily engaged in providing skilled nursing services;
- b] Has policies, established by a group of professional personnel associated with the agency or organization (including one (1) or more Physicians and one (1) or more Registered Nurses), to govern and supervise the services which it provides (referred to in subdivision [a]) and provides for the supervision of such services by a Physician or Registered Nurse.

12.33 *HOME HEALTH SERVICES* shall mean the items and services which are furnished to a Covered Person who is under the care of a Physician. Such items and services may be furnished by a licensed Home Health 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 Covered Person's home or, if necessary, at the nearest facility equipped to provide such services when not available at the Covered Person's place of residence, and shall consist of:

- a] 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.
- b] Part-time or intermittent nursing care provided by or under the supervision of a Registered Nurse; 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:
 1. medical social services under the direct supervision of a Physician;
 2. medical supplies (other than drugs and biologicals), and the use of medical appliances while under such a plan;
 3. 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.

12.34 *HOSPICE CARE* shall mean 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:

- a] 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 Covered Person; and
- b] 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.

12.35 *HOSPITAL* means a licensed institution engaged in providing for payment, care and treatment for sick and injured people, which meet all the following requirements:

- a] Provides care by Registered Nurses on call twenty-four (24) hours per day;
- b] Has on staff at all times one (1) or more licensed Physicians; and
- c] Has on its immediate premises, (except in the case of an institution specializing in the care and treatment of psychiatric disorders) an operating room and related equipment for performing surgery.

The term *HOSPITAL* will not include a facility which is primarily for any of the following: rest or convalescence, custodial care, the aged, rehabilitation training, schooling, or occupational therapy. Confinement in a special unit of a Hospital (i.e. units primarily used as a nursing, rest or convalescent home) is not deemed as hospital confinement for purposes of this definition.

12.36 HOSPITAL MISCELLANEOUS CHARGES shall mean the Reasonable and Customary charges by the Hospital for the necessary services, medicine or supplies for the diagnosis or treatment of an illness or injury (except services of a Physician and drugs or supplies not consumed or used in the Hospital) while the Covered Person is Hospital confined and a charge is made for room and board, or if such services are rendered in connection with a surgical procedure performed on an "Outpatient" basis.

12.37 ILLNESS means bodily sickness or disease, pregnancy of an employee or spouse, psychiatric disorders, or congenital abnormalities.

12.38 IMMEDIATE FAMILY MEMBER shall mean the Covered Person's mother, father, sister, brother, husband, wife and/or child whether by birth or by marriage.

12.39 INDIVIDUAL DEDUCTIBLE AMOUNT is the amount shown in the Schedule of Benefits which must be accumulated in Eligible Expenses by a Covered Person during each Calendar Year before benefits are payable under this Plan.

12.40 INJURY means a condition which results independently of an illness and is a result of an accidental externally violent force.

12.41 INJURY TO SOUND NATURAL TEETH shall mean an injury to the teeth caused by an external object. Intrinsic force such as a force of chewing does not meet the definition of injury.

12.42 IN-NETWORK refers to BlueCross® BlueShield® of Arizona providers.

12.43 INPATIENT means confined in a Hospital facility for which a room and board charge has been made.

12.44 INTENSIVE CARE UNIT shall mean a section, ward, or wing within the Hospital which is separated from other Hospital facilities, and:

- a] Is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;
- b] Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use; and
- c] Provides room and board and constant observation and care by Registered Nurses and other specially trained Hospital personnel.

12.45 LIFE THREATENING means unexpected, acute, sudden and serious conditions which require *immediate* medical treatment.

12.46 LIFETIME PLAN MAXIMUM means the maximum Plan benefits available for any one (1) Covered Person for all conditions during his/her lifetime while covered under any plan provided by this Employer, whether or not there has been any interruption in his/her coverage under this Plan.

12.47 MEDICALLY NECESSARY OR MEDICAL NECESSITY means any health care, service, supplies, or accommodations received by the Covered Person for illness or injury which is consistent with the following criteria as determined by the Plan or its designee:

- a] Must be consistent with the symptom(s) or diagnosis;
- b] Must be received in the most appropriate setting that can be used safely (for example, in a Provider's office or Ambulatory Surgery Service Facility instead of a Hospital);
- c] Must not be solely for the convenience of the Covered Person, the Physician, the Hospital, healthcare provider or any other person;
- d] Must be the most appropriate with regard to standards of good medical practice and could not have been omitted without adversely affecting the Covered Person's condition or the quality of medical care received, as determined by established medical review mechanisms;
- e] Must be the most appropriate and cost efficient level of service that can be safely provided to the Covered Person.

The fact that a Physician may recommend or approve a service or supply does not in itself make the service or supply medically necessary.

12.48 MEDICARE means Title XVIII of the United States Social Security Amendment of 1965 (Federal Health Insurance for the Aged), or as later amended.

12.49 MENTAL HEALTH / BEHAVIORAL HEALTH refers to disorders, conditions and diseases as defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD-9-CM) manual, and is not a specific Plan exclusion.

12.50 *MENTAL HEALTH / BEHAVIORAL HEALTH TREATMENT FACILITY* shall mean a public or private facility, licensed and operated according to the law, which provides a program for diagnosis, evaluation, and effective treatment of mental health disorders, and provides skilled nursing care by licensed nurses under the direction of a full-time R.N. The facility must have at least one Physician on staff and on call. The facility must prepare and maintain a written plan of treatment for each patient. The treatment plan must be based on medical, psychological and social needs.

12.51 *NEWBORN NURSERY CHARGES* means the room and board and miscellaneous charges made by a Hospital for the care, other than for an illness or injury, of a newborn baby immediately following birth (DRG 391).

12.52 *NON-DURABLE* means 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.

12.53 *NURSE* means a Registered Graduate Nurse (R.N.), a Licensed Vocational Nurse (L.V.N.), a Licensed Practical Nurse (L.P.N.), or a Registered Nurse First Assistant (RNFA).

12.54 *NURSE-MIDWIFE* means a Certified Nurse-Midwife holding the degree of C.N.M. and practicing within the scope of his/her license. Services rendered must only be for obstetrical care or well woman care.

12.55 *ORTHOGNATHIC* refers to services dealing with the cause and treatment of malposition of the bones of the jaw.

12.56 *OUT-OF-NETWORK* means any provider that is not contracted with the BlueCross BlueShield provider network.

12.57 *OUTPATIENT* shall mean any care or treatment that is rendered while the Covered Person is not confined in a Hospital or other Facility.

12.58 *PARTICIPATING or PREFERRED PROVIDER* means a provider who is under contract with the BlueCross Blue Shield network to provide services to Covered Persons at negotiated rates.

12.59 *PERIOD OF COVERAGE* means the period beginning on the date of the Qualifying Event and lasting until the earliest of the dates indicated under COBRA Article IV.

12.60 *PHYSICIAN OR DOCTOR* means a duly licensed or certified practitioner acting within the scope of his/her license or certification and holding the degree of:

- a] M.D. - Doctor of Medicine; or
- b] D.O. - Doctor of Osteopathy.

An eligible Physician shall not include the Covered Person, or a Physician who is part of the Covered Person's immediate family.

12.61 *PLAN* shall refer to the benefits and provisions for payment described herein.

12.62 *PLAN DOCUMENT* shall mean and refer to this written document.

12.63 *PODIATRIST* means a duly licensed practitioner acting within the scope of his or her license and holding the degree of Doctor of Podiatric Medicine (DPM).

12.64 *PRACTITIONER* shall mean a person acting within the scope of applicable state licensure/certification requirements and holding the degree of Certified Nurse Midwife (CNM), Registered Nurse First Assistant (RNFA), Certified Surgical Assistant (CSA), Certified Registered Nurse Anesthetist (CRNA), Registered Physical Therapist (RPT), Occupational Therapist, Speech Therapist, Physician's Assistant (PA), Nurse Practitioner (NP) or Registered Respiratory Therapist. An eligible practitioner shall not include the Covered Person, or anyone who is a member of the Covered Person's family or resides with the Covered Person. Eligible Mental Health/Behavioral Health practitioners are limited to Psychiatrist, Psychologists and other counselors as specified in Article V, Section 5.51. 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.

12.65 *PRE-CERTIFICATION* refers to the process of reviewing the necessity, appropriateness, location, duration and/or cost efficiency of a health care service before it is rendered.

12.66 *PREFERRED & PARTICIPATING PROVIDERS* are the health care providers (i.e. Hospitals, Physicians, Laboratories, etc.) that have been contracted by BlueCross BlueShield to provide services at a reduced rate.

12.67 *PRE-EXISTING CONDITION* means any condition for which an individual was diagnosed, received medical care or treatment (including but not limited to diagnostic testing, consultation, or consumption of prescribed medication, or self-administered drugs or biologicals) during the six (6) month period immediately preceding his/her enrollment date of

coverage with this Plan. Under this plan condition means any disease, illness, ailment or bodily malfunction of a Covered Person. Under this plan treatment means medical or surgical management of a Covered Person. Under this plan consultation means the seeking or rendering of medical treatment by or from a physician or doctor. Under this plan biologicals means any natural compound processed and used for the treatment and/or cure of a medical condition.

12.68 *QUALIFIED BENEFICIARY* shall mean a person so defined under COBRA, Article IV.

12.69 *QUALIFYING EVENT* as used and defined under COBRA, Article IV.

12.70 *RECONSTRUCTIVE SURGERY* shall mean a procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease, tumor, or for breast reconstruction following a mastectomy.

12.71 *REHABILITATION THERAPY* shall mean 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.

12.72 *RESIDENTIAL TREATMENT FACILITY* means a facility duly licensed or certified by the State Department of Health for treatment of chemical dependency or substance abuse.

12.73 *ROUTINE NEWBORN / WELL BABY CARE* means charges made by a Provider for inpatient or outpatient examination or care of a healthy newborn or infant other than treatment or diagnosis in connection with an illness or injury.

12.74 *SEMIPRIVATE ROOM CHARGE* means the charge by a Hospital for a room containing two (2) or more beds.

12.75 *SKILLED NURSING CARE* refers to services performed by a licensed health care professional which:

- a) Has been ordered and provided under the direct supervision of a Physician;
- b) Is intermittent and part-time, not exceeding sixteen (16) hours per day and typically is required on less than a daily basis;
- c) Requires the skills of technical or professional personnel in that the service is so inherently complex that it can only safely and effectively be performed by same.

12.76 *SKILLED NURSING FACILITY (SNF) OR EXTENDED CARE FACILITY* shall mean an institution, or a distinct part thereof, which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from injury or illness, and:

- a) Is approved by and is a participating Skilled Nursing Facility under Medicare;
- b) Has organized facilities for medical treatment and provides twenty-four (24) hour nursing services under the full-time supervision of a Physician or Registered Nurse;
- c) Maintains daily clinical records on each patient and has available the services of a Physician under the established agreement;
- d) Provides appropriate methods of dispensing and administering drugs and medicines;
- e) Has transfer arrangement with one or more Hospitals, a utilization review plan in effect and an operations policy developed with the advice of, and reviewed by, a professional group including at least one Physician; &
- f) Is not an institution or part thereof which is primarily a place of rest, a place for custodial care, a place for the aged, a hotel or similar institution.

12.77 *SPINAL MANIPULATION AND CHIROPRACTIC CARE* means the treatment rendered for the correction of structural imbalance, distortion, misalignment or subluxation of or in the vertebral column by manual or mechanical means.

12.78 *SOUND AND NATURAL TEETH* means a tooth which is free of decay or periodontal disease, contains a live nerve and root, and has never been capped or crowned.

- 12.79** *SURGERY* means any of the following medical procedures:
- a] To incise, excise, or electrocauterize any organ or body part.
 - b] To repair, revise or reconstruct any organ or body part.
 - c] To reduce by manipulation a fracture or dislocation.
 - d] To puncture or aspirate.
 - e] Use of a scope for diagnostic procedures.
 - f] Use of endoscopy or laparoscopy, etc. for exploration, or removal of tissue.
 - g] Use of a Laser.

In the case of multiple surgeries performed through the **same incision** the maximum allowable expense shall be equal to the negotiated rate agreed upon between BCBSAZ and the Network Provider for the procedure with the greatest scheduled amount. Additional allowances (modifiers) may be given when the additional surgeries add significant complexity to the surgical session. If during the same surgical session multiple surgeries are performed through **separate incisions**, the allowable expense shall be calculated at the full negotiated rate agreed upon between BCBSAZ and the Network Provider of the primary procedure, and at fifty percent (50%) of the negotiated rate agreed upon between BCBSAZ and the Network Provider of each of the lesser procedure(s) that are through their own separate incision(s).

- 12.80** *SURGICAL CENTER, FREESTANDING OR AMBULATORY* means hospital based or freestanding legally operated center which;
- a] Has permanent operating rooms and at least one (1) recovery room, and all necessary equipment for use before, during and after surgery; and
 - b] Is other than a private office or clinic of a Physician; and
 - c] Has full-time Registered Nurses available for care in an operating room or recovery room; and
 - d] 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; and
 - e] Is supervised by an organized staff of medical professionals.

12.81 *TOTAL DISABILITY* means 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 non-occupational 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.

12.82 *TREATMENT* shall mean having received a diagnosis, consultation, or taking prescribed drugs or medications (including self-administered drugs or biologicals not requiring a Physician's prescription) for an illness or injury.

12.83 *URGENT CARE FACILITY* is a public or private Hospital based or free-standing facility that is licensed or legally operating as an Urgent Care Facility, that primarily provides minor or emergency and episodic medical care, in which one or more Physicians, Nurses, and x-ray technicians are in attendance at all times when the facility is open, and that includes x-ray and laboratory equipment and a life support system.

12.84 *USUAL, CUSTOMARY AND REASONABLE (UCR)* means 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 providers, the UCR charge is defined as the fee allowance as outlined in the agreements between the EPO providers and the EPO.

12.85 *VISIT* shall mean an in person interview/consultation between a Physician or other eligible health care practitioner and a Covered Person. A telephone consultation will only be considered eligible for an acute emergency situation.

ARTICLE XIII

GENERAL PROVISIONS

The Plan Document constitutes the entire Plan. The Plan does not constitute a contract of employment or in any way affect the right of the employer to discharge any employee. If the language in this Plan Document conflicts with the Schedule of Benefits, the Schedule of Benefits will be considered correct and benefits paid accordingly.

13.01 PURPOSE

The Plan Administrator has established and maintains the self-funded Employee Benefit Trust contained herein to provide for the payment or reimbursement of specified medical expenses incurred by its Covered Employees and their Covered Dependents. The name of the Plan is the Pinal County Employee Benefit Trust, hereinafter referred to as the "Plan". The purpose of this Plan Document is to set forth the provisions of the Plan which provide and/or affect such payment or reimbursement.

13.02 EFFECTIVE DATE

The revised Effective Date of the Plan is January 1, 2010 as of 12:01 a.m., Mountain Standard Time in the State of Arizona. Eligibility for, and the amount of benefits, if any, payable with respect to employees of the Employer or their dependents, prior to the effective date, shall be determined in accordance with any applicable group benefit plan maintained by the Plan Administrator at that time. As of the effective date, eligibility for, and the amount of benefits, if any, payable with respect to employees of the Employer or their dependents, shall be determined pursuant to the terms and conditions of this Plan Document.

13.03 AMENDMENTS

To carry out its obligation to maintain, within the limits of the funds available to it, a sound economic program dedicated to providing quality benefits for Covered Employees and Covered Dependents, the Trust expressly reserves the right, at its sole discretion and without notice to eligible individuals but on a nondiscriminatory basis to:

- a] Cancel or discontinue the Plan;
- b] Amend either the amount or conditions with respect to any benefits or provisions of the Plan, even though such amendment affects the claims in process and/or expenses already incurred;
- c] Alter or postpone the method of payment of any benefit; and
- d] Amend any provisions of these Rules and Regulations.

13.04 SUMMARY PLAN DESCRIPTIONS

Each employee covered under this Plan will receive a Summary Plan Description describing the benefits to which the Covered Persons are entitled, to whom benefits are payable, and summarizing the provisions of the Plan.

13.05 MISSTATEMENT OF AGE

If the age of a covered individual has been misstated and if the amount of contribution is based on age, an adjustment of contributions shall be made based on the covered individual's true age. If age is a factor in determining eligibility or amount of benefits, or both, the amount for which the person is covered shall be adjusted in accordance with the covered individual's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Contributions and benefits will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

13.06 MISREPRESENTATION OR FRAUD

In the event of misrepresentation or fraud by a Covered Person or by a Covered Person's representative, the Plan has the right to deny claims in whole or in part. If information is misrepresented on an application for coverage, this Plan has the right to rescind coverage.

13.07 DISCLAIMER OF LIABILITY

The Plan has no control over any diagnosis, treatment, care (or lack thereof), or other services delivered to a Covered Person by a provider, and disclaims liability for any loss or injury caused to the Covered Person by any provider by reason of negligence, or failure to determine the correct diagnosis, or failure to provide treatment or otherwise.

13.08 PRIVACY, CONFIDENTIALITY, RELEASE OF RECORDS OR INFORMATION

Any information collected by the Plan will be treated as confidential information, and will not be disclosed to anyone without your written consent, except as follows:

- a] Information will be disclosed to those who require that information to administer the Plan or to process claims.
- b] Information with respect to duplicate coverages will be disclosed to the plan or insurer that provides the duplicate coverage.
- c] Information will be disclosed as required by law or regulation or in response to a duly issued subpoena.

13.09 RIGHT TO RECEIVE AND RELEASE INFORMATION

For the purpose of implementing the terms of this Plan, information may be released to or obtained from any insurance company, organization or individual, concerning any Covered Person when it is deemed necessary. Any Covered Person claiming benefits under this Plan will furnish the Plan the information necessary to implement the Plan provisions. The Plan reserves the right to suspend or deny a claim based on lack of information and/or records.

ARTICLE XIV

MISCELLANEOUS PLAN PROVISIONS

14.01 FILING OF INFORMATION

Each Covered Person is responsible to file with the Claims Administrator, within thirty-one (31) days of the event, the pertinent information concerning eligibility, name and address changes, marriage, divorce, disability, Medicare eligibility, death, student status, proof or continued proof of dependency, in order to be entitled to benefits under the Plan.

14.02 PROOF OF CLAIM and TIMELY FILING REQUIREMENTS

Written notice and proof of claim hereunder must be given to the Plan with particulars sufficient to identify the Covered Person and the services rendered, within twelve (12) months of the date such claim was incurred. Completed claim forms (when required), itemized statements, diagnosis, treatment details and medical information must be submitted for a claim to be processed. If a claim has been closed for lack of response to requests for information, the Covered Person has a maximum of one hundred and eighty (180) days from the date the claim was closed to provide the additional information. Any exceptions to these filing requirements are subject to approval by the Pinal County EBT Board of Trustees.

14.03 INTERPRETATION OR PLAN PROVISIONS

The Plan Administrator shall have the discretion to interpret and apply the provisions of this Plan, and the decision of the Plan Administrator shall be upheld unless arbitrary or capricious.

14.04 PROVIDER ARRANGEMENT

The Board shall have the right to contract with Providers or existing networks of Providers in order to establish an Exclusive Provider Network. Participants elect to utilize these Providers in order to obtain the benefits described in this Plan. All other Plan restrictions and limitations will remain the same.

14.05 INDEPENDENT PHYSICIAN EXAMINATION

The Plan, at its own expense, shall have the right and opportunity to have a Physician of its choice examine the Covered Person when and so often as it may reasonably require during the pendency of any claim.

14.06 MANAGED CARE RECOMMENDATIONS

This Plan, together with the Utilization Review firm, Excess Loss Carrier and the Claims Administrator have the option of overriding 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.

14.07 FACILITY OF PAYMENT

If a valid release cannot be rendered for the payment of any benefit payable under this Plan, payment may be made to the individual or individuals that have assumed the care and support of the Covered Person and are, therefore, entitled thereto. In the event of the death of the Covered Person prior to such times as all benefit payments due him/her have been made, benefit assignments made prior to the death of the Covered Person will be honored. Any payment in accordance with the above provisions shall fully discharge the obligation of the Plan to the extent of such payments.

14.08 ASSIGNMENT

The Covered Person's benefits may not be assigned, other than to the provider of service, except by consent of the Plan. This Plan contains an automatic assignment of benefits to the provider of service unless evidence of previous payment is submitted with the claim. Any payment made by the Plan in accordance with this provision will fully release the Plan of its liability to the Covered Person.

14.09 RIGHT OF RECOVERY

If for any reason payments are made in excess of the correct amount due, the Plan has the right to recover any excess payments from any other company, organization, or individual, including the reduction or suspension of future Plan benefits that may be due the Covered Person or any Covered Family Member, or, by requiring the Covered Person to pay back the overpayment in full or in accepted and approved installments until the overpayment is fully recovered.

14.10. SUBROGATION AND RIGHT OF REIMBURSEMENT

The Plan has a first priority Subrogation and Reimbursement right if it provides benefits resulting from or related to an injury, occurrence, or condition for which the eligible person has a right of redress or recovery against any Third-Party.

What does first priority right of Subrogation and Reimbursement mean? It means that if the Plan pays benefits which are, in any way, compensated by a Third-Party, such as an insurance company, you agree that when a recovery is made from that Third-Party, the plan is fully reimbursed out of that recovery for the benefits the Plan previously paid. If you do not agree to the Plan's Subrogation and Reimbursement rules, benefits will not be paid.

The rights of Subrogation and Reimbursement are incorporated into this Plan for the benefit of each participant in recognition of the fact that the value of benefits provided to each participant will be maintained and enhanced by enforcement of these rights.

Subrogation and Reimbursement - Rules for the Plan

The following rules apply to the Plan's rights of Subrogation and Reimbursement:

- a) Subrogation and Reimbursement Rights in Return for Benefits: In return for the receipt of benefits from the Plan, the eligible person agrees that the Plan has the Subrogation and Reimbursement rights as described in this Subrogation and Reimbursement section. Further, the eligible person, or the eligible member for his his/her minor dependent will sign, if requested, a form acknowledging the Plan's Subrogation and Reimbursement rights prior to payment, or further payment, of benefits. Benefits will not be paid if the eligible person refuses to sign the acknowledgment. Regardless of whether the eligible person refuses to sign the acknowledgment form, or if the acknowledgment form is not requested, the Plan's Subrogation and Reimbursement rights to benefits paid are not waived or limited in any way.
- b) Constructive Trust or Equitable Lien: The Plan's Subrogation and Reimbursement rights grant the Plan an equitable lien on the proceeds of any recovery obtained by the eligible person from a Third-Party, whether by settlement, judgment, or otherwise. When a recovery is obtained, the recovered proceeds are held in trust for the Plan. The Plan then imposes a constructive trust or equitable lien on the recovered proceeds in trust, which in no way prejudices or adversely impacts the Plan's Subrogation and Reimbursement rights. The Plan reserves the right to, among other things, pursue all available equitable actions and to offset any future benefits payable to the eligible person under the Plan.
- c) Plan Paid First: Amounts recovered or recoverable by or on the eligible person's behalf are paid to the Plan first, to the full extent of its Subrogation and Reimbursement rights, and the remaining balance, if any, to the eligible person. The Plan's Subrogation and Reimbursement right comes first even if the eligible person is not paid for all of their claims for damages. If the Plan's Subrogation and Reimbursement rights are not fully satisfied directly by a Third-Party, the Plan's right to reimbursement may be enforced to the full extent of any recovery that the eligible person may have received or may be entitled to receive from the Third-Party.
- d) Right to Take Action: The Plan's right of Subrogation and Reimbursement is an equitable one and applies to all categories of benefits paid by the Plan. The Plan and any Plan member can bring an action (including in the eligible person's name) for specific performance, injunction, or any other equitable action necessary to protect its rights in the cause of action, right of recovery, or recovery by an eligible person. The Plan will commence any action it deems appropriate against an eligible person, an attorney, or any Third-Party to protect its Subrogation and Reimbursement rights. These Subrogation and Reimbursement rights apply to claims of eligible dependents covered by the Plan regardless of whether such dependent is legally obligated for expenses of treatment.
- e) Applies to all Rights of Recovery or Causes of Action: The Plan's Subrogation and Reimbursement rights apply to any and all rights of recovery or causes of action the eligible person has or may have against any Third-Party.
- f) No Assignments: The eligible person cannot assign any rights or cause of action they may have against a Third-Party to recover medical expenses without the express written consent of the Plan.
- g) Full Cooperation: The eligible person will cooperate fully with the Plan and do nothing to prejudice or adversely affect the Plan's Subrogation and Reimbursement rights. Benefits will be denied if the eligible

person does not cooperate with the Plan. Repayment to the Plan is to be made within sixty (60) days of the receipt of the settlement or judgment payment from the Third-Party.

- h) Notification to the Plan: The eligible person must promptly advise the Plan Administrator, in writing, of any claim being made against any person or entity to pay the member for their injuries, sickness, or death. Further, the eligible person must periodically update the Plan regarding the claim and notify the Plan of a settlement prior to reaching a compromise of their claims.
- i) Third-Party: Third-Party includes, but is not limited to, all individuals, entities, federal, state or local governments, and insurers (including, but not limited to, liability, medical expense, wage loss, workers' compensation, premises liability, no-fault, uninsured or underinsured motorist insurers), who reimburse, compensate or pay for a member's loss, damage, injuries, or claims relating in any way to the injury, occurrence, conditions, or circumstances leading to the Plan's payment of benefits. This right of Subrogation and Reimbursement exists regardless of whether the policy of insurance is owned by the eligible person.
- j) Apportionment, Comparative Fault, Contributory Negligence, Make-Whole, and Common-Fund Doctrines Do Not Apply: The Plan's Subrogation and Reimbursement rights include all portions of the eligible person's claim regardless of any allocation or apportionment that purports to dispose of any portion of the claims not otherwise subject to subrogation, including, but not limited to, any apportionment for pain and suffering, wage loss, partial or total disability, or to a spouse for loss of consortium. The Plan's Subrogation and Reimbursement rights are not affected, reduced, or eliminated by comparative fault, contributory negligence, the make-whole and/or common-fund doctrines, or any other equitable defenses.
- k) Attorney's Fees: The Plan will not be responsible for any attorneys' fees or costs incurred by the eligible person in any legal proceeding or claim for recovery, unless prior to incurring such fees or costs, the Trustees agree in writing to pay all or some portion of attorneys' fees or costs.
- l) Course and Scope of Employment: If the Plan has paid benefits for any injury which arises out of and in the course and scope of employment, the Plan's right of Subrogation and Reimbursement will apply to all awards or settlements received by the eligible person regardless of how the award or settlement is characterized and regardless of whether the Plan has intervened in the action. If attorneys' fees are awarded to the eligible person's attorney from the Plan's recovery, the eligible person will reimburse the Plan for the attorneys' fees.

14.11 SETTLEMENT OF DISPUTE

No Covered Person, Covered Dependent or other beneficiary shall have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to eligibility, type, amount or duration of benefits under this Plan or any amendment or modification thereof shall be resolved by the Board of Trustees or their designated representative under and pursuant to this Plan Document. The decision of the dispute shall be final and binding upon all parties to the dispute. No action may be brought for benefits provided by this Plan or any amendment or modification thereof, or to enforce any right thereunder, until after the claim has been submitted to and determined by the Board of Trustees or their designated representative, and thereafter the only action which may be brought is one to challenge the decision of the Plan Sponsor. No such action may be brought unless brought within one year after the date of such determination.

14.12 BENEFITS EXEMPT FROM ATTACHMENT

To the full extent permitted by law, all right and benefits under this policy are exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Covered Person or any beneficiary.

14.13 REGULATORY REPORTING

The Plan Administrator shall be responsible for filing all reports and accounting which governmental regulatory bodies may require. It shall be the Board's duty and responsibility to provide the Plan Administrator with such information, upon request, as deemed necessary to prepare such required reports and accounting and to reasonably assist in the preparation of such reports and accounting to the extent requested by the Plan Administrator.

14.14 INDEMNIFICATION OF TRUSTEES

A person who accepts trusteeship duty, with respect to the Plan, shall be indemnified by the Trust against any and all liabilities arising by reason of any act or failure to act made in good faith pursuant to the provisions of the Plan, including expenses incurred in the defense of any claim relating thereto.

ARTICLE XV

CLAIM FILING PROCEDURE

15.01 This Plan has incorporated the BlueCross® BlueShield® of Arizona Exclusive Provider Organization (EPO) into the benefit program. All medical claims submitted are reviewed and repriced in accordance with the BlueCross® BlueShield® of Arizona negotiated fee schedule. All claims are sent to the AmeriBen by the network providers for claims processing.

To be eligible for processing, claims submitted must be original itemized statements and include the following:

- a] Patient name;
- b] Diagnosis;
- c] Date of service;
- d] Description of each service rendered, including procedure codes;
- e] Amount charged for each service; and
- f] The provider's signature, title/credentials, address and tax identification number.

Balance due statements, photocopies, cash register receipts, canceled checks or credit card receipts will not be acceptable as proof of charges incurred.

15.02 If the Covered Person must file a claim directly to AmeriBen, obtain and complete an AmeriBen claim form. Claim forms can be obtained directly from AmeriBen or at Human Resources.

15.03 The completed claim form should be attached to the itemized statement, and submitted to AmeriBen for processing. The claim form can be found on the Plan Administrator website, www.co.pinal.az.us/humanhumanresources/forms

15.04 Benefits will automatically be assigned to the provider of service unless the bills are clearly marked as paid.

15.05 Claims must be submitted to AmeriBen on a timely basis (as stated in Article XIV, Section 14.02) in order to be eligible for benefit consideration. AmeriBen will accept charges that are submitted within twelve (12) months of the date the charge was incurred.

15.06 AmeriBen's mailing address for Medical, Dental & Vision claims:

**AmeriBen
P.O. Box 7186
Boise, ID 83707**

15.07 For claim inquires:

**AmeriBen
1-877-955-1548
www.ameriben.com**

15.08 For eligibility information and benefit descriptions:

**AmeriBen
Fax # 208-947-3164
www.ameriben.com**

ARTICLE XVI

CLAIMS APPEAL PROCEDURE

16.01 In the event that a claim is denied in whole or in part, the Covered Person, or his or her duly authorized representative, may:

- a] Inspect and obtain copies of the documents and information in the claim file used to deny the claim. Such requests are to be made in writing to the Claims Administrator (or the Plan Consultant for Prescription Drugs). Any actual inspection will take place during regular business hours and at the location designated by the Claims Administrator (or the Plan Consultant for Prescription Drugs).
- b] File a written request for review of the denied claim by submitting such request to the Claims Administrator (or the Plan Consultant for Prescription Drugs) no later than sixty (60) days from the date of the initial written denial of the claim;
- c] Submit any additional documentation to the Claims Administrator (or Plan Consultant for Prescription Drugs) to support a request for review.

16.02 Upon receipt of the Covered Person's written request for review, the Claims Administrator (or the Plan Consultant for Prescription Drugs) will, within thirty (30) days of receipt:

- a] Review the claim denial and all submitted documentation to determine if the claim denial was appropriate; and
- b] Provide the Covered Person a written decision concerning the claim denial review including both the specific reasons for the claim determination, and specific reference to the provisions within the Plan that controlled the decision.

16.03 If, upon review, the claim is again denied, the Covered Person may appeal the denial to the Board of Trustees. The appeal must be made in writing and sent to the Claims Administrator (or Plan Consultant for Prescription Drugs) within sixty (60) days of the date of the written claim review decision. The Covered Person shall include with their appeal any additional information or documentation not previously submitted to the Claims Administrator (or Plan Consultant for Prescription Drugs). Upon receipt of the written request for appeal, the Claims Administrator will immediately notify the Plan Administrator for inclusion on the agenda of the next regularly scheduled meeting of the Board of Trustees. The Claims Administrator (or Plan Consultant for Prescription Drugs) will present the appeal at the meeting and the Board of Trustees will:

- a] Hear the appeal and render a decision in the matter; or
- b] Designate a hearing officer to review evidence, prepare a record and present a recommendation to the Board of Trustees for decision. The Hearing Officer is appointed and will hear the appeal within forty-five (45) days. The Hearing Officer may extend the time by agreement of the parties. Upon conclusion of the Hearing, the Hearing Officer shall issue written findings and recommendations to the Board of Trustees. Within thirty (30) calendar days of receipt of the Hearing Officer's recommendations, the Board of Trustees shall meet to render a final appeal decision. The Covered Person will be sent a written notice of the Board's final appeal decision within thirty (30) days following the Trust Board's meeting. The decision of the Board is final and binding on all parties to the dispute.

16.04 A BlueCross BlueShield of Arizona Contracted Provider has twelve (12) months from the date of the original payment to appeal a pricing issue with BlueCross BlueShield of Arizona. If the corrected pricing is received by the Claims Administrator within thirty (30) days of the provider's appeal, a claims adjustment will be allowed.

16.05 Any requests for review or appeal that do not comply with the procedures set forth above, or are not brought within the time limits set forth above, will not be considered for review or appeal.

ARTICLE XVII

PRIVACY OF PROTECTED HEALTH INFORMATION

This summary establishes the circumstances under which the Plan may share your protected health information with the Plan Sponsor (your employer), and limits the uses and disclosures that the Plan Sponsor may make of your protected health information.

There are three circumstances under which the Plan may disclose your protected health information to the Plan Sponsor.

First, the Plan may inform the Plan Sponsor whether you are enrolled in the Plan.

Second, the Plan may disclose summary health information to the Plan Sponsor. The Plan Sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.

Third, the Plan may disclose your protected health information to the Plan Sponsor for Plan administrative purposes. This is because employees of the Plan Sponsor perform many of the administrative functions necessary for the management and operation of the Plan. The Plan Sponsor has certified to the Plan that the Plan's terms have been amended to incorporate the terms of this summary. The Plan Sponsor has agreed to abide by the terms of this summary. The Plan's privacy notice also permits the Plan to disclose your protected health information to the Plan Sponsor as described in this summary.

Here are the restrictions that apply to the Plan Sponsor's use and disclosure of your protected health information.

- The Plan Sponsor will only use or disclose your protected health information for Plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the Plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the Plan Sponsor discloses any of your protected health information to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.
- The Plan Sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the Plan Sponsor.
- The Plan Sponsor will promptly report to the Plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this summary.
- The Plan Sponsor will allow you or the Plan to inspect and copy any protected health information about you that is in the Plan Sponsor's custody and control. The HIPAA Regulations set forth the rules that you and the Plan must follow in this regard. There are some exceptions.
- The Plan Sponsor will amend, or allow the Plan to amend, any portion of your protected health information to the extent permitted or required under the HIPAA Regulations.
- With respect to some types of disclosures, the Plan Sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). You have a right to see the disclosure log. The Plan Sponsor does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations.
- The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the Plan and to the U.S. Department of Health and Human Services.

- The Plan Sponsor will, if feasible, return or destroy all of your protected health information in the Plan Sponsor's custody or control that the Plan Sponsor has received from the Plan or from any business associate when the Plan Sponsor no longer needs your protected health information to administer the Plan. If it is not feasible for the Plan Sponsor to return or destroy your protected health information, the Plan Sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The Trustees of the Plan may be given access to your protected health information for the purposes set forth in this document.

If any Trustee uses or discloses your protected health information in violation of the rules that are set out in this summary, the employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to you.

ARTICLE XVIII

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of **PINAL COUNTY EMPLOYEE BENEFIT TRUST** (the "Plan") to protect the privacy of your medical information. The Plan provides health and/or dental benefits to you as described in your summary plan description(s). The Plan receives and maintains your medical information in the course of providing these health benefits to you. The Plan hires business associates, such as AmeriBen, to help it provide these benefits to you. These business associates also receive and maintain your medical information in the course of assisting the Plan. The Plan is sponsored by Pinal County (the "Plan Sponsor").

THE EFFECTIVE DATE OF THIS NOTICE IS APRIL 14, 2003. The Plan is required to follow the terms of this notice until it is replaced. The Plan reserves the right to change the terms of this notice at any time. If the Plan makes changes to this notice, the Plan will revise it and send a new notice to all subscribers covered by the Plan at that time. The Plan reserves the right to make the new changes apply to all your medical information maintained by the Plan before and after the effective date of the new notice.

Purposes for which the Plan May Use or Disclose Your Medical Information Without Your Consent or Authorization

The Plan may use and disclose your medical information for the following purposes:

- Health Care Providers' Treatment Purposes. For example, the Plan may disclose your medical information to your doctor, at the doctor's request, for your treatment by him/her.
- Payment. For example, the Plan may use or disclose your medical information to pay claims for covered health care services or to provide eligibility information to your doctor when you receive treatment.
- Health Care Operations. For example, the Plan may use or disclose your medical information (i) to conduct quality assessment and improvement activities, (ii) for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of a contract of health insurance, (iii) to authorize business associates to perform data aggregation services, (iv) to engage in care coordination or case management, and (v) to manage, plan or develop the Plan's business.
- Health Services. The Plan may use your medical information to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan may disclose your medical information to its business associates to assist the Plan in these activities.
- As required by law. For example, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records. The Plan may also disclose your medical information as authorized by and to the extent necessary to comply with workers' compensation or other similar laws.
- To Business Associates. The Plan may disclose your medical information to business associates the Plan hires to assist the Plan. Each business associate of the Plan must agree in writing to ensure the continuing confidentiality and security of your medical information.
- To Plan Sponsor. The Plan may disclose to the Plan Sponsor, in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. The Plan may also disclose to the Plan Sponsor that fact that you are enrolled in, or disenrolled from the Plan. The Plan may disclose your medical information to the Plan Sponsor for Plan administrative functions that the Plan Sponsor provides to the Plan if the Plan Sponsor agrees in writing to ensure the continuing confidentiality and security of your medical information. The Plan Sponsor must also agree not to use or disclose your medical information for employment-related activities or for any other benefit or benefit plans of the Plan Sponsor.

The Plan may also use and disclose your medical information as follows:

- To comply with legal proceedings, such as a court or administrative order or subpoena.
- To law enforcement officials for limited law enforcement purposes.
- To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give your agreement to the Plan to do this.
- To your personal representatives appointed by you or designated by applicable law.
- For research purposes in limited circumstances.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.
- To a governmental agency authorized to oversee the health care system or government programs.
- To federal officials for lawful intelligence, counterintelligence and other national security purposes.
- To public health authorities for public health purposes.
- To appropriate military authorities, if you are a member of the armed forces.

Uses and Disclosures with Your Permission

The Plan will not use or disclose your medical information for any other purposes unless you give the Plan your written authorization to do so. If you give the Plan written authorization to use or disclose your medical information for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your medical information the Plan maintains, unless the Plan has taken action in reliance on your authorization.

Your Rights

You may make a written request to the Plan to do one or more of the following concerning your medical information that the Plan maintains:

- To put additional restrictions on the Plan's use and disclosure of your medical information. The Plan does not have to agree to your request.
- To communicate with you in confidence about your medical information by a different means or at a different location than the Plan is currently doing. The Plan does not have to agree to your request unless such confidential communications are necessary to avoid endangering you and your request continues to allow the Plan to collect premiums and pay claims. Your request must specify the alternative means or location to communicate with you in confidence. Even though you requested that we communicate with you in confidence, the Plan may give subscribers cost information.
- To see and get copies of your medical information. In limited cases, the Plan does not have to agree to your request.
- To correct your medical information. In some cases, the Plan does not have to agree to your request.
- To receive a list of disclosures of your medical information that the Plan and its business associates made for certain purposes, other than treatment, payment or operations, for the last 6 years (but not for disclosures before April 14, 2003).
- To send you a paper copy of this notice if you received this notice by e-mail or on the internet.

If you want to exercise any of these rights described in this notice, please contact the Contact Office (below). The Plan will give you the necessary information and forms for you to complete and return to the Contact Office. In some cases, the Plan may charge you a nominal, cost-based fee to carry out your request.

Complaints

If you believe your privacy rights have been violated by the Plan, you have the right to complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with the Plan at our Contact Office (below). We will not retaliate against you if you choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

Contact Office

To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact us at the following Contact Office:

Contact Office: AmeriBen/IEC Group

Telephone: 1-877-955-1548

Address: 3449 East Copper Point Drive Meridian, Idaho 83642

Fax: 208-424-0595

ARTICLE XIX

Women's health and cancer rights act (WHCRA)

What is the Women's Health and Cancer Rights Act (WHCRA)?

The Women's Health and Cancer Rights Act (WHCRA), signed into law on October 21, 1998, includes important protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

WHCRA Enrollment Notice

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:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Protheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Human Resources Department at Pinal County or AmeriBen.

ARTICLE XX

MEDICARE PART D NOTICE



IMPORTANT NOTICE from Pinal County Employee Benefit Trust about Your Prescription Drug Coverage and Medicare

Pinal County Employee Benefit Trust (PCEBT) Beneficiary:

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 Pinal County Employee Benefit Trust (hereafter PCEBT) and about your options under Medicare's prescription drug coverage. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. PCEBT has determined that the prescription drug coverage offered by the PCEBT is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.**

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage (as long as you remain eligible) and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. In addition, beneficiaries who lose or decide to leave employer/union coverage, will be eligible to join a Part D plan at that time using a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered and at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan, your current PCEBT coverage will not be affected. However, the PCEBT plan will NOT coordinate prescription benefits so you will need to determine which Plan (i.e., PCEBT or Medicare) you will use each time you go to the pharmacy and fill a prescription.

If you do decide to enroll in a Medicare prescription drug plan and drop your PCEBT prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. It should also be noted that the PCEBT prescription benefit is linked to the medical plan so one cannot be dropped without dropping the other.

You should also know that if you drop or lose your coverage with PCEBT and don't enroll in Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage...

Contact the Pinal County Human Resources Department at 520.866.6594. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if the coverage through PCEBT changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember - Keep this notice!

If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	June 1, 2009
Name of Entity/Sender:	Pinal County Employee Benefit Trust
Contact--Position/Office:	Elizabeth Knobloch, Pinal County Human Resources
Address:	Administration Bldg. A 31 N. Pinal Street PO BOX 1590 Florence, Arizona 85232
Phone Number:	520.866.6594