



**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR
PINAL COUNTY EMPLOYEE BENEFIT TRUST**

**Amended and Restated Effective:
07/01/2013**

Non-Grandfathered Plan

It is your responsibility to read and understand the contents of this Summary Plan Document (SPD) before you receive services. In addition to providing benefit information and descriptions, this document includes notices of your rights and responsibilities under various United States laws including, without limitations, the Consolidated Omnibus Budget Reconciliation Act (COBRA); the Health Insurance Portability and Accountability Act (HIPAA); Women's Health and Cancer Rights Act; Newborns & Mothers Health Protection Act; Prescription Drug Coverage and Medicare; Patient Protection and Affordable Care Act (PPACA); Mental Health Parity; and Medicaid and the Children's Health Insurance Program (CHIP).

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SECTION I—INTRODUCTION

PINAL COUNTY EMPLOYEE BENEFIT TRUST

To All Covered Plan Participants

The "PINAL COUNTY EMPLOYEE BENEFIT TRUST" (PCEBT), hereinafter called the Plan, assures the Covered Plan Participants during the continuance of this Plan, that all benefits hereinafter described, shall be paid to them or on their behalf in the event the 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 in the State of Arizona on July 01, 2013.

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 and all physical, occupational and speech therapy /Rehabilitation Therapy.
- 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.

A. It Is Your Responsibility to Understand Your Coverage

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

A referral from an In-Network provider to any Out-of-network provider (i.e., laboratory, radiology, Physician, etc.) does NOT make the claim from the Out-of-network provider payable at the In-Network rate.

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

Review your explanation of benefits (EOB) forms, other claim-related information and available claims history. Notify the Claims Administrator of any discrepancies or inconsistencies between amounts shown and amounts you actually paid.

The Plan's Claims Administrator (AmeriBen) and your Human Resources Department are available to answer questions and assist you in exploring options for coverage, but ultimately, it is your responsibility to understand this Plan.

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!

B. For Help or Information

When you need information, please check this document first. If you need further help, call the people listed in the following Quick Reference Chart:

QUICK REFERENCE INFORMATION	
Information Needed	Whom to Contact
Group Number	PCE001 or 0110001
Plan Administrator/Plan Sponsor	Pinal County 31 North Pinal Florence, AZ 85132 (800) 208-6897
Claims Administrator <i>(Medical, Vision, STD & Flex)</i> <ul style="list-style-type: none"> • Claim Forms (Medical) • Medical Claims and Appeals • Eligibility for Coverage • Plan Benefit Information • HIPAA Certificate of Creditable Coverage • Medicare Part D Notice of Creditable Coverage • Health FSA/DCAP Claims Administrator 	AmeriBen/IEC Group P.O. Box 7186 Boise, ID 83707 (877) 955-1548 Fax: (208) 424-0595 www.MyAmeriBen.com Flex Fax: (800) 723-4703 Flex Email: flex@ameriben.com
Medical Review / Pre-certification <i>(Pre-certification and Second Opinions)</i> <ul style="list-style-type: none"> • Precertification, Concurrent Review and Case Management • Appeals of Precertification 	American Health Group (AHG) 2152 South Vineyard #103 Mesa, AZ 85210 (602) 265-3800 or (800) 847-7605
Dental Claims Administrator <ul style="list-style-type: none"> • Dental Plan Benefit Information • Dental Claims Forms 	Ameritas P.O. Box 82520 Lincoln, NB 68501 Administration/Eligibility Verification (800) 659-2223 Claims Department (877) 313-0033
Exclusive Provider Organization <i>(Names of Physicians & Hospitals in the Network)</i> <ul style="list-style-type: none"> • Network Provider Directory – see website <i>Blue Cros^s® Blue Shield[®] of Arizona, (BCBSAZ) an independent licensee of the Blue Cross Blue Shield Association, does not provide administrative or claims payment services.</i>	BlueCross® BlueShield® of Arizona P.O. Box 13466 Phoenix, AZ 85002 (800) 232-2345 www.azblue.com/CHSNetwork

QUICK REFERENCE INFORMATION

Information Needed	Whom to Contact
<p>Prescription Drug Program</p> <ul style="list-style-type: none"> • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information & Formulary • Preauthorization of Certain Drugs • Reimbursement for non-network retail pharmacy use • Specialty Pharmacy Program 	<p>Navitus Health Solutions, LLC 5 Innovation Court Appleton, WI 54914 (866) 333-2757 www.navitus.com</p> <p>Mail Order WellDyneRx P.O. Box 3129 Englewood, CO 80155 (866) 490-3326 Fax: (888) 830-3608</p>
<p>Employee Assistance Program</p> <ul style="list-style-type: none"> • EAP counseling and referral services 	<p>Jorgensen/Brooks Group (888) 520-5400</p>

SECTION II—SCHEDULE OF BENEFITS

IMPORTANT INFORMATION

The Plan Year will be a twelve (12)-month period beginning July 1 and ending June 30.

Deductibles and Visit-limited plan benefits, as well as the Plan's Co-Insurance Out-of-Pocket Maximum are calculated on a Plan Year basis.

A. Schedule of Medical Benefits

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and Treatment is Medically Necessary; that charges are Usual and Customary and/or Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

The Plan Administrator retains the right to audit claims to identify Treatment(s) that are, or were, not Medically Necessary; are, or were, Experimental; are, or were, Investigational; and are, or were, not Usual And Customary and/or Reasonable.

B. 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. When you need medical care select a provider from BlueCross® BlueShield® of Arizona by contacting BCBSAZ at (800)232-2345 or www.azblue.com/CHSNetwork. 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 Copayment and will submit your claim to BCBSAZ 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 your "patient responsibility."

A link to BlueCross® BlueShield® of Arizona is available on the Pinal County Website at www.pinalcountyaz.gov/departments/humanresources.

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

- **Medical Emergency**: If the need for medical care due to a Life Threatening Emergency occurs outside of the Plan's Arizona EPO network, services may be considered under the EPO Schedule of Benefits if it is determined by the Claims Administrator that immediate medical attention was required due to an Accident or Illness which is serious enough to constitute an "Emergency" as defined in this document.
- **No Choice of Provider**. If, while receiving Treatment at a Network facility, a Covered Person receives ancillary services or supplies from a Non-Network Provider in a situation in which they have no control over Provider selection (such as in the selection of an Emergency room Physician, an anesthesiologist, or a provider for diagnostic services), such Non-Network services or supplies will be covered at Network benefit levels. This provision will not apply in situations where the provider sends lab work to non-contracted facilities.

If a Plan Member lives in another state, benefits will be payable in accordance with the "Out-of-State" schedule of benefits shown in Section II.

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



An Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross[®] BlueShield[®] of Arizona

(800)232-2345

www.azblue.com/CHSNetwork

(BlueCross[®] BlueShield[®] of Arizona, an independent licensee of the Blue Cross and Blue Shield Association, provides network access only and does not provide administrative or claims payment and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross Blue Shield Plans outside of Arizona.)

C. Medical Review / Pre-Certification

1. Pre-certification is required on the following:
 - a. All Hospital and/or Facility admissions;
 - b. Diagnostic tests over one thousand five hundred dollars (\$1,500);
 - c. Durable Medical Equipment (DME) over seven hundred and fifty dollars (\$750)
 - d. Injectable medications over one thousand dollars (\$1,000) administered in a Physician's office or in conjunction with Home Health services;
 - e. Physical, occupational and speech therapy /Rehabilitation Therapy over one thousand five hundred dollars (\$1,500); and
 - f. Psychological/neuropsychological testing.
 - g. Surgical procedures over one thousand five hundred dollars (\$1,500);

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

D. Schedule of Medical Benefits

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

The benefits listed as **Network Providers** 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 living in another state. All Out-of-State benefits are subject to the Deductible(s) except in a Life Threatening Emergency.

	NETWORK PROVIDERS	OUT OF STATE BENEFITS
<p>Note: The maximums listed below are the total for network and non-network expenses. For example, if a maximum of sixty (60) days is listed under a service, the Plan Year maximum is sixty (60) days total which may be split between network and non-network providers.</p>		
<p>Deductible, per Plan Year The Deductible amount excludes Copayments. The network and non-network Deductible amounts do not cross apply.</p>		
Per Plan Participant	\$250	\$1,000
<p>Co-Insurance Maximum Out-of-Pocket Amount, per Plan Year The out-of-pocket amount excludes Copayments and Deductibles.</p>		
Per Plan Participant	\$2,500	
<p>The Plan will pay the designated percentage of Covered Charges until Out-of-Pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.</p> <p>Note: The following charges do not apply toward the out-of-pocket amount and are never paid at 100%:</p> <ul style="list-style-type: none"> • Amounts over Usual and Customary and/or Reasonable Charges; • Copayments; • Penalties for noncompliance with Pre-certification requirements; and • Deductible amounts. 		

COVERED SERVICES	NETWORK PROVIDERS	OUT OF STATE BENEFITS	SPECIAL COMMENTS
General Percentage Payment Rule	80% after Deductible	80% after Deductible	Generally, most covered charges are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments section provides additional information and limitations about the applicable covered charges, including the expenses that must be pre-certified and those expenses to which the out-of-pocket maximum does not apply.
Supplementary Accident Charge Benefit If more than one person is involved in an Accident, then only one Deductible must be satisfied for the Accident.			
HOSPITAL SERVICES			
Emergency Room	\$150 Copay (Copay waived if admitted to Hospital)		Emergency room Treatment is limited to medical emergencies having sudden and unexpected onset requiring immediate care to safeguard the life of the Plan Participant. The Emergency room Copayment is waived if the patient is admitted to the Hospital on an Emergency basis. Out-of-network Emergency rooms are covered at the In-network benefit level.
Intensive Care Unit	80% after Deductible	80% after Deductible	Pre-certification is required.
Outpatient Surgery Facility Charges	\$150 Copay per day	80% after Deductible	Pre-certification is required on surgical procedures over one thousand five hundred dollars (\$1,500)
Outpatient Facility Services	80% after Deductible	80% after Deductible	Covered charges include facility charges made for covered services and supplies provided by the Outpatient department of a Hospital or other facility.
Room and Board	80% after Deductible	80% after Deductible	Limited to the semi-private room rate. Pre-certification is required.
Skilled Nursing Facility / Rehabilitation Facility	80% after Deductible	80% after Deductible	Plan Year Maximum: Sixty (60) days per Plan Participant. (Combined In-Network and Out-of-State Maximum) Pre-certification is required.

COVERED SERVICES	NETWORK PROVIDERS	OUT OF STATE BENEFITS	SPECIAL COMMENTS
PHYSICIAN SERVICES			
Acupuncture Care	\$35 Copay	80% after Deductible	Out-of-network Acupuncture Care is covered at the In-network benefit level.
Allergy Serum, Injections and Testing			
Primary Care Physician	\$25 Copay per day of service	80% after Deductible	
Specialist	\$35 Copay per day of service	80% after Deductible	
Ambulance Service	100% Deductible waived	80% after Deductible	Out-of-network Ambulance services are covered at the In-network benefit level when due to an Emergency.
Anesthesiologist	100% after Deductible	80% after Deductible	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.
Chemotherapy, Radiation and Dialysis	80% after Deductible	80% after Deductible	
Chiropractic Treatment / Spinal Manipulations	\$35 Copay	80% after Deductible	Plan Year Maximum: \$1,000 per Plan Participant.
Diabetic Education	80% after Deductible	80% after Deductible	Plan Year Maximum: \$200 per Plan Participant.
Diagnostic Testing and X-Ray	\$35 Copay	80% after Deductible	Only one Copay will be required for all associated charges. Pre-certification is required on diagnostic tests over one thousand five hundred dollars (\$1,500)
Durable Medical Equipment	\$25 Copay per item per month	80% after Deductible	Pre-certification is required on Durable Medical Equipment over seven hundred and fifty dollars (\$750). (Combined In-Network and Out of State)

COVERED SERVICES	NETWORK PROVIDERS	OUT OF STATE BENEFITS	SPECIAL COMMENTS
PHYSICIAN SERVICES continued			
Hearing Aids	50% after Deductible	50% after Deductible	Hearing Aids from a Non-Network Provider will be payable at the Network level of benefits. Plan Year Maximum: \$1,500 per Plan Participant. (Combined In-Network and Out of State)
Hearing Examinations	80% after Deductible	80% after Deductible	This benefit does not apply to the routine hearing screening for newborns which is mandated under PPACA and covered under the Preventive Care Section.
Home Health Care	100% after Deductible	80% after Deductible	Plan Year Maximum: One hundred (100) Visits per Plan Participant.
Home Infusion	100% after Deductible	80% after Deductible	Home Infusion does not contribute to the Home Health Care maximum.
Hospice Care	\$25 Copay	80% after Deductible	Lifetime maximum: One hundred (100) days per Plan Participant. (Combined In-Network and Out of State)
Inpatient Physician Visits			
Primary Care Physician	\$25 Copay	80% after Deductible	
Specialist	\$35 Copay	80% after Deductible	
Maternity			
Initial Office Visit	\$25 Copay	80% after Deductible	Copayment on first office Visit only. Benefit Maximum: One (1) routine maternity ultrasound per Pregnancy.
All Other Services	80% after Deductible	80% after Deductible	Additional ultrasounds are allowed if Medically Necessary. Dependent child pregnancy is not covered.
Occupational Therapy			
Inpatient	80% after Deductible	80% after Deductible	Pre-certification is required.
Outpatient	80% after Deductible	80% after Deductible	Pre-certification is required on Outpatient Rehabilitation Therapy over one thousand five hundred dollars (\$1,500).

COVERED SERVICES	NETWORK PROVIDERS	OUT OF STATE BENEFITS	SPECIAL COMMENTS
PHYSICIAN SERVICES continued			
Office Visit			
Primary Care Physician	\$25 Copay	80% after Deductible	Includes X-Ray and Lab performed in the office.
Specialist	\$35 Copay	80% after Deductible	
Orthotics	80% after Deductible	80% after Deductible	Foot Orthotics Benefit Maximums: Ages 19 and Older - Once in each twelve (12) month period. Under Age 19 - Once in each six (6) month period if necessitated by growth.
Outpatient Lab	\$25 Copay	80% after Deductible	Only one Copay will be required for all associated charges
Outpatient Surgery Physician	100% Deductible waived	80% after Deductible	Pre-certification is required on surgical procedures over one thousand five hundred dollars (\$1,500)
Physical Therapy			
Inpatient	\$35 Copay	80% after Deductible	Plan Year Maximum: Sixty (60) Day and \$1,000 per Day Limit per Plan Participant. (Combined In-Network and Out of State) Pre-certification is required.
Outpatient	\$35 Copay	80% after Deductible	Plan Year Maximum: Three (3) Month Treatment Plan and \$1,500 Maximum Benefit per Condition per Plan Participant. Pre-certification is required on Physical/Rehabilitation Therapy over one thousand five hundred dollars (\$1,500).
Prosthetics	80% after Deductible	80% after Deductible	
Routine Newborn Care	80% after Deductible	80% after Deductible	Services include Routine Newborn Nursery care while the newborn is Hospital-confined after birth and includes room, board and other care for which a Hospital makes a charge. Charges for covered Routine Newborn Nursery care will be applied toward the Plan of the covered mother,

COVERED SERVICES	NETWORK PROVIDERS	OUT OF STATE BENEFITS	SPECIAL COMMENTS
PHYSICIAN SERVICES continued			
Speech Therapy			
Inpatient	80% after Deductible	80% after Deductible	Plan Year Maximum: Sixty (60) Day and \$1,000 per Day Limit per Plan Participant. (Combined In-Network and Out of State) Pre-certification is required.
Outpatient	80% after Deductible	80% after Deductible	Plan Year Maximum: Three (3) Month Treatment Plan and \$1,500 Maximum Benefit per Condition per Plan Participant. Pre-certification is required on Rehabilitation Therapy over one thousand five hundred dollars (\$1,500).
TMJ/ Jaw Joint	80% after Deductible	80% after Deductible	Plan Year Maximum: \$300 per Plan Participant.
Urgent Care Facility	\$50 Copay	80% after Deductible	Freestanding and Hospital Based Covered Charges from a Non-Network Provider for a Life Threatening Emergency will be payable at the Network level of benefits.
Wig After Chemotherapy	80% after Deductible	80% after Deductible	
MENTAL DISORDERS & SUBSTANCE ABUSE			
Inpatient Physician			
Primary Care Physician	\$25 Copay	80% after Deductible	Combined Mental Health and Substance Abuse Inpatient Benefit Maximums: Plan Year Maximum -Thirty (30) Days per Plan Participant. Lifetime Maximum - Sixty (60) Days per Plan Participant.
Specialist	\$35 Copay	80% after Deductible	
Inpatient Facility	80% after Deductible	80% after Deductible	(Combined In-Network and Out-of-State) Pre-certification is required.
Outpatient			
Primary Care Physician	\$25 Copay	80% after Deductible	Combined Mental Health and Substance Abuse Outpatient Plan Year Maximum: Thirty (30) Visits per Plan Participant.
Specialist	\$35 Copay	80% after Deductible	

COVERED SERVICES	NETWORK PROVIDERS	OUT OF STATE BENEFITS	SPECIAL COMMENTS
<p>PREVENTIVE CARE</p> <p>If service listed as A or B rated on U.S. Preventive Service Task Force, or preventive care for children under Bright Future guidelines, then the service is covered at 100% In-network, if the primary reason for the appointment is preventive care. For more information about preventive services please refer to the following website:</p> <p style="text-align: center;">http://www.healthcare.gov/what-are-my-preventive-care-benefits/</p>			
<p>Routine Wellness Care (Ages 21 and Over)</p>			
Primary Care Physician	\$25 Copay	80% after Deductible	Services include Routine Care not defined by PPACA.
Specialist	\$35 Copay	80% after Deductible	Plan Year Maximum: \$500 per Plan Participant.
Preventive Services	\$0 Copay	80% after Deductible	Services include, but not limited to: Preventive Well Baby and Child Care through Age 21, Well Woman Visits; Routine Immunizations in accordance with CDC Guidelines; Mammograms, Cervical Cancer Screenings and Colorectal Exams (fecal occult blood testing, sigmoidoscopy and colonoscopies from age 50 to 75).
Contraceptive Services	\$0 Copay	80% after Deductible	Services include FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, not including Drugs that induce abortion. Benefit Limitations: Services are available to all female Participants.
<p>TRANSPLANTS</p>			
Organ Transplants	Covered the same as any other Illness	Covered the same as any other Illness	Refer to Section IV. Covered Charges, (2.) (d.) for specific details regarding this benefit. Pre-certification is required.

E. Prescription Drug Benefit Schedule

The prescription Drug benefit program is separate from the medical benefits and is administered by the Prescription Drug Program vendor listed on the Quick Reference Chart in the front of this document. Refer to the Prescription Drug Section for details on the prescription Drug benefit.

MEDICATION	RETAIL 30	RETAIL 90	MAIL ORDER
Mandatory Generic (including Diabetic Supplies/Drugs)	\$10	\$20	\$20
Preferred Brand (when no Generic available)	\$25	\$50	\$50
Non-Preferred Brand or Brands with a Generic available	\$50 + Cost Difference Between Generic & Brand	\$100 + Cost Difference Between Generic & Brand	\$100 + Cost Difference Between Generic & Brand
Certain prescription medications mandated under the Affordable Care Act (including contraceptives) received by a network pharmacy are covered at 100% and the Deductible/Copayment (if applicable) is waived.			

NOTE: For a complete list of covered Drugs and supplies, and applicable limitations and exclusions, please refer to the Drug Coverage List, which is available by calling the Prescription Drug Program vendor phone number listed on the Quick Reference Chart in the front of this document.

U.S. Preventive Services Task Force

USPSTF A and B Recommendations

The following is a list of preventive services that have a [rating of A or B](#) from the U.S. Preventive Services Task Force that are relevant for implementing the Affordable Care Act. The preventive services are listed alphabetically. For a list of preventive services by date of release of the current recommendation, go to <http://www.uspreventiveservicestaskforce.org/uspstf/uspsrecsdate.htm>.

For more information about the Affordable Care Act and preventive services, go to <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>.

Topic	Description	Grade	Release Date of Current Recommendation
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	B	February 2005
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B	May 2013*
Anemia screening: pregnant women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.	B	May 2006
Aspirin to prevent cardiovascular disease: men	The USPSTF recommends the use of aspirin for men ages 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.	A	March 2009
Aspirin to prevent cardiovascular disease: women	The USPSTF recommends the use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.	A	March 2009
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A	July 2008
Blood pressure screening in adults	The USPSTF recommends screening for high blood pressure in adults age 18 years and older.	A	December 2007
BRCA screening, counseling about	The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in <i>BRCA1</i> or <i>BRCA2</i> genes be referred for genetic counseling and evaluation for BRCA testing.	B	September 2005
Breast cancer preventive medication	The USPSTF recommends that clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.	B	July 2002

Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	B	September 2002†
Breastfeeding counseling	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.	B	October 2008
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.	A	March 2012*
Chlamydial infection screening: nonpregnant women	The USPSTF recommends screening for chlamydial infection in all sexually active nonpregnant young women age 24 years and younger and for older nonpregnant women who are at increased risk.	A	June 2007
Chlamydial infection screening: pregnant women	The USPSTF recommends screening for chlamydial infection in all pregnant women age 24 years and younger and for older pregnant women who are at increased risk.	B	June 2007
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.	A	June 2008
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.	A	June 2008
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	A	October 2008
Dental caries prevention: preschool children	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than age 6 months whose primary water source is deficient in fluoride.	B	April 2004
Depression screening: adolescents	The USPSTF recommends screening adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy	B	March 2009

	(cognitive-behavioral or interpersonal), and follow-up.		
Depression screening: adults	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.	B	December 2009
Diabetes screening	The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	B	June 2008
Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Falls prevention in older adults: vitamin D	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Folic acid supplementation	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A	May 2009
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.	A	July 2011*
Gonorrhea screening: women	The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).	B	May 2005
Healthy diet counseling	The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.	B	January 2003
Hearing loss screening: newborns	The USPSTF recommends screening for hearing loss in all newborn infants.	B	July 2008
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.	A	September 2007
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A	June 2009
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.	B	June 2013
HIV screening: nonpregnant adolescents and	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased	A	April 2013*

adults	risk should also be screened.		
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A	April 2013*
Hypothyroidism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.	A	March 2008
Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.	B	January 2013
Iron supplementation in children	The USPSTF recommends routine iron supplementation for asymptomatic children ages 6 to 12 months who are at increased risk for iron deficiency anemia.	B	May 2006
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m ² or higher to intensive, multicomponent behavioral interventions.	B	June 2012*
Obesity screening and counseling: children	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.	B	January 2010
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	B	January 2012*
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.	A	March 2008
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B	February 2004
Sexually transmitted infections counseling	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) in all sexually active adolescents and for adults at increased risk for STIs.	B	October 2008
Skin cancer behavioral counseling	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.	B	May 2012
Tobacco use	The USPSTF recommends that clinicians ask all adults	A	April 2009

counseling and interventions: nonpregnant adults	about tobacco use and provide tobacco cessation interventions for those who use tobacco products.		
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.	A	April 2009
Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	B	August 2013
Syphilis screening: nonpregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.	A	July 2004
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A	May 2009
Visual acuity screening in children	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.	B	January 2011*

†The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act, utilizes the [2002 recommendation on breast cancer screening](#) of the U.S. Preventive Services Task Force. To see the USPSTF 2009 recommendation on breast cancer screening, go to <http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm>.

* Previous recommendation was an "A" or "B."

Current as of August 2013

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<http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>

SECTION III—ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A. Eligible Employee

All active full-time Employees scheduled to work 40 hours or more each week 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.

B. Unpaid Leave of Absence

If a Covered Employee is granted an approved unpaid 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 (required contribution is the full premium amount; there is no County contribution toward insurance during an approved unpaid leave of absence). 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 Section XVI for additional COBRA information).

C. 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 (Employees who fail to complete proper enrollment will receive "Employee Only" medical coverage and basic life insurance for the remainder of the Plan Year. They will not be eligible to change this coverage until the next open enrollment period.); and
- b. Any required contributions have been authorized.

D. 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 the last day of the month in which they turn twenty six (26) (assuming they meet all eligibility criteria). The following children will also be considered as eligible dependents:
 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; and
4. Married children under age 26, including legally adopted children. Dependents of married children are not eligible for coverage under this Plan.

For a dependent to be eligible for coverage under this Plan, reasonable proof that the dependent meets the eligibility requirements set forth in this document must be provided. Such proof will include marriage certificates, birth certificates, etc.

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.

Disabled 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 disability; and
- b. Became disabled prior to the attainment of age twenty six (26); 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 disability prior to approval and at reasonable intervals thereafter.

E. 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, proof of dependency provided, and any required contributions have been authorized.

F. Newborn Dependents

Newborn children will be covered from the time of birth *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.

G. 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).

H. 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 children under age nineteen (19) and certain family status changes if enrollment is made within thirty-one (31) days of the event.

I. 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 Section 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 children under age nineteen (19) or pregnancy.

For New Employees

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.

For Late Enrollees

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.

J. Creditable Coverage

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.

"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.

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

K. 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.

L. 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 mid-year 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 under 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 to the Employee 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.

Please refer to Section III, K. Special Enrollments Due to Loss of Other Coverage for special enrollment rights due to loss of other coverage.

Four rules apply to making changes to the benefit selection during the year, otherwise the eligible employee and/or dependent will have to wait until open enrollment to make any change in coverage:

1. 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;
2. The Plan must be notified in writing within thirty one (31) days of the qualifying change in status.

3. For changes in status related to death of a spouse or dependent, the Plan must be notified in writing within sixty (60) days of the death.
4. 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.

Except for children under age 19, 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.

M. Continuation during Family and Medical Leave (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 over age 19 will be subject to the pre-existing limitation (Section III, I. Pre-Existing Conditions), 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.

Once FMLA leave expires, if the employee continues to remain off work in an authorized unpaid leave of absence, the employee will be responsible for payment of the full premium (no County contribution toward insurance will be made). If Employee or Dependent coverage is terminated for failure to make payments, coverage may not be reinstated until the next open enrollment period. Returning Employees and their Dependents over age 19 will be subject to the pre-existing limitation (Section III, I. Pre-Existing Conditions), 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.

N. Continuation of Coverage for Certain Public Safety Employees

Pursuant to Arizona Revised Statute § 38-961, eligible Public Safety Employees who are injured while on duty, to the extent that they cannot perform the functions of their position, may be eligible to continue their coverage under this Plan on the same conditions and with the same coverage as an actively-at-work employee. The Public Safety Employee must be receiving Workers' Compensation benefits and meet established injury standards as determined by the employer. Continuation of coverage will be offered for a period of six (6) months.

O. Uniformed Services Employment and Reemployment Rights Act (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 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.

P. Termination of Coverage

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 Section XVI.

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;
- 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;
- h. The date the Employee (or any person seeking coverage on behalf of the Employee) performs an act, practice, or omission that constitutes fraud; or
- i. The date the Employee (or any person seeking coverage on behalf of the Employee) makes an intentional misrepresentation of a material fact.

Q. Dependents Termination of Coverage

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;
- e. The date the dependent becomes eligible for coverage as an Employee with this Plan;
- f. The date the Dependent (or any person seeking coverage on behalf of the Dependent) performs an act, practice, or omission that constitutes fraud; or
- g. The date the Dependent (or any person seeking coverage on behalf of the Dependent) makes an intentional misrepresentation of a material fact.

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.

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

SECTION IV—MEDICAL BENEFITS

If, as a result of a covered Injury or Illness, a Covered Person incurs charges for services and supplies described in this Section, the Plan will pay benefits subject to 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; 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; or g) if (f) does not apply, a usual and customary amount for the service that is rendered or the item that is purchased as determined by the Plan or its designee.

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 or which exceed Usual, Customary and Reasonable will not be eligible under this Plan. Unless otherwise stated, all benefits are calculated on a per Covered Person per Plan 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 Copay provisions, and shall not exceed the maximums specified.

A. Copayment / Copay

The Copayment 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. Copayment amounts are not applied to the Deductible or to the Co-insurance out-of-pocket maximums.

B. Co-insurance

Co-insurance is the percentage of a claim that represents the amount the Covered Person is financially responsible for after the Deductible has been satisfied.

C. Co-insurance Out-of-Pocket Maximum

The Co-insurance out-of-pocket maximum is the total dollar amount shown in the Schedule of Benefits that is accumulated per person per Plan Year in of Eligible Expenses and paid at the Co-insurance percentage (i.e., 80%). After the out-of-pocket maximum has been reached, the Plan will pay Eligible Expenses for the remainder of the Plan Year at one hundred percent (100%). Expenses for Copayments and penalties for noncompliance with Pre-certification requirements do not accumulate toward the Co-insurance out-of-pocket maximum.

D. Individual Deductible

The individual Deductible represents the dollar amount shown in the Schedule of Benefits which must be accumulated in Eligible Expenses by a Covered Person during each Plan Year, before benefits are payable under this Plan. The Deductible is applied in the order of the Plan's receipt of Eligible Expenses.

Carryover Deductible Provision

Eligible Expenses Incurred during the last three (3) months of the Plan Year which are actually applied toward satisfaction of the Deductible may be "carried over" towards satisfying the subsequent Plan Year's Deductible.

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 Plan Year.

E. Covered Charges

Covered Charges are the Usual and Customary and/or Reasonable Charges that are Incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is Incurred on the date that the service or supply is performed or furnished. A charge for prescription medication is Incurred on the date it is ordered by the Participant or Physician.

1. HOSPITAL / FACILITIES

a. 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 Copay as indicated in the Schedule of Benefits unless the patient is admitted to the Hospital.

b. 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 Copay 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.

c. 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.

d. Licensed Birthing Center

Charges by a Hospital based or freestanding licensed Birthing Center.

e. 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 Plan Year.

f. Surgical Facility

Charges by a Hospital based or freestanding ambulatory/surgical facility.

g. Urgent Care Facility

Charges Incurred at an Urgent Care Facility for appropriate medical charges necessitated by an acute medical condition.

2. SURGERY / ANESTHESIA

a. 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.

b. 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.

c. 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.

d. 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 and Stem Cell (stem cell transplants for breast cancer are considered Experimental/Investigational by this Plan). These transplants will only be covered if:

- i. The Covered Person is a likely candidate for a successful outcome of the procedure; and
- ii. 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

- iii. The procedure is performed at an In-Network BCBSAZ 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 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* Eligible Expenses under this Plan.

e. Reconstructive Surgery

Charges for reconstructive Surgery provided:

- i. Reconstructive Surgery is required as the direct result of an accidental Injury, an infection or disease of the involved part.
- ii. Reconstructive Surgery is necessary for the correction of congenital abnormalities which result in a functional defect.
- iii. Reconstructive Surgery is necessary post mastectomy. Eligible charges will include reconstruction of the breast on which the mastectomy was performed, Surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and Treatment of any physical complications at all stages of mastectomy, including lymphedemas.

f. 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.

g. Surgery

Charges by a Physician for Surgery performed at a Hospital, a licensed Surgical Venter 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 or to the Usual, Customary and Reasonable amount 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 or the full Usual, Customary and Reasonable amount of the primary procedure, and at fifty percent (50%) of the negotiated rate agreed upon between BCBSAZ and the Network Provider or the Usual, Customary and Reasonable amount of each of the lesser procedure(s) that are through their own separate incision(s).

3. MEDICAL / PHYSICIAN SERVICES

a. Acupuncture

Charges Incurred for acupuncture administered by an M.D., D.O., D.C. or a Licensed Acupuncturist.

b. 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.

c. 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.).

d. Colonoscopy

In addition to the benefits provided for preventative colonoscopies as defined in 5.3, this Plan covers Medically Necessary colonoscopies subject to the Copay stated in the Schedule of Benefits.

e. Dialysis

Charges for dialysis are considered Eligible Expenses.

f. Hearing Examinations and Hearing Aids

Charges for hearing examinations are payable at eighty percent (80%). Charges for hearing aids are payable at fifty percent (50%) up to a maximum of one thousand five hundred dollars (\$1,500) per Plan Year. Hearing Aids from a Non-Network Provider will be payable at the Network level of benefits. Refer to the Schedule of Medical Benefits for specific

g. 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 Plan Year. Charges for Custodial Care, Mental Health care, or substance abuse or Chemical Dependency Treatment would not be eligible under this provision.

h. Immunizations

Charges for immunizations are considered Eligible Expenses. Coverage for such immunizations will be provided based on the most current CDC Guidelines unless Medically Necessary.

i. Diabetic Counseling / Education

Charges for diabetic counseling or classes will be payable up to the Lifetime Maximum listed in the Schedule of Benefits.

j. 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.

k. Physical Therapy/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. If, at any time, Treatment becomes of a maintenance or custodial nature, benefits will cease.

Outpatient Rehabilitation Treatment is limited to a three (3) month Treatment plan per condition. Inpatient Rehabilitation is limited to a maximum of sixty (60) days per condition. If the condition mandates Outpatient or Inpatient Treatment of a longer duration or cost, 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.

l. 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.

m. Preventative Services

In accordance with the Patient Protection and Affordable Care Act (PPACA), a number of preventative services will be provided with no Copay or Co-insurance. Such preventative services include, but are not limited to:

- i. Well Baby and Well Child Care to age 21;
- ii. Well Woman Visits;
- iii. Immunizations in accordance with CDC guidelines;
- iv. Mammography for women over age 40;
- v. Screening for cervical cancer once every 3 years;
- vi. Screening for colorectal cancer (i.e., fecal occult blood test, sigmoidoscopy and colonoscopy) for Covered Persons over age 50.

Note: Additional preventive care shall be provided as required by applicable law if provided by a Network Provider. A current listing of required preventive care can be accessed at <http://www.healthcare.gov/law/about/provisions/services/lists.html>.

n. 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.

o. TMJ

Charges Incurred for the Treatment of Temporomandibular Joint Dysfunction or Syndrome (TMJ) including splints and appliances.

p. Urgent Care

Services rendered at an Urgent Care Facility when immediate medical attention is necessary.

q. Wellness

Charges for routine wellness care not covered by PPACA such as routine physicals, and routine laboratory tests and x-rays. Benefits payable are subject to a maximum benefit of five hundred dollars (\$500) per Plan Year.

4. MATERNITY / FAMILY PLANNING

a. 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.

b. Contraception

Charges for contraceptive devices that require a prescription, insertion and removal of I.U.D.s, the cost for a diaphragm and its fitting, and medication (birth control pills, Depo-Provera shots, Norplant, etc.) for birth control purpose All contraceptives are covered under the Contraceptive Service portion of the Preventive Care Section of this Plan.

c. 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.

d. Newborns

Charges Incurred at a Hospital for "routine" newborn care (DRG 795), 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.

e. 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 and one (1) routine ultrasound during the course of pregnancy.

Note*Breastfeeding support, supplies, and counseling are also available without cost-sharing when services are received from an In-network provider.

Pregnancy is not covered for a dependent child. Screenings, comprehensive support and preventative care as required by the Preventative Care provision of the Affordable Care Act, are covered for a pregnant dependent child, to include the following:

- Alcohol misuse counseling
- Anemia screening
- Bacteriuria screening
- Breastfeeding support, supplies, and counseling
- Chlamydial infection screening
- Domestic and Interpersonal Violence
- Folic acid supplementation (available through the Prescription Drug Program)
- Gestational diabetes screening: In pregnant women between 24 and 28 weeks of gestation and at the first prenatal Visit for pregnant women identified to be at high risk for diabetes.
- Gonorrhea screening
- Hepatitis B screening
- Rh incompatibility screening: first pregnancy Visit
- Rh incompatibility screening: 24-28 weeks gestation
- Tobacco use counseling
- Syphilis screening

f. Sterilizations

Services for vasectomy or other voluntary sterilization procedures for male Participants. When a vasectomy is elected, only the Physician's charge for the Surgery in his/her office will be covered. Facility charges for vasectomies will not be eligible.

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

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

5. AMBULANCE

Charges by a licensed professional Ambulance service as follows:

- a. Ground ambulance to the nearest appropriate Hospital within twenty four (24) hours of an Accident or the sudden onset of severe symptoms of an Illness;
- b. Transfer by ground ambulance to the nearest Hospital with the necessary equipment, staff and facilities to treat the patient's condition, if Treatment cannot be performed at the initial Hospital;
- c. Ground ambulance service from the Hospital to the 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.

6. MEDICATIONS / EQUIPMENT / SUPPLIES

a. 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.

b. Bras

Charges for prosthesis bras (up to two per year) and the related post mastectomy prosthetic devices.

c. Contact Lenses

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

d. 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/prosthesis 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, will be covered 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.

e. 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. Pre-certification is required on charges in excess of \$750.

f. 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. Most prescriptions are purchased with the Rx card issued by the Plan. Covered Persons present their Rx card to the Pharmacist and pay the Copay amount indicated in the Prescription Drug Benefit Schedule.

Medications that can be purchased over-the-counter, including those that can be purchased at a lesser strength, are *not* eligible for coverage under this 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.

Injectables given in the Physician's office may be required to be dispensed through the prescription plan when it is in the best interest of the Plan to do so. In the event the Plan determines that an injectable must be dispensed through the prescription plan, the Physician and patient will be notified. If the Physician refuses to cooperate with the Plan in the procurement of the injectable through the prescription plan, the patient must decide whether to pay for the injectable out-of-pocket or select another Physician who will work with the Plan. In such cases, the patient will not be held financially responsible for the full cost of the injectable until such time as they have received proper notification and been given an appropriate timeframe in which to make a decision.

g. 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 Plan Year.

h. Supplies

Charges for the following Non-durable (disposable) supplies are eligible: a) sterile surgical supplies required following a covered Surgery; b) supplies required to operate/use Durable Medical Equipment or Corrective Appliances; c) supplies required for use by skilled home health or home infusion personnel, only for the duration of their services; d) anti-embolism garments (e.g., Jobst) up to three (3) per Plan Year; e) ostomy supplies; f) cervical collars; and g) orthopedic braces.

i. 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 an M.D. or D.P.M. and dispensed by a certified orthotics laboratory.

j. Oxygen

Charges for oxygen and for the equipment to use it. The equipment cost is covered under Durable Medical Equipment provision.

7. MENTAL HEALTH CARE / SUBSTANCE ABUSE

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. Inpatient Treatment is limited to 30 days each Plan Year and 60 days in a lifetime.

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 Psychiatric Nurse Practitioner (PSYNP), 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)

Outpatient Treatment is limited to 30 Visits in a Plan Year.

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

SECTION V—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.

1. **Administrative Examinations.** Examinations, vaccinations, inoculations or immunizations related to employment, premarital or pre-adoptive requirements, issuance of insurance, obtaining a license, judicial or administrative procedures, or medical research.
2. **Before or After Eligibility.** Charges for any Illness or Injury Incurred prior to a Covered Person's eligibility date or after the Covered Person's termination date as defined in Section III.
3. **Complications from a Non-Covered Service.** Expenses associated with complications of a non-covered condition, Illness, procedure or service (except for complications arising from an elective termination of pregnancy).
4. **Court Ordered Treatment.** Charges Incurred due to a court ordered Treatment or Hospitalization unless a clear medical necessity also exists.
5. **Excess Charges.** Charges in excess of (i.) the negotiated rate agreed upon between BCBSAZ and the Network Provider for services and supplies, (ii.) charges which exceed any Plan benefit limitation or maximum allowable benefit, whether the Plan is a primary or secondary payor, or (iii.) the Usual, Customary and Reasonable charge for services and supplies.
6. **Government Coverage.** 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. **Illegal Acts.** Treatment received, including the use of ambulance services as described in Section IV, E. (5), for an Illness or Injury sustained as a result of being engaged in an illegal occupation, or while incarcerated, or sustained during the commission of, or the attempted commission of a crime, an assault or a felony, whether or not there is a criminal charge or a conviction of a crime, if the offense is defined as a criminal act by the state in which the incident occurred, including Injuries received while operating a motor vehicle in an illegal manner, driving while under the influence of alcohol or illegal Drugs, negligent driving or driving at excessive speeds. Treatment of an Illness or Injury caused by participating in a civil insurrection or a riot.
8. **Immediate Family Member Giving Service,** 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.
9. **No Charge.** 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.
10. **Non-Medical Expenses.** Charges Incurred for preparing medical reports, itemized bills, or claim forms. Expenses for broken appointments, telephone calls, photocopying fees, mailing, shipping or handling expenses.
11. **Not Medically Necessary.** 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 Section IV, E.

12. **Not Specified as an Eligible Expense.** 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.
13. **Occupational or Workers' Compensation.** Charges for an Illness or Injury deemed to have arisen out of or in the course of doing any 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.
14. **Outside the United States.** 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.
15. **Refund or Rebate Charge.** Charges, or a portion of a charge, for services or supplies that are discounted or reimbursed by a refund or rebate.
16. **Unnecessary Examinations.** Examinations or tests not incidental to or necessary to diagnose an Injury or Illness except the coverage for the routine care specifically allowed in Section IV, E.
17. **Veterans Affairs (VA) Hospital / Facility Services.** 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.
18. **War.** 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).

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.

1. **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.
2. **Adoption** charges and/or charges Incurred by a surrogate mother.
3. **Assistant surgeon** when the need for an assistant is not documented.
4. **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.
5. **Autologous blood donations** are not covered unless the blood is actually used during a scheduled Surgery.
6. **Autopsies** (unless required by the Plan).
7. **Behavior modification type therapy**, hypnosis, biofeedback, or charges considered educational (i.e. stress management, weight reduction, etc.), except as noted in Article V, Section 5.33.
8. **Breast reconstruction** (except as covered under Section IV, E. e. Reconstructive Surgery) 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.
9. **Chelation therapy**, except when necessary for Treatment of heavy metal poisoning.

10. **Cochlear implants** or any similar implants to improve hearing.
11. **Cosmetic:** Charges Incurred for services, supplies or Surgery which are primarily for personal comfort or to improve or enhance personal appearance, including, but not limited to, collagen injections, Botox injections, sclerotherapy, liposuction, tattoos or tattoo removal.
12. **Cosmetic surgery**, plastic Surgery, or Reconstructive Surgery or any complications thereof, except as covered under Section IV, (E.)(2.)(e.) Reconstructive Surgery .
13. **Counseling.** Counseling charges Incurred for marriage, career, sexual, social adjustment, financial or religious counseling, except as noted in Section IV, E. 7. Mental Health Care / Substance Abuse.
14. **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.
15. **Dental care.** Dental procedures or dental Treatment of any kind, except as provided for under Section IV, (E.)(2.)(c.) Oral Surgery or under Section VIII, the optional Dental Benefits.
16. **Disposable (non-durable) supplies**, including but not limited to diapers, incontinence pads and bandages, except as covered under Section IV, (E.)(6.)(h.) Supplies.
17. **Modifications to Home.** Elevators, chairlifts or other modifications to home, stairs or vehicles.
18. **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.
19. **Experimental / Investigational:** Charges for services, procedures, equipment or supplies which are considered Experimental or Investigational as defined in Section XVII.
20. **Eye surgery.** (Kerato-refractive Surgery) to correct nearsightedness or farsightedness and/or astigmatism, including, but not limited to, Radial Keratotomy, keratomileusis Surgery, refractive keratoplasties and LASIK Surgery.
21. **Genetic testing/screening** as follows:
 - a. Rendered during pregnancy (or in anticipation of pregnancy), including tests and procedures performed for the purpose of detecting, evaluating or treating chromosomal abnormalities or genetically transmitted characteristics, except alphafetoprotein analysis;
 - b. Rendered only because of family history; and
 - c. This exclusion does not apply to genetic testing as provided by the Patient Protection and Affordable Care Act (PPACA).
22. **Hair Loss.** Services or supplies for the prevention or restoration of natural hair loss (i.e.: Rogaine, Minoxidil, Propecia, etc.), or charges for hair transplants, hair weaving, toupees or wigs.
23. **Health Maintenance Organization (HMO) providers** when services are rendered to a covered HMO plan member.
24. **Holistic services**, supplies or accommodations provided in connection with holistic or homeopathic Treatment or medicine.
25. **Infertility.** Charges related to the Treatment of infertility, infertility Drugs or ultrasounds associated with infertility medication therapy, collection of semen and/or ovum, artificial insemination, in-vitro fertilization, Gamete Intro Fallopian Transfer (GIFT), Zygote Intra Fallopian Transfer (ZIFT), embryonic transfer, sperm banking and/or storage, sperm donor costs, sperm washing or any other similar procedure (charges to diagnose the condition of infertility will be considered Eligible Expenses).

26. **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.
27. **Maintenance rehabilitation** therapy or therapy for coma stimulation Inpatient or Outpatient.
28. **Magnet Therapy.**
29. **Massage Therapy.**
30. **Maternity** related charges for dependent daughters, or any complications thereof, except as provided by the Patient Protection and Affordable Care Act (PPACA).
31. **Medical students**, interns or residents.
32. **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. Certain preventive over-the-counter medications are covered without cost-sharing only when prescribed by a health care provider. Non-smoking aids, Drugs for Cosmetic purposes, weight control Drugs or fertility agents. All eligible prescriptions are provided through the prescription Drug card.
33. **Music Therapy.**
34. **Myofunctional therapy** or the Treatment of tongue thrusts.
35. **Naturopathic treatment** or Treatment rendered by a Naturopath.
36. **Occupational therapy** and supplies, except during an Inpatient Hospital Confinement or as included in Section IV, (E.)(3.)(k.) Physical Therapy/Rehabilitation Services and Section IV, (E.)(3.)(n.) Speech Therapy.
37. **Organ or tissue transplants** (except as provided in Section IV, (E.)(2.)(c.) Organ Transplants), including insertion or maintenance of an artificial heart or organ and charges for artificial, Experimental or non-human body organs or tissue transplants.
38. **Orthognathic surgery**, except in cases where a significant dysfunction exists due to an extreme congenital or developmental anomaly.
39. **Orthotics**, except as covered under Section IV, (E.)(6.)(i.) Orthopedic Shoes / Orthotics.
40. **Standby Services.** 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.
41. **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.
42. **Personal service** items while confined in a Hospital or health care facility (i.e. guest meals, television, telephone, etc.).
43. **Private Duty Nursing Services.**
44. **Prosthesis replacement** unless necessitated by the growth of a child or the prosthesis has exceeded its maximum life expectancy.
45. **Reversal surgery** of any kind.
46. **Sexual dysfunction** or sexual inadequacy, including but not limited to sex therapy, sex change operations, penile prosthetic implants or similar devices.

47. **Sleep Disorders:** Charges related to the diagnosis and Treatment of sleep disorders, except in the case of sleep apnea.
48. **Smoking cessation** aids or devices.
49. **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.
50. **Surrogate Mothers.** Any and all costs for and relating to surrogate motherhood, or charges Incurred by a Covered Person acting as a surrogate mother.
51. **Temporomandibular Joint Syndrome (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 IV, (E.)(3.)(n.) TMJ.
52. **Transportation charges** except for ambulance provided in Section IV, (E.)(5.) Ambulance.
53. **Travel charges** (transportation, lodging, meals and related expenses) by a Covered Person, a Physician or any healthcare provider except as provided in Section IV, (E.)(3.)(g.) Home Health Care.
54. **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 Section II, (D.) Schedule of Medical Benefits. (for children under 17) or as covered under the optional Vision Benefits, Section IX.
55. **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 Section IV, (E.)(6.)(g.) Nutritional Food Supplements and Section IV, (E.)(3.)(m.) Preventative Services.
56. **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.
57. **Vocational or educational training** services, supplies or materials unless covered in the Preventative Services required by the Plan's non-grandfathered status under the Patient Protection and Affordable Care Act (PPACA)..
58. **Weight Control / Obesity.** Charges Incurred for weight control Drugs, supplies, supplements, substances, weight reduction programs (except as noted under Section IV, (E.)(6.)(g.) Nutritional Food Supplements) or Surgery, including any type or variation of bariatric Surgery.

Bariatric Surgery may be considered eligible if the Covered Person meets all of the following criteria and the procedure is performed by In-Network providers at an In-Network facility known to have an effective program for doing such a Surgery and a follow-up program:

- a. The Covered Person has been covered under this Plan for a minimum of 24 months immediately preceding the date of the procedure; and
- b. The Covered Person is at least eighteen (18) years of age, is physically mature, and is not older than sixty five (65) years of age; and
- c. Two separate Physicians confirm in writing that the Covered Person:
 1. Is, and has been for two (2) or more years prior to the procedure, morbidly obese; and
 2. Is an acceptable surgical interventional risk (i.e., s/he must otherwise be a good surgical candidate); and

3. Does not have a specifically correctable cause of obesity, such as a glandular or endocrine problem; and
- d. The Covered Person provides evidence of Physician documented compliance with a structured, medically guided weight reduction program for at least six (6) months prior to the proposed Surgery and the Covered Person has failed to maintain weight loss; and
- e. A licensed psychologist or psychiatrist, a dietitian, an exercise physiologist and a surgeon have all confirmed in writing that the Covered Person has met with them and the Covered Person is both physically and mentally prepared to undergo the proposed bariatric Surgery and a structured post-operative exercise, diet and related follow-up program; and
- f. The Covered Person provides written documentation from a licensed psychologist or psychiatrist confirming the absence of a significant psychopathology that may limit the Covered Person's understanding of the procedure, ability to comply with medical/surgical recommendations and post-Surgery lifestyle changes necessary for the procedure to be successful.

Benefits will not be provided for subsequent procedures to correct further Injury or Illness resulting from the Covered Person's non-compliance with prescribed medical Treatment follow-up post Surgery. Expenses which are Medically Necessary, in connection with services or supplies and surgical procedures performed in connection with morbid obesity will receive benefits as described in the Schedule of Medical Benefits.

The term "morbid obesity" for purposes of this exclusion and this Plan, means the Covered Person meets one or more of the following:

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

The benefits payable for bariatric Surgery, gastric bypass, or any other type of surgical weight loss procedure are limited to once during the life of the Covered Person.

SECTION VI—PRESCRIPTION DRUG COVERAGE

Prescription Drug Coverage is provided for all employees enrolled in the medical plan. The Plan contracts with Navitus Health Solutions for pharmacy benefit management. Covered Employees receive an identification card that contains prescription coverage information that must be presented to the pharmacy to process claims. To locate a participating retail pharmacy, access the Navitus website at www.navitus.com. Navitus' list of participating pharmacies includes most major chains and many independent pharmacies as well.

A. 30-Day Retail Option

To have a prescription filled, present the ID card and prescription at any participating pharmacy. The 30-day retail benefit program is available for medications that are needed on a short-term basis (such as antibiotics).

B. Retail 90 Option

Retail 90 is available for maintenance medications (those that are taken for long periods of time for conditions such as high blood pressure, asthma, etc.) at participating pharmacies.

C. Mail Order Option

In addition to obtaining prescriptions from a retail pharmacy, Navitus offers a convenient mail order service for maintenance medications through WellDyneRx. Prescriptions are mailed directly to an address specified by the member (home, office, etc.). In order to take advantage of the mail order option, members must:

- a. Register for mail order online at www.myWDRX.com or by completing a Mail Service Form available from Pinal County Human Resources or online at www.myWDRX.com;
- b. Submit a written 90-day prescription either via mail or fax (only prescribers may fax prescriptions to WellDyneRx);
- c. Pay by charge; and
- d. Order refills online at www.myWDRX.com or via phone at (866) 490-3326.

D. Copayments

Current Copayments for medications are listed in the Prescription Drug Benefit Schedule located in Section II (E.)

E. Generic

Members pay the lowest Copay for generic Drugs. Generic medications are FDA approved and are as safe and effective as their brand name equivalents. All generic Drugs are part of the Formulary.

F. Preferred Brand

For Preferred Brand name Drugs, members pay a higher Copay than 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.

G. Non-Preferred Brand

Members pay the highest Copay for any brand name Drug not listed on the Navitus Formulary OR for brand name Drugs that have a generic equivalent. Even if a Physician determines there is a medical reason to take a non-formulary medication, the member is still responsible to pay the higher Copay.

H. Tablet Splitting

The tablet splitting program, which is optional for Participants has identified medications which are taken once daily. The price for a low or high dose tablet is on average the same. Because of this “flat” pricing of dosage strengths, splitting a tablet of a higher strength to get the desired dose lowers the cost of the medication by up to 50%. In these cases the Copayment amount would be reduced by up to 50%.

I. Covered Prescription Drugs

1. All Drugs prescribed by a Physician that require a prescription either by federal or state law. This excludes any Drugs stated as not covered under this Plan.
2. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
3. **Contraceptives.** Contraceptives including; oral, implants, injectable, and non-injectable contraception. Preferred generic and brand name contraceptives are covered at 100% In-network and the Deductible, Copayment or Co-insurance is waived.
4. **Diabetic supplies.** Diabetic Supplies include both over-the-counter and legend products including insulin, insulin syringes and needles, injection devices, pen needles, alcohol swabs, blood monitors / kits, test strips (urine and glucose), lancets and lancet devices.
5. **Self-Injectable Drugs;** or a prescription directing administration by injection. May require prior authorization; refer to subsection (J.) below.
6. **Sexual Dysfunction.** Medications for sexual dysfunction; quantity limits apply.
7. **Smoking Cessation.** Prescription smoking cessation products limited to \$500 per Plan Year.
8. Generic Prescription Drugs Mandated Under the Affordable Care Act. Certain preventive medications (including contraceptives) received by a network pharmacy are covered at 100% and the Deductible/Copayment (if applicable) is waived. Please refer to the following website for information on the types of payable preventive medications
<http://www.healthcare.gov/law/about/provisions/services/lists.html>

J. Limits to This Benefit

This benefit applies only when a Plan Participant incurs a covered prescription Drug charge. The covered Drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a Physician.
2. Refills up to one year from the date of order by a Physician.

K. Clinical Prior Authorization

Prescriptions for certain medications or circumstances require clinical approval before they can be filled, even with a valid prescription. Prescriptions may be limited to quantity, frequency, dosage or may have age restrictions. The authorization process may be initiated by the member, the local pharmacy, or the Physician by calling Navitus at (866) 333-2757.

L. Specialty Pharmacy Program

Navitus SpecialtyRx is a specialty pharmacy program offered through a partnership with Walgreens which covers some limited expensive Drugs, such as specialty injectables, cancer Drugs, and certain respiratory therapies used to treat various chronic conditions. Navitus SpecialtyRx program also provides personalized support, education, a proactive refill process, free delivery, as well as information about health care needs related to the chronic disease.

To start using Navitus SpecialtyRx, call toll free at 1-800-218-1488 or visit www.navitus.com.

M. Non-Covered Drugs

Certain medications are not covered as part of the pharmacy plan. Alternatives may be discussed with the member's Physician.

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

1. **Administration.** Any charge for the administration of a covered prescription Drug.
2. **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
3. **Consumed on premises.** Any Drug or medicine that is consumed or administered at the place where it is dispensed.
4. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
5. **Drugs used for cosmetic purposes.** Charges for Drugs used for Cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.
6. **Experimental/Investigational.** Experimental/Investigational Drugs and medicines, even though a charge is made to the Plan Participant. A Drug or medicine labeled: "Caution - limited by federal law to Investigational use".
7. **FDA.** Any Drug not approved by the Food and Drug Administration.
8. **Growth Hormones.** Charges for Drugs to enhance physical growth or athletic performance or appearance.
9. **Immunization.** Immunization agents or biological sera.
10. **Infertility.** A charge for infertility medication.
11. **Inpatient medication.** A Drug or medicine that is to be taken by the Plan Participant, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of Drugs and medicines on its premises.
12. **Medical Exclusions.** A charge excluded under Medical Plan Exclusions.

13. **No Charge.** A charge for prescription Drugs which may be properly received without charge under local, state or federal programs.
14. **Non-Legend Drugs.** A charge for FDA-approved Drugs that are prescribed for non-FDA-approved uses.
15. **Refills.** Any refill that is requested more than one (1) year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

SECTION VII—MEDICAL REVIEW / PRE-CERTIFICATION PROGRAM

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. It is always up to you and the Physician you choose to determine what services you need and who will provide your care, regardless of what this Plan will pay for.

This program is designed as a cost containment measure to maximize the Plan benefits and reduce unnecessary Hospitalizations, surgical procedures, other diagnostic services, and physical therapy. 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.**

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.

Medical Review / Pre-certification Program Contact Information

American Health Group (AHG)
(602) 265-3800 or (800) 847-7605
2152 South Vineyard #103
Mesa, AZ 85210

A. Management of the Medical Review Program

The health care professionals at AHG focus their review on the necessity and appropriateness of Hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the Plan, AHG has been given discretionary authority by the Plan Administrator to determine if a course of care or Treatment is Medically Necessary with respect to the patient's condition and within the terms and provisions of this Plan.

B. Elements of the Medical Review Program

The Plan's Medical Review Program consists of:

1. Pre-certification (pre-service) review: Reviews of proposed health care services before the services are provided;
2. Concurrent (continued stay) review: Ongoing assessment of the health care as it is being provided, especially (but not limited to) Inpatient Confinement in a Hospital or covered health care facility;
3. Second and third opinions: Consultations and/or examinations designed to take a second, and, when required, a third look at the need for certain elective health care services;
4. Retrospective review: Review of health care services after they have been provided; and
5. Case Management: This is a voluntary program. Case management services are particularly helpful for members who have catastrophic or long-term medical conditions, complex, costly, and/or high-technology services, and/or when assistance is needed to guide the member through a maze of health care providers and processes. Nurse case managers work closely with the member, family and caregivers, health care providers, and Claims Administrators to facilitate and coordinate a quality, timely, and cost-effective medical Treatment plan. Case managers also explore alternative options as needed. Any Physician, health care provider or member may request case management services by calling the Medical Management Company. However, in

most cases, the Medical Management Company will actively search for those members who could benefit from services.

C. Restrictions and Limitations of the Medical Review Program

1. The fact that your Physician recommends Surgery, Hospitalization, Confinement in a Health Care Facility, or that your Physician or other Health Care Provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be considered Medically Necessary for determining coverage or payment under the Medical Plan.
2. The Medical Review Program is not intended to diagnose or treat medical conditions, determine eligibility for coverage, or guarantee payment of Plan benefits. AHG's certification that a service is Medically Necessary doesn't mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.
3. All Treatment decisions rest with you and your Physician (or other Health Care Provider). You should follow whatever course of Treatment you and your Physician (or other Health Care Provider) believe to be the most appropriate, even if:
 - AHG does not certify a proposed Surgery or other proposed medical Treatment as Medically Necessary; or
 - the Plan will not pay regular Plan benefits for a Hospitalization or Confinement in a Health Care Facility because AHG does not certify a proposed Confinement; the benefits payable by the Plan may, however, be affected by the determination of AHG.
4. With respect to the administration of this Plan, the Employer, the Plan Administrator, and AHG are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by AHG as Medically Necessary, or for the results if the patient chooses not to receive health care services that have not been certified by AHG as Medically Necessary.

D. Pre-certification Review

How Pre-certification Review Works

Pre-certification Review is a procedure, administered by AHG, to assure that the admission and length of stay in a Hospital or Health Care Facility, Surgery, and other health care services are Medically Necessary. AHG's medical staff use established medical standards to determine if recommended Hospitalizations, Confinements in Health Care Facilities, Surgery and/or other health care services meet or exceed accepted standards of care and meet any defined requirements designated by the plan (i.e., Experimental/Investigational definitions). See the section titled Restrictions and Limitations of the Utilization Management Program in this section

E. What Services Must Be Pre-certified

Pre-certification is required on the following:

- a. All Hospital and/or Facility admissions*;
- b. Cardiac and pulmonary Rehabilitation; and
- c. Diagnostic tests over one thousand five hundred dollars (\$1,500);

- d. Durable Medical Equipment (DME) over seven hundred and fifty dollars (\$750)
- e. Injectable/infusion medications over one thousand dollars (\$1,000) administered in a Physician's office or in conjunction with Home Health services;
- f. Physical, occupational and speech therapy Rehabilitation Therapy over one thousand five hundred dollars (\$1,500); and
- g. Psychological/neuropsychological testing.
- h. Surgical procedures over one thousand five hundred dollars (\$1,500);

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

F. How to Request Precertification

You or your Physician must call AHG at the telephone number shown in the Quick Reference Chart in the front of this document.

1. **Calls for Elective services should be made at least 7 business days before the expected date of service.**
2. The caller should be prepared to provide all of the following information: the Employer's name, Employee's name, patient's name, address, and phone number and social security number; Physician's name, and phone number or address; the name of any Hospital or Outpatient facility or any other Health Care Provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.
3. For surgical procedures and physical, occupational and speech therapy /Rehabilitation Therapy over \$1,500 and all Hospital admissions, the Covered Person or his/her Physician must contact AHG prior to the admission or in advance of the procedure or therapy. 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.
4. If additional information is needed, AHG will advise the caller. AHG will review the information provided, and will let you, your Physician and the Hospital or other Health Care Provider, and the Claims Administrator know whether or not the proposed health care services have been certified as Medically Necessary. AHG will usually respond to your treating Physician or other Health Care Provider by telephone within 3 working days after it receives the request and any required medical records and/or information, and its determination will then be confirmed in writing.

If your admission or service is determined not to be Medically Necessary, you and your Physician will be given recommendations for alternative Treatment. You may also pursue an appeal by following the provisions described in the Claim and Appeals Section of this document. The patient will be informed of any denial or non-certification in writing.

G. Concurrent (Continued Stay) Review

How concurrent (continued stay) review works:

1. When you are receiving medical services in a Hospital or other Inpatient health care facility, AHG will monitor your stay by contacting your Physician or other health care providers to assure

that continuation of medical services in the health care facility is Medically Necessary, and to help coordinate your medical care with benefits available under the Plan.

2. Concurrent review may include such services as coordinating home health care or Durable Medical Equipment with the health care facility case manager, assisting with discharge plans, determining the need for continued medical services; and/or, advising your Physician or other health care providers of various options and alternatives for your medical care available under this Plan.
3. If at any point your stay is found to NOT be Medically Necessary and that care could be safely and effectively delivered in another environment, such as through home health or in another type of health care facility, you and your Physician will be notified. This does not mean that you must leave the Hospital, but if you choose to stay, all expenses Incurred after the notification will be your responsibility. If it is determined that your Hospital stay was not Medically Necessary, no benefits will be paid on any related Hospital, medical or surgical expense. Refer to Section XIV, Claim and Appeals Procedures.

Emergency Hospitalization

If an Emergency requires Hospitalization, there may be no time to contact AHG before you are admitted. If this happens, AHG must be notified of the Hospital admission within 48 hours. Your Physician, a family member or others can contact AHG. This will enable AHG to assist with discharge plans, determining the need for continued medical services, and/or advising your Physician or other health care providers of the various recommendations, options and alternatives for your medical care.

Pregnancies

Pregnant women should notify AHG as soon as possible once they know they are pregnant. This helps to assure that the pregnant woman will receive adequate prenatal care, allow for planning for the upcoming delivery, and enable the Plan to provide adequate educational material regarding pregnancy. It also enables AHG to work with the treating Physician to monitor for high risk pregnancy factors and to assist pregnant women in completing the steps to assure that Plan benefits will be available for the newborn child.

H. Second and Third Opinions

How the Second and Third Opinion Process Works: If the proposed procedure/Surgery/Treatment cannot be certified as Medically Necessary, AHG can provide you with three names of Physicians from which to choose for your second opinion. The names are chosen from a list of Providers within the EPO network, if possible. AHG may coordinate the office Visit, if requested. Once the Physician is chosen by you, AHG must be notified of the name of that Physician so all pertinent medical information can be sent to the Second Opinion Physician.

If a second opinion is required, AHG will inform you that the examination must be by a Physician who is certified by the American Board of Medical Specialists in the field related to the proposed service, is independent of the Physician who proposed the service ; and will not be eligible to perform the service.

The second opinion Physician may review past medical records along with clinical findings from his or her own examination of the patient, and will report his or her findings to AHG. If the second opinion recommendation differs from the treating Physician's recommendation, you may be required to obtain a third opinion from another Physician who will be selected in the same manner as the second opinion Physician. The results of the third opinion will be reviewed by AHG, and the recommendation of the majority of the Physicians (the attending Physician, and the Second and third opinion Physicians) will prevail. If, as a result of the second and/or third opinion, it is determined that the procedure

recommended by the treating Physician is not Medically Necessary, **no benefits will be payable if you choose to undergo the procedure.**

I. Retrospective Review

All claims for medical services or supplies that have not been reviewed under the Plan's Precertification, Concurrent (Continued Stay) Review, or second and third opinion Programs may be subject to retrospective review, at the option of the Claims Administrator, to determine if they are Medically Necessary.

- If the Claims Administrator determines that the services or supplies were not Medically Necessary, **no benefits will be provided by the Plan for those services or supplies.**
- After your Claim has been processed, you may request a review of the Claim decision. For complete information on claim review, see the Claim and Appeals Section of this document.

J. Appeals and 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.

Please refer to the provisions of Section XIV, Claims and Appeal Procedures, of this Summary Plan Description for specific procedures and timelines.

SECTION VIII—OPTIONAL DENTAL BENEFITS

(Only available if elected during the enrollment period)

A. “Basic” Dental Plan Schedule

BASIC DENTAL PLAN SCHEDULE	
Maximum per Plan Participant per Plan Year	
Per Plan Participant	\$1,500
Covered Services	Maximum Benefit Amount
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

B. “Extended” Dental Plan Schedule

BASIC DENTAL PLAN SCHEDULE	
DENTAL CARE DEDUCTIBLE, PER PLAN YEAR	
Per Plan Participant	\$50
Per family	\$100
Maximum per Plan Participant per Plan Year	
Per Plan Participant	\$1,500
Covered Services	Dental Percentage Payable
Initial Annual Oral Exam (Not subject to Deductible)	100%
X-Rays, Cleaning, Scaling & Fluoride Treatment	100%
Additional Preventive Services	80% after Deductible
Restorations (Amalgam or Composite)	80% after Deductible
Endodontics (Root Canal Treatments)	80% after Deductible
Periodontics	80% after Deductible
Oral Surgery	80% after Deductible
Prosthodontics (Inlays, Crowns, Bridges, Dentures)	50% after Deductible

This is a benefit summary. For further detail regarding your dental benefits please refer to the Pinal County Employee Benefit Trust Ameritas Dental SPD.

C. 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 “Basic Dental Plan” and “Extended Dental Plan” Plan Year dental maximums stated in the Schedule of Dental 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 eligible Ameritas PPO contracted fee when an In-network dental provider is used or the Usual, Customary and Reasonable eligible charge at the percentage indicated in the Schedule of Dental Benefits when an Out-of-network provider is used. 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 for a written pre-Treatment estimate.

D. 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 Plan 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 Plan Year.

E. 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 the 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.

F. Covered Dental Services

1. Diagnostic and Preventive Services

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 (Periodontic cleanings can be substituted at the Usual, Customary and Reasonable rate payable for a routine cleaning).
- c. Topical fluoride Treatments, for children under age sixteen (16).
- d. Full mouth and bitewing x-rays.
- e. Sealants on permanent bicuspid 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, other than x-rays, is provided, 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 Plan Year.
- b. Bitewing x-rays limited to one (1) set per Plan 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 children under age sixteen (16) and one (1) application per Plan Year.
- e. Sealants are limited to permanent bicuspid and molars on children under age fourteen (14) and once per three (3) year period.

2. Restorative Services

The necessary procedures to restore teeth to normal contour and function.

- a. Fillings: amalgam, synthetic, porcelain, plastic or composite materials.
- b. Simple extractions.

3. Endodontic Services

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.

4. Periodontic Services

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 periodontal services are limited to once every three (3) years per quadrant.

- b. Non-surgical periodontal services are limited to once every two (2) years per quadrant.
- c. Crown lengthening.
- d. Periodontal prophylaxis are limited to once every six (6) months.

5. Oral Surgery

The necessary examinations and procedures for Treatment by extraction or other oral Surgery not covered under periodontic services.

- a. Provides the necessary procedures for complex extractions and other oral surgical procedures including removal of 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).

6. Prosthodontic Services

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.

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:

- a. Placement is due to the extraction of one or more natural, injured or diseased teeth; and
- b. Placement of bridge or denture includes replacement of extracted tooth.

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

- a. Prosthetic appliance to be replaced was placed more than five (5) years ago and cannot be made satisfactory; or
- b. Addition of teeth is needed to replace one (1) or more natural teeth extracted; or
- c. 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 partial dentures are only allowed when anterior teeth are missing.
- b. Temporary full dentures are not covered.
- c. Charges for replacement due to loss or theft of denture or fixed bridge is **not** covered.
- d. Implants are only payable up to the benefit that would be allowed for a comparable bridge or fixed partial denture.
- e. Replacement of an existing bridge or denture which can be made satisfactory is not covered.
- f. 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.

G. General Dental Limitations and Exclusions

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

- a. **Analgesia.** sedation or hypnosis for relief of anxiety or apprehension.
- b. **Anesthesia,** unless administered in conjunction with a covered oral Surgery (not covered for simple extractions).
- c. **Appliances** to increase vertical dimension or to restore or alter occlusion for Cosmetic or non-Cosmetic purposes.
- d. **Assignment** of dental benefits to a provider outside of the United States.
- e. **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.
- f. **Charges** in excess of the Usual, Customary and Reasonable charge.
- g. **Complications** resulting from a non-covered service.
- h. **Congenital** or developmental malformations.
- i. **Cosmetic** dental procedures performed for reasons including, but not limited to, bleaching, whitening, altering or extracting and replacing sound natural teeth to change appearance.
- j. **Dental procedures** covered under the medical expense provisions of this Plan.
- k. **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 when charges by an M.D. or D.O. would be eligible.
- l. **Duplicate** or spare prosthetic devices or appliances.
- m. **Extra oral grafts** (grafting of tissue from outside the mouth to oral tissues).
- n. **Fluoride** Treatments on persons age sixteen (16) or older.
- o. **Hospital** or a surgical facility charges Incurred for dental services.
- p. **Myofunctional** therapy.
- q. **Nightguards,** athletic mouthguards, splints, or harmful habit appliances.
- r. **Oral hygiene** instructions or supplies, dietary or plaque programs, or other educational programs.
- s. **Orthodontia** related charges.
- t. **Orthognathic** or **TMJ** Treatment or Surgery.

- u. **Precision attachments**, semi-precision attachments or stress-breakers.
- v. **Preparation of dental reports**, itemized bills or claim forms, or charges for broken appointments, telephone calls, photocopying fees, or mailing.
- w. **Prescription drugs**, unless available through the Prescription Program.
- x. **Replacement** of lost or stolen appliances (i.e.: denture, bridges etc.).
- y. **Sealants** on persons age fourteen (14) and older.
- z. **Services or supplies** not recognized or recommended by the American Dental Association.
- aa. **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.

SECTION IX—OPTIONAL VISION BENEFITS

(Only available if elected during the enrollment period)

A. Vision Schedule of Benefits

VISION SCHEDULE OF BENEFITS		
VISION CARE DEDUCTIBLE, PER PLAN YEAR		
Single Participation		\$50
Per Family Unit Participation*		\$150
Covered Service	Frequency Limit	Benefit Maximum
Examination	One (1) examination per Plan Year	Maximum Benefit Allowance: \$50 per Participant.
Lenses*	One (1) pair of lenses per Plan Year	Maximum Benefit Allowance: \$100 per Participant..
Frames*	One (1) set of frames per Plan Year	Maximum Benefit Allowance: \$50 per Participant.
Contacts*	One (1) set of lenses per Plan Year*	Maximum Benefit Allowance: \$125 per pair per Participant.
*Lenses and frames, or contacts (not both)		

B. 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 Plan 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.
- b. The purchase of appropriate lenses and frames once per Plan Year in accordance with the Schedule of Vision Benefits.
- c. The purchase of contact lenses in lieu of lenses and frames up to the amount noted in the Schedule of Vision Benefits.

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

C. Limitations on Vision Expenses

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

SECTION X—OPTIONAL FLEXIBLE SPENDING ACCOUNT

(Only available if elected during the enrollment period)

A. What is a Flexible Spending Account (FSA)

An optional benefit provided by Pinal County that allows an Employee to pay certain unreimbursed medical, dental and vision and/or dependent care expenses with pre-tax money. The Employee agrees to set aside a portion of their pre-tax salary in an account and that money is deducted from their paycheck over the course of the Plan Year (or remaining portion of the year for mid-year enrollments). The amount contributed is not subject to federal, Social Security (FICA), state or local taxes – effectively reducing the annual taxable salary. Savings are estimated at \$20 to \$40 on every \$100 deferred. The actual savings amount depends on the Employee's federal, state and local tax bracket.

B. Eligibility

All full-time Employees are eligible to participate in the FSA on their benefits effective date and annually thereafter. The FSA Plan is also subject to mid-year Qualifying Events as defined in Section III. Employees can participate in the FSA even if they do not participate in any other Pinal County sponsored benefit plans.

C. Contribution Limits

Pinal County has established the following contribution limits for 2013:

- a. For the Jan 1, 2013 – June 30, 2013 Plan Year the Health FSA Maximum is \$1,250
 - i. For subsequent Plan Years the Health FSA Maximum is \$2,500
- b. For the Jan 1, 2013 – June 30, 2013 Plan Year the Dependent Care FSA is the lesser of \$2,500 (\$1,250 if married filing separately); or the lesser of the Employee or spouse's yearly wages. The maximum is reduced by the spouse's contribution to a Dependent Care FSA.
 - i. For subsequent Plan Years the Dependent Care FSA is the lesser of \$5,000 (\$2,500 if married filing separately); or the lesser of the Employee or spouse's yearly wages. The maximum is reduced by the spouse's contribution to a Dependent Care FSA.

D. Changes in Elections

Once an Employee has enrolled in the FSA, they may not make any changes to the election unless they have a change in status as defined in Section III, (i.) Change in Status. The election may be increased or decreased but such increase or decrease must be consistent with the change in status (i.e., after marriage, the election can be increased but not decreased) and the election can never be reduced to less than the amount that has already been reimbursed or deposited, whichever is greater.

E. Reimbursement

Employees enrolled in the FSA Plan have the option of using a "Benny" Card (credit card) to pay for eligible services such as Copays, etc. or can instead pay for expenses and seek reimbursement using a claim form.

- a. Claim forms are available at the Pinal County Human Resources Department or from AmeriBen/IEC Group. Forms are also available on the Pinal County website at: <http://pinalcountyz.gov/Departments/Human Resources/Pages/HRForms.aspx>.
- b. Claim forms must be signed and include an itemized receipt which includes the date of service, provider name, provider's social security number or tax ID number and, for dependent care reimbursements, the name of the dependent receiving care.
- c. Claims are processed weekly.
- d. Claims for Healthcare FSA expenses that exceed the account balance but are not in excess of the annual election are eligible for reimbursement. Funds that are reimbursed will be recovered as payroll deductions.
- e. Claims for Dependent Care FSA expenses are reimbursed up to the balance in the account at the time a claim is submitted. If a claim exceeds the account balance, it will be tracked by the FSA Administrator (AmeriBen) and automatically reimbursed once the account balance meets or exceeds the claim amount.

F. Automatic Rollover Option

If the Employee is enrolled in a medical, dental or vision plan that is administered by AmeriBen, they can elect Automatic Rollover. This will allow claims with out-of-pocket expenses to be automatically reimbursed under the FSA. No claim form is required. Automatic Rollover is offered in lieu of the "Benny" Card and must be elected.

G. "Benny" Card

The "Benny" Card is a special benefits debit card that contains the value of the annual FSA election amount. The card can be used instead of cash to pay for qualified health care expenses.

H. Forfeiture of Funds

All pre-tax funds that are not used for Eligible Expenses Incurred during the Plan Year will be forfeited. This is mandated under the Internal Revenue Service (IRS) "use it or lose it" rule. To avoid forfeiture, plan contributions carefully.

I. Transfer of Funds

IRS regulations do not allow money to be transferred between reimbursement accounts. Employees may not transfer unused funds from Healthcare to Dependent Care or vice versa.

J. Healthcare Reimbursement

Funds can be set aside in the Healthcare Reimbursement FSA for unreimbursed medical, dental and/or vision expenses such as Copays, Deductibles, etc., for the Employee and his/her eligible dependents, regardless of whether or not they are covered under any Pinal County benefit plan.

Eligible healthcare expenses must be Incurred during the Plan Year and include, but are not limited to:

- a. Acupuncture;
- b. Dental Treatment;

- c. Coinsurance/Deductibles;
- d. Copayments;
- e. Contact Lenses and Solution;
- f. Optometrists;
- g. Laser Eye Surgery;
- h. Diagnostic Services;
- i. Eye Exams/Glasses;
- j. Prescribed Massage Therapy;
- k. Smoking Cessation Prescriptions/Products;
- l. Prescribed Medications.

Examples of ineligible expenses include, but are not limited to:

- a. Funeral Expenses;
- b. Household Help;
- c. Cosmetic Surgery/Procedures;
- d. Diaper Services;
- e. Maternity Clothes;
- f. Bottled Water;
- g. Vitamins and Supplements;
- h. Custodial Care;
- i. Toiletries, Toothpaste and Related Items;
- j. Marriage/Family Counseling;

For a more complete and up-to-date list of covered and ineligible expenses, please refer to <http://www.sharemethods.net/nepal/servlet/open?keepath=false&aid=27117>.

K. Dependent Care Reimbursement

Funds can be set aside in the Dependent Care FSA for dependent care expenses for a qualified dependent/child.

Eligible dependents must be under age thirteen (13) and claimed as an exemption on the Employee's tax return and can include stepchildren, grandchildren, adopted children or foster children. In a divorce situation, the Employee must have custody of the child in order for the child to be considered an eligible dependent. Eligible dependents may also include a disabled spouse, child or elderly parents who live with the Employee and are physically or mentally unable to care for themselves.

For dependent care expenses to be eligible for reimbursement, the Employee must be working during the time the eligible dependents are receiving care. If the Employee is married, the spouse must either be:

- a. Working at the time services are rendered;
- b. Full-time student for 5 months during the year; or
- c. Mentally or physically disabled and unable to provide care for him/herself.

Eligible dependent care expenses include, but are not limited to:

- a. Nursery School;
- b. Private Preschool;
- c. Day Camps;
- d. Au Pairs;
- e. Before/After School Care;
- f. Nannies;
- g. Sick Child Centers;
- h. Licensed Day Care Centers;
- i. Day-Care for Elderly or Disabled Dependent.

Examples of ineligible expenses include, but are not limited to:

- a. Registration Fees;
- b. Overnight Camps;
- c. Leave of Absence or Vacation Fees;
- d. Tuition Expenses;
- e. Babysitting for Social Events;
- f. Food Expenses (if separate from dependent care expense);
- g. Care Provided by Children Under 19 (or by anyone the Employee claims as a dependent);
- h. Days the Employee or Spouse Don't Work (even if the provider still requires payment).

SECTION XI—EMPLOYEE ASSISTANCE PROGRAM (EAP)

A. What Is An Employee Assistance Program?

An EAP is a confidential, professional counseling, referral and educational service for Employees who face problems they cannot solve. Concerns can sometimes become overwhelming and affect personal happiness, family relations, work performance and health. When this occurs, professional help may be needed in resolving the problem.

The current EAP provider for Pinal County is Jorgensen Brooks Group, who maintains offices throughout Arizona.

B. Eligibility

Employees, spouses and dependents may use the services of the EAP.

C. Services Provided

The EAP provides a full range of counseling and referral services for individual, family and marital concerns; stress and job related matters; child and domestic abuse; and chemical and alcohol dependency assessment. Other services include:

- a. 24-hour crisis intervention;
- b. Assessment and short-term therapy for personal problems;
- c. Referral to professionals and Treatment resources throughout Arizona for ongoing specialized therapy;
- d. Information and referral to community resources for social service issues (legal concerns, child and elder care, budgeting, self-help groups, etc.).

D. Confidentiality

EAP services are provided with the strictest confidentiality possible, as set forth in State and Federal statutes. No one will have knowledge of EAP appointments, discussions, etc., including Pinal County, co-workers, family members, etc. If sufficient need is shown, the counselor may recommend or encourage other family members to participate, but only with the member's approval. Release of information by the EAP concerning an individual can only be given with written consent, except where required by law (i.e., suspected child abuse or posing a danger to oneself or others).

E. Visits

Eligible members are entitled to six (6) Visits per year, per problem/condition.

F. Cost

There is no cost to the member for EAP services. This is a benefit provided and paid for by Pinal County.

SECTION XII—LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT

The Employee Life Insurance Plan provides benefits for your designated beneficiaries in the event of your death. You can be secure in the knowledge that your family will be taken care of should you die unexpectedly.

Certain states are community property jurisdiction. They are Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin. This means that the Pinal County group Life and AD&D policies issued to a married employee should have the spouse designated as the beneficiary, unless the spouse consents in writing to another designee. If no consent is obtained, then by law, the spouse legally becomes the beneficiary upon death, even if someone else is named as the beneficiary. This is not to be construed as legal advice. You should consult your own trust and/or legal advisor for further information.

A. Basic Term Life Insurance/Accidental Death & Dismemberment (AD&D)

Employees are automatically covered for \$10,000 of Basic Life through Mutual of Omaha at no cost. The Basic Life includes an additional \$10,000 of Accidental Death & Dismemberment (AD&D) coverage.

B. Employee Supplemental Term Life Insurance

Supplemental life insurance coverage is available for Employee's who would like additional life insurance beyond the \$10,000 provided by Pinal County. The cost is based on the Employee's age as of the first day of the Plan Year and the amount of coverage elected. The maximum amount of supplemental coverage that can be elected is five (5) times the Employee's annual base salary, or \$350,000, whichever is less. Coverage may be elected in multiples of \$5,000.

The first \$150,000 of additional coverage is available for thirty (30) days from the date of original insurance eligibility without providing "Evidence of Insurability." Amounts in excess of \$150,000 are subject to approval of the Employee's medical history by the insurance carrier. In addition, after thirty (30) days, all amounts are subject to "Evidence of Insurability."

In the event of the Employee's death, benefits are paid to the designated beneficiary.

C. Dependent Supplemental Term Life Insurance

Supplemental life insurance coverage is also available for dependents when supplemental coverage has been purchased for the Employee. Dependent Supplemental Term Life is a flat after tax premium no matter how many eligible family members are covered. The legal spouse is entitled to \$5,000 in additional coverage and eligible dependents up to nineteen (19) years of age are entitled to an additional \$1,000 of coverage. In the event of a claim, the Employee is the beneficiary.

Dependent Supplemental Life Insurance may not be purchased with the County Benefit Allowance or pre-tax payroll deductions. Federal tax laws require that Employees pay for this coverage with "after" tax payroll deductions.

In the event of death of the Employee or Covered Dependent, please contact Pinal County Human Resources immediately.

SECTION XIII—OPTIONAL SHORT TERM DISABILITY BENEFIT

(Only available if elected during the enrollment period)

A. Schedule of Short Term Disability Benefits

Schedule of Short Term Disability Benefits							
Benefit Eligibility Period	1st day of disability following the end of the 30 day waiting period through the 180th day of disability						
Waiting Period	Thirty (30) calendar days of Total Disability						
Benefit Payable	60% of Weekly Earnings						
Minimum Payable	\$15 per week						
Benefit Offsets	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"></td> <td>State of Arizona Disability</td> </tr> <tr> <td></td> <td>No Fault Auto Insurance</td> </tr> <tr> <td></td> <td>Social Security Disability</td> </tr> </table>		State of Arizona Disability		No Fault Auto Insurance		Social Security Disability
	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.

B. 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 thirty (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.

C. 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 Utilization Review firm 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.
- 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.

D. 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. 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 Short Term Disability Benefits.
- b. Disability benefits will begin after the thirty (30) day waiting period has been met and/or after all sick leave, 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.

E. 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 Short Term Disability 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 submit 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.

F. 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.

G. Short Term Disability Limitations and Exclusions

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

- 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.

SECTION XIV—CLAIM AND APPEALS PROCEDURE

A. Claims Review and Appeal Procedures

This section contains the claims and appeals procedures and requirements for the Pinal County Employee Benefit Trust. All claims must be received by the Plan within twelve (12) months from the date of incurring the expense. The Plan's representatives will follow administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing Plan Documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants.

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination".

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." An "appeal" is defined as review by the Plan of an Adverse Benefit Determination, as required under the Plan's internal claims and appeals procedures. If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant may have the right to request an independent external review. The External Review procedures are described below.

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

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within one year after the final determination of an Appeal. All lawsuits against public entities must also comply with the notice of claims requirement set forth in A.R.S. § 12-821.01.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Claims Administrator must decide whether to approve or deny the Claim. The Claims Administrator's notification to the claimant of its decision must be made as shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Claims Administrator, the claimant may be Notified that the period for providing the notification will need to be extended. If the period is extended because the Claims Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Claims Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the

timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days. If you have any questions regarding this procedure, please contact the Plan Administrator.

In addition to terms defined in the Plan Document, this section uses the following defined terms:

B. Definitions

Adverse Benefit Determination

Any of the following: (A) a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment (for pre-service or Post-Service Claims) that is based on: (1) a determination of an individual's eligibility to participate in a plan or health insurance coverage; (2) a determination that a benefit is not a covered benefit; (3) the imposition of a preexisting condition exclusion, source-of-Injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or (4)(a) a determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate; or (b) a denial that involves the application of any review under the Medical Review/Pre-Certification program, and determination that an item or service is Experimental/Investigational or not Medically Necessary or appropriate.

Assignment of Benefits

Form under which a provider obtains the right to direct reimbursement from the Plan for services rendered by the provider.

Authorized Representative

To designate an authorized representative a claimant must provide written authorization on a form provided by the Plan, and clearly indicate on the form the nature and extent of the authorization. However, where an Urgent Care Claim is involved, a health care professional with knowledge of the medical condition will be permitted to act as a claimant's authorized representative without a prior written authorization.

Benefit Determination

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

Claimant

A Claimant is any Plan Participant or beneficiary making a claim for benefits. Claimant may file claims themselves or may act through an authorized representative. In this document, the words "you" and "your" are used interchangeably with Claimant.

Concurrent Care Decision

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

Final Internal Adverse Benefit Determination

An Adverse Benefit Determination that has been upheld by the *Plan* at completion of the *Plan's* internal appeals procedures; or an Adverse Benefit Determination for which the internal appeals procedures have been exhausted under the "deemed exhausted" rule contained in the appeals regulations. For plans with

two levels of appeals, the second-level appeal results in a Final Internal Adverse Benefit Determination that triggers the right to external review when eligible.

Independent Review Organization

An Independent Review Organization is an entity that performs independent external reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations

Notice/Notify/Notification

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

Post-Service Claim

Any claim for a benefit under the Plan related to care or Treatment that the Covered Person or beneficiary has already received.

Pre-Service Claim

Any claim that requires Plan approval prior to obtaining medical care for the Claimant to receive full benefits under the Plan. For example, a request for Pre-certification under the Medical Review program is a Pre-Service Claim.

Urgent Care Claim

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

C. Claim Filing Process and Procedures

Initial claims for Plan benefits are made to the Claims Administrator. The Claims Administrator will review the claim itself or appoint an individual or an entity to review the claim following these procedures:

D. Non-Urgent Pre-Service Claims

Procedures for filing Pre-Service Claims are discussed in the Medical Review / Pre-Certification Program section of this Summary Plan Document. The reviewer will Notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim by the Plan. If, due to matters beyond the control of the Plan, the reviewer needs additional time to process a claim, the reviewer may extend the time for notifying the Claimant of the Plan's benefit determination for up to fifteen (15) additional days, provided that the reviewer notifies the Claimant within fifteen (15) days after the Plan receives the claim, of those special circumstances and of when the reviewer expects to make its decision. However, if such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the Notice of extension must specifically describe the required information, and the Claimant will be afforded at least forty-five (45) days from receipt of the Notice within which to provide the specified information.

E. Urgent Care Claims

In order to file an Urgent Care Claim, you or your authorized representative must call the utilization review administrator as outlined in the Medical Review / Pre-Certification section and provide the Plan: (a) Information sufficient to determine whether, or to what extent, benefits are covered under the Plan; and (b) A description of the medical circumstances that give rise to the need for expedited review.

If you or your authorized representatives fail to provide the Plan with the above information, the Plan will provide Notice as soon as reasonably possible, but not later than seventy-two (72) hours after receipt of your claim. You will be afforded a reasonable amount of time under the circumstances, but not less than forty-eight (48) hours, to provide the specified information.

F. Concurrent Care Claims

If the Plan has approved an ongoing course of healthcare Treatment to be provided over a period of time or number of Treatments, any reduction or termination by the Plan of the previously approved course of Treatment (other than by Plan amendment or Treatment) before the approved time period or number of Treatments constitutes an adverse benefits determination. In such a case, the reviewer will Notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before reduction or termination of the benefit.

Any request by a Claimant to extend a previously approved course of urgent care Treatment beyond the approved period of time or number of Treatments shall be decided as soon as possible, taking into account the medical exigencies, and the reviewer will Notify the Claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of Treatments.

G. Post-Service Claims

In order to file a Post-Service Claim, you or your authorized representative must submit the claim in writing on a form pre-approved by the Plan. Pre-approved claim forms are available from your Employer.

Claims should be filed within a twelve (12) month period from the date charges for the services were Incurred. Benefits are based on the Plan's provisions at the time the charges were Incurred. Claims filed later than that date may be declined or rejected unless:

- a. It's not reasonably possible to submit the claim in that time; and
- b. The claim is submitted within one year from the date Incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The third party administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the Claimant. The Plan reserves the right to have a Covered Person seek a second medical opinion.

This Plan has incorporated the BlueCross® BlueShield® of Arizona Exclusive Provider Organization (EPO) into the benefit program. All medical claims submitted are reviewed and re-priced in accordance with the BlueCross® BlueShield® of Arizona (BCBSAZ) negotiated fee schedule. The Claims Administrator (AmeriBen) has partnered with BCBSAZ for electronic claims submission. Electronic claims will be routed via BCBSAZ for re-pricing and then will be forwarded to the Claims Administrator

for processing. Claims submitted via paper will be submitted directly to the Claims Administrator for handling.

To be eligible for processing, all claims and claims information must be submitted in the English language. The original itemized statement must include the following:

- a. The Covered Person's name, Social Security number and address;
- b. Patient's name, Social Security number and address if different from the Covered Person's;
- c. Provider's name, tax identification number, address, degree and signature;
- d. Date(s) of service;
- e. Diagnosis;
- f. Procedure codes (describes the Treatment or services rendered);
- g. Assignment of benefits, signed (if payment is to be made to the provider);
- h. Release of information statement, signed;
- i. Coordination of benefits (COB) information if another plan is the primary payor; and
- j. Sufficient medical information to determine whether and to what extent the expense is a covered benefit under the Plan.

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

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 Pinal County Human Resources. The completed claim form should be attached to the itemized statement and submitted to AmeriBen.

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

Claims must be submitted to AmeriBen on a timely basis (as stated in Section XIX, (B.) Proof of Claim and Timely Filing Requirements) 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.

AmeriBen's mailing address for Medical & Vision claims:

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

For claim inquires:

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

For eligibility information and benefit descriptions:

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

H. Benefit Verifications

Oral or written communications with AmeriBen regarding Covered Person’s or beneficiary’s eligibility or coverage under the Plan are not claims for benefits, and the information provided by AmeriBen or other Plan representatives in such communications does not constitute a certification of benefits or a guarantee that any particular claim will be paid. Benefits are determined by the Plan at the time a formal claim for benefits is submitted according to the procedures outlined above.

I. Notification of Benefit Determinations

The Plan will Notify you or your authorized representative of its benefit determinations as follows:

Urgent Care Claim

Notice of a benefit determination (whether adverse or not) will be provided as soon as possible, taking into account the medical circumstances, but not later than seventy-two (72) hours after receipt of the claim. However, if the Plan gives you Notice of an incomplete claim, the Notice will include a time period of not less than forty-eight (48) hours for you to respond with the requested specific information. The Plan will then provide you with the Notice of benefit determination with forty-eight (48) hours after the earlier of: (a) Receipt of the specified information; or (b) The end of the period of time given you to provide the information. If the benefit determination is provided orally, it will be followed in writing no later than three (3) days after the oral Notice.

If the Urgent Care Claim involves a Concurrent Care decision, Notice of the benefit determination (whether adverse or not) will be provided as soon as possible, but not later than twenty-four (24) hours after receipt of your claim for extension of Treatment or care, as long as the claim is made at least twenty-four (24) hours before the prescribed period of time expires or the prescribed number of Treatments ends.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to Claimant of Claim determination	72 hours
Insufficient information on the Claim, or failure to follow the <i>Plan’s</i> procedure for filing a Claim:	
Notification to Claimant, orally or in writing	24 hours
Response by Claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a Claimant that benefits for a course of Treatment that has been previously approved for a period of time or number of Treatments is to be reduced or eliminated. In that case, the Plan must Notify the Claimant sufficiently in advance of the effective date of the reduction or elimination of Treatment to allow the Claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to Claimant of rescission	30 days
Notification of determination on Appeal of Urgent Care Claims	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Other Pre-Service Claims

Notice of a benefit determination (whether adverse or not) will be provided in writing within a reasonable period appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim. However, this period may be extended one time by the Plan for up to an additional fifteen (15) days if the Plan both determines that such an extension is necessary due to matters beyond its control and provides you written Notice, prior to the end of the original fifteen (15) day period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the Notice of extension will specifically describe the required information, and you will be given at least forty-five (45) days from your receipt of the Notice to provide the specified information.

Notice of an Adverse Benefit Determination regarding a Concurrent Care Decision will be provided sufficiently in advance of any termination or reduction of benefits to allow you to appeal and obtain a determination before the benefit is reduced or terminates.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to Claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the <i>Plan</i>	15 days
Insufficient information on the Claim:	
Notification of claim	15 days
Response by Claimant	45 days
Notification, orally or in writing, of failure to follow the <i>Plan's</i> procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	15 days per benefit appeal
Reduction or termination before the end of the Treatment	15 days
Request to extend course of Treatment	15 days

Post-Service Claims

Notice of Adverse Benefit Determinations will be provided, in writing, within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. However, this period may be extended one time by the Plan for up to an additional fifteen (15) days if the Plan both determines that such an extension is necessary due to matters beyond its control and provides you written Notice, prior to the end of the original thirty (30) day period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the Notice of extension will specifically describe the required information, and you will be given at least forty-five (45) days from your receipt of the Notice to provide the specified information.

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

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

In the case of a Post-Service Claim, the following timetable applies:

Notification to Claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the <i>Plan</i>	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	30 days per benefit appeal

J. Calculation of Time Periods

For purposes of the time periods relating to the Plan’s initial benefit determination, the period of time during which an initial benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to a claimant’s failure to submit all information necessary, the period for making the determination shall be “frozen” from the date the notification requesting the additional information is sent to the Claimant until the date the Claimant responds to the request for additional information.

K. Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Claims Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The Notice will include the information listed below i in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the Claimant:

- a. Identification of the claim, including date of service, name of provider, claim amount (if applicable), the diagnosis code and its corresponding meaning, and the Treatment code and its corresponding meaning;
- b. The specific reason(s) for the Adverse Benefit Determination, including the denial codes and its corresponding meaning, and the Plan’s standard, if any, used in denying the claim;
- c. Reference to the specific Plan provisions on which the determination was based;
- d. A description of any additional information or material needed from you to complete the claim and an explanation of why such material or information is necessary;
- e. A description of the Plan’s review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures;
- f. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
- g. If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol or criterion will be provided free of charge. If this is not practical, a statement will be included that such rule, guideline, protocol or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the Claimant upon request;

- h. If the Adverse Benefit Determination is based on the medical necessity or Experimental/Investigational Treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge, upon request.

L. Claims Appeal Process and Procedures

Internal Review of Initially Denied Claim

In the event of an Adverse Benefit Determination, the Claimant may request a review of that determination in accordance with the following procedures:

- a. A Claimant for health benefits has one hundred eighty (**180**) days following receipt of a notification of an initial adverse initial benefit determination within which to request a review of the Adverse Benefit Determination (first-level appeal). Such review is conducted by the third party administrator in accordance with the requirements noted in (c) below.
- b. In the event a first-level appeal results in the Adverse Benefit Determination being upheld, a Claimant may request a second level appeal to the Board of Trustees. For a request for a second level appeal, the Claimant has sixty (60) days following receipt of notification of an Adverse Benefit Determination at the first level of appeal.
- c. In the event of an appeal in accordance with (a) or (b) above, the review will meet the following requirements:
 - 1. The Plan will provide a review that does not afford deference to the Adverse Benefit Determination and that is conducted by an individual reviewing the appeal on behalf of the Plan who did not make the Adverse Benefit Determination that is the subject of the appeal, nor is a subordinate of the individual who made the adverse initial determination.
 - 2. The individual reviewing the appeal on behalf of the Plan will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any Adverse Benefit Determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular Treatment, Drug or other item is Experimental, Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
 - 3. The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse initial benefit determination, without regard to whether the advice was relied upon in making the adverse initial benefit determination.
 - 4. In the case of a requested review of a denied Adverse Benefit Determination involving urgent health care, the review process shall meet the expedited deadlines described below. The claimant's request for such an expedited review may be submitted orally or in writing by the Claimant and all necessary information, including the Plan's determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.
 - 5. The reviewer will afford the Claimant an opportunity to review and receive, without charge, all relevant documents, information and record relating to the claim for benefits

and to submit issues and comments relating to the claim for benefits in writing to the Claims Administrator. The reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

6. The Claimant will be provided, free of charge, any new or additional evidence or rationale considered, relied upon, or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible, and sufficiently in advance of the date in which the Notice of Final Internal Adverse Benefit Determination to give Claimant a reasonable opportunity to respond prior to such determination.
7. The Plan will ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.
8. The Plan will provide a Claimant with continued coverage pending the outcome of an internal appeal.

All requests for review of initially denied claims or of an Adverse Benefit Determination (including all relevant information) must be submitted to the Claims Administrator at the following address:

AmeriBen
P.O. Box 7186
Boise, ID 83707

M. Deadline for Internal Review of Initially Denied Claims

- a. **Urgent Care Claims.** The Plan provides for two levels of appeals for Urgent Care Claims. For each level of appeal, the reviewer will Notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claimant's request for review of the Adverse Benefit Determination (or of the first-level appeal Adverse Benefit Determination) by the Plan.
- b. **Concurrent Care Claims.** Decisions are made when the Plan has approved an ongoing course of treatments to be provided over a period of time. If the Plan reduces or terminates the course of treatment, it will Notify you in advance so that you will have sufficient time to appeal and obtain a determination on review before the ongoing benefit is reduced or terminated.
- c. **Pre-Service Claims.** The Plan provides for two levels of appeal for a pre-service health claim. At each level of appeal, the reviewer will Notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than thirty (30) days after the Plan receives the claimant's request for review of the Adverse Benefit Determination (or of the first-level appeal Adverse Benefit Determination).
- d. **Post-Service Claims.** The Plan provides for two levels of appeal for a post-service health claim. At each level of appeal, the reviewer will Notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than thirty (30) days after the Plan receives the claimant's request for review of the Adverse Benefit Determination (or of the first-level appeal Adverse Benefit Determination).

N. Manner and Content of Notice of Decision on Internal Review of Initially Denied Claims

Upon completion of its review of an Adverse Benefit Determination (or a first-level appeal Adverse Benefit Determination), the reviewer will give the Claimant, in writing or by electronic notification, a Notice containing:

- a. Its decision;
- b. The specific reason(s) for the decision;
- c. The relevant Plan provisions or insurance contract provisions on which its decision is based;
- d. Information sufficient to identify the claim involved, including the date of service, the healthcare provider, the claim amount (if applicable), the diagnosis code (and an explanation of its meaning) and the Treatment code (and an explanation of its meaning);
- e. As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;
- f. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
- g. A statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the claimant's claim for benefits;
- h. A statement describing the claimant's right to request a second-level appeal, or, if applicable, an external review;
- i. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to the Claimant upon request; and
- j. If the adverse determination on review is based on a medical necessity, Experimental Treatment or similar exclusion or limit, either: (i) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances; or (ii) a statement that such an explanation will be provided without charge upon request.

O. External Review Rights

On August 23, 2010, the U.S. Departments of Labor (DOL), Health and Human Services (HHS), and Treasury collectively released interim guidance to establish procedures for the Federal external review process required by healthcare reform.

Until the final procedure becomes available, the Plan will make every effort to comply with the limited enforcement safe harbor provisions established by DOL Technical Release 2010-01 which provides guidance on the interim review process for self-funded group health plans.

If your final appeal for a claim is denied, you will be Notified in writing if your claim may be eligible for an external review and you will be informed of the time frames and the steps necessary to request an external review. You must complete all levels of the internal claims and appeal procedure before you can request a voluntary external review.

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

P. External Review of Denied Claims

The External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a Treatment is Experimental or Investigational, or (3) a rescission of coverage. If your appeal is denied, you or your authorized representative may request further review by an Independent Review Organization (IRO). This request for external review must be made, in writing, within four (4) months of the date you are Notified of an Adverse Benefit Determination or final Adverse Benefit Determination. The request for an external review must be submitted to the Claims Administrator at the following address:

AmeriBen
P.O. 7186
Boise, ID 83707

“External Review” means a review of an Adverse Benefit Determination, including a Final Internal Adverse Benefit Determination under applicable state or federal external review procedures.

Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

- a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- b. The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant’s failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);
- c. The Claimant has exhausted the Plan’s internal appeal process;
- d. The Claimant has provided all the information and forms required to process an external review.

The Plan will Notify the Claimant within **one (1) business day** of completion of its preliminary review if:

- a. The request is complete but not eligible for external review, in which case the Notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)); or
- b. The request is not complete, in which case the Notice will describe the information or materials needed to make the request complete, and allow the Claimant to perfect the request for external review within the four-month filing period, or within the 48 hour period following receipt of the notification, whichever is later.

NOTE: If the Adverse Benefit Determination or Final Internal Adverse Benefit Determination relates to a Plan Participant’s or beneficiary’s failure to meet the requirements for eligibility under the terms of the Plan, it is not within the scope of the external review process, and no external review may be taken.

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

- a. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
- b. The assigned IRO will timely Notify the Claimant in writing of the request’s eligibility and acceptance for external review. This Notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the Notice additional information that the IRO must consider when conducting the external

review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

- c. Within five business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must Notify the Claimant and the Plan.
- d. Upon receipt of any information submitted by the Claimant, the assigned IRO must, within one business day, forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Plan must not delay the external review. The external review by the IRO shall be terminated following the reconsideration by the Plan, but only if the Plan decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written Notice of its decision to the Claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the Notice from the Plan.
- e. The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - i. The claimant's medical records;
 - ii. The attending health care professional's recommendation;
 - iii. Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or the claimant's treating provider;
 - iv. The terms of the claimant's plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
 - v. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - vi. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
 - vii. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this Notice to the extent the information or documents are available.
- f. The assigned IRO must provide written Notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the Notice of final external review decision to the Claimant and the Plan.
- g. The assigned IRO's decision Notice will contain:
 - i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its

- corresponding meaning, and the Treatment code and its corresponding meaning, and the reason for the previous denial);
- ii. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - iii. The references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - iv. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - v. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the Claimant;
 - vi. A statement that judicial review may be available to the Claimant; and
 - vii. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Generally, a Claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review.

Q. Plan's Failure to Follow Procedures

If the Plan fails to follow the claims procedures described in this Section, a Claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under State or Federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Any requests for appeals that do not comply with the above-stated procedures will not be considered for review.

SECTION XV—COORDINATION OF BENEFITS

All medical and dental 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" offering the same type of coverage to which the Covered Person may also be entitled.

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

A. General Terms / 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.

Applicable Policies means any of the following plans that provide coverage for Hospital, surgical, medical or dental care; group plans (insured or noninsured); labor-management trustee plans; union welfare plans; Employer organization group plans; employee benefit organized 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); any insurance or similar provisions.

COB Benefit Determination Period shall mean one (1) Plan 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 Plan Year (accumulated credit savings can be used when necessary).

B. Order of Benefit Determination

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

- a. The rules for determining primary vs. secondary for the order of benefit payments are as follows:
 1. A plan which does not have a non duplication of Benefits provision will pay as primary and this Plan will be secondary.
 2. The plan which covers the claimant as an Employee, member, subscriber or retiree shall be primary.
 3. The plan which covers the claimant as a Dependent shall be considered secondary.
 4. 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.
 5. 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.

6. 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:
 - i. The plan of the parent whose birthday (excluding year of birth) occurs earlier in a Plan Year is primary over the plan of the parent whose birthday occurs later in a Plan Year.
 - ii. 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.
 7. If none of the above are applicable, the plan covering the person the longest will be Primary.
- b. 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:
1. 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.
 2. Second: The plan of the natural or adoptive parent who has custody of the Dependent child.
 3. Third: The plan of the stepparent, provided the child's permanent primary residence is with the stepparent.
 4. Fourth: The plan of the natural or adoptive parent who does not have custody.
 5. 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.
 6. 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.

C. Coordination with Medicare

The term "Medicare" as used herein means the Medicare program 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).

D. 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 plan, 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.

SECTION XVI—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 the Claims Administrator.

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

A. 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.

B. 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; or
- 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; or
- d. The Covered Dependent no longer satisfies the Plan's definition of an eligible dependent.

C. 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 Claims Administrator or its designee 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. A parent or legal guardian may elect COBRA coverage for a minor child.

D. 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:

1. The end of twenty-nine (29) months from the date of the Qualifying Event; or
 2. The date the disabled person becomes entitled to Medicare; or
 3. 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.

Second Qualifying Event: 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.

E. 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 dependents lose coverage under this Plan before the end of what would be the maximum COBRA continuation period.

F. 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.

G. 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 initial payment within forty five (45) days of notifying the Plan Administrator or its designee of their election to continue coverage. The initial payment must include all monthly premiums due back to the date regular coverage terminated.
- b. Future payments must be made within thirty (30) days of the scheduled due date.
- c. The scheduled due date for COBRA premiums is the first day of each month.
- d. Rates and payment schedules are established by the 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.

SECTION XVII—DEFINITIONS

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

ACCIDENT

Non-occupational 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.

ACTIVE

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.

ACUPUNCTURIST

A Practitioner duly licensed by the State (and acting within the scope of that license) to practice the science of acupuncture.

ADMINISTRATOR OR PLAN ADMINISTRATOR

Defined by Federal Law means the Employer in the case of an employee benefit plan established or maintained by a single Employer.

BIRTHING CENTER

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.

CHEMICAL DEPENDENCY

Alcohol and/or Drug dependence as defined in the current edition of the International Classification of Disease Manual (ICD) or the Diagnostic and Statistical Manual (DSM). See also definitions for Mental Health/Behavioral Health and Substance Abuse.

CHIROPRACTOR

A Physician duly licensed by the State (and acting within the scope of such license) to practice the science of chiropractic medicine.

CLAIMS ADMINISTRATOR

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.

CO-INSURANCE

The percentage of a claim that is the financial responsibility of the Covered Person after this Plan's eligible benefit percentage has been calculated.

CO-INSURANCE OUT-OF-POCKET MAXIMUM

The total dollar amount of eligible charges which is accumulated per person and paid at the Co-insurance percentage (i.e., 20%), after which the Plan will pay Eligible Expenses for the remainder of the Plan Year at one hundred percent (100%). Expenses for Copayments and penalties for noncompliance with Pre-certification requirements do not accumulate toward the Co-Insurance Out-of-Pocket Maximum.

COPAYMENT / COPAY

The specified dollar amount which a Covered Person must pay in conjunction with the receipt of eligible services under the terms of this Plan.

CORRECTIVE APPLIANCE

Items which are prosthetic or orthotic and necessary for the restoration of function or replacement of body parts.

- a. Prosthetic is an item used to replace all or part of a natural body part or the function thereof.
- b. Orthotic is an item used to support a weakened body part or to correct a body defect.

COSMETIC

Treatment, Surgery or service performed which will preserve or improve appearance (i.e.: reshape the structure) and which will not affect the physiological function.

COVERED DEPENDENT

Those Dependents who are eligible according to the eligibility rules provided herein under Section III—Eligibility, Funding, Effective Date and Termination Provisions," and are enrolled by a Covered Employee.

COVERED EMPLOYEE

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 Section III—Eligibility, Funding, Effective Date and Termination Provisions.

COVERED PERSON / PLAN PARTICIPANT

A Covered Employee, Covered Dependent, or a Qualified Beneficiary under COBRA.

CUSTODIAL CARE

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.

DEDUCTIBLE

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.

DENTIST

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).

DRUG

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.

DURABLE MEDICAL EQUIPMENT

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.

ELECTION PERIOD

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.

ELIGIBLE EXPENSES

Charges for services and supplies described in this Plan Incurred as a result of a covered Illness or Injury by a Covered Person. 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 or a Usual, Customary and Reasonable charge 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 Section IV, (E.). Eligible charges shall not include expenses which are specifically excluded or reduced as a result of specific Plan requirements not satisfied.

EMERGENCY

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.

EMERGENCY HOSPITALIZATION OR CONFINEMENT

A Hospital admission which takes place within twenty-four (24) hours of the onset of a sudden and unexpected severe symptom of an Illness or within twenty-four (24) hours of an accidental Injury during a Life Threatening situation.

EMERGENCY SURGERY

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.

EMPLOYER

Used herein shall mean Pinal County.

ENROLL

To make written application for coverage on the prescribed forms, within the stipulated time-frames. In the absence of completing the prescribed forms, eligible Employees shall be automatically enrolled in Employee Only medical coverage and Basic Life and Accidental Death & Dismemberment in accordance with Section III—Eligibility, Funding, Effective Date and Termination Provisions.

EXPENSE INCURRED

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.

EXPERIMENTAL / INVESTIGATIONAL TREATMENT, PROCEDURE OR EQUIPMENT

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

The Plan Administrator must make an independent evaluation of the Experimental or Non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed Treatment. The decision of the Plan Administrator will be final and binding on the Plan. In addition to the above, the Plan Administrator will be guided by the following principles to determine whether a proposed Treatment is deemed to be Experimental and/or Investigational:

1. If the Drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the Drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or
2. If the Drug, device, medical Treatment or procedure, or the patient informed consent document utilized with the Drug, device, medical Treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval, then it is deemed to be Experimental and/or Investigational; or
3. If Reliable Evidence shows that the Drug, device, medical Treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, or is the subject of research, Experimental, study, Investigational or other arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of Treatment or diagnosis, then it is deemed Experimental and/or Investigational; or
4. If Reliable Evidence shows that the prevailing opinion among experts regarding the Drug, device, medical Treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of Treatment or diagnosis, then it is deemed to be Experimental and/or Investigational.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) or another facility studying substantially the same Drug, service, medical Treatment or procedure, or the written informed consent used by the treating facility or by another facility studying substantially the same Drug, device, medical Treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the FDA for general use.

Expenses related to off-label Drug use (the use of a Drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

1. The named Drug is not specifically excluded under the General Limitations of the Plan; and

2. The named Drug has been approved by the FDA; and
3. The off-label Drug use is appropriate and generally accepted by the medical community for the condition being treated; and
4. If the Drug is used for the Treatment of cancer, the American Hospital Formulary Service Drug Information or the NCCN Drugs and Biologics Compendia recognize it as an appropriate Treatment for that form of cancer.

Expenses for Drugs, devices, services, medical Treatments or procedures related to an Experimental and/or Investigational Treatment (related services) and complications from an Experimental and/or Investigational Treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational Treatment.

The Plan Administrator has the discretion to determine which Drugs, services, supplies, care and/or Treatments are considered Experimental, investigative or unproven.

GRACE PERIOD

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.

HOME HEALTH CARE AGENCY

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.

HOME HEALTH SERVICES

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 any or all of the following:

- 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;
- c. 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.

HOSPICE CARE

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.

HOSPITAL

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.

HOSPITAL MISCELLANEOUS CHARGES

The Usual Customary and Reasonable 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.

ILLNESS

Sickness or disease, pregnancy of an employee or spouse, psychiatric disorders, or congenital abnormalities.

IMMEDIATE FAMILY MEMBER

The Covered Person's mother, father, sister, brother, husband, wife and/or child whether by birth or by marriage.

INCURRED

An expense for a service or supply is incurred on the date the service or supply is furnished.

INDIVIDUAL DEDUCTIBLE AMOUNT

The amount shown in the Schedule of Medical Benefits which must be accumulated in Eligible Expenses by a Covered Person during each Plan Year before benefits are payable under this Plan.

INJURY

A condition which results independently of an Illness and is a result of an accidental externally violent force.

INJURY TO SOUND NATURAL TEETH

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.

IN-NETWORK

Refers to BlueCross® BlueShield® of Arizona providers.

INPATIENT

Confined in a Hospital facility for which a room and board charge has been made.

INTENSIVE CARE UNIT

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.

LIFE THREATENING

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

MEDICALLY NECESSARY OR MEDICAL NECESSITY

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.

MEDICARE

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

MENTAL HEALTH / BEHAVIORAL HEALTH

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.

MENTAL HEALTH / BEHAVIORAL HEALTH TREATMENT FACILITY

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.

NEWBORN NURSERY CHARGES

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 795).

NON-DURABLE

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

NURSE

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).

NURSE-MIDWIFE

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.

ORTHOGNATHIC

Services dealing with the cause and Treatment of malposition of the bones of the jaw.

OUT-OF-NETWORK

Any provider that is not contracted with the BlueCross BlueShield of Arizona provider network.

OUTPATIENT

Any care or Treatment that is rendered while the Covered Person is not confined in a Hospital or other Facility.

PARTICIPATING OR PREFERRED PROVIDER

A provider who is under contract with the BlueCross Blue Shield of Arizona network to provide services to Covered Persons at negotiated rates.

PERIOD OF COVERAGE

The period beginning on the date of the Qualifying Event and lasting until the earliest of the dates indicated under Section XVI, Continuation of Coverage (COBRA).

PHYSICIAN OR DOCTOR

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;
- b. D.O. - Doctor of Osteopathy;
- c. P.A. – Physician’s Assistant;
- d. N.P. – Nurse Practitioner; or
- e. D.P.M. – Doctor of Podiatry.

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

PLAN

The benefits provided through the Pinal County Employee Benefit Trust as described herein. The Pinal County Employee Benefit Trust Plan is a distinct entity, separate from the legal entity that is your Employer.

PLAN DOCUMENT

This written document, any amendments thereto, and any successor document that states the benefits provided by the Trust.

PLAN PARTICIPANT

Refer to the definition of COVERED PERSON, located in this section.

PLAN YEAR

The Plan Year will be a twelve (12)-month period beginning July 1 and ending June 30.

Deductibles and Visit-limited plan benefits, as well as the Plan’s Co-Insurance Out-of-Pocket Maximum are calculated on a Plan Year basis.

PRACTITIONER

A person acting within the scope of applicable state licensure/certification requirements and holding the degree of Certified Nurse Midwife (CNM), Certified Surgical Assistant (CSA), Certified Registered Nurse Anesthetist (CRNA), Registered Physical Therapist (RPT), Occupational Therapist, Speech Therapist, 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, Psychologist, Certified Professional Counselor and other counselors as specified in Section IV, E. 7. Mental Health Care / Substance Abuse. Optometrists administering topical pharmaceutical agents or removing superficial foreign bodies from the eye must be appropriately licensed and meet any additional state requirements for such services.

PRE-CERTIFICATION

The process of reviewing the necessity, appropriateness, location, duration and/or cost efficiency of a health care service before it is rendered.

PRE-EXISTING CONDITION

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.

PRIMARY CARE PHYSICIAN (PCP)

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

PROSTHETICS

A Corrective Appliance customized to replace all or part of a missing body part as an artificial limb.

QUALIFIED BENEFICIARY

A person so defined under Section XVI, Continuation of Coverage (COBRA).

QUALIFYING EVENT

Used and defined under Section XVI, Continuation of Coverage (COBRA).

RECONSTRUCTIVE SURGERY

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.

REHABILITATION / REHABILITATION THERAPY

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

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

RESIDENTIAL TREATMENT FACILITY

A facility duly licensed or certified by the State Department of Health for Treatment of Chemical Dependency or substance abuse.

ROUTINE NEWBORN / WELL BABY CARE

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.

SEMPRIVATE ROOM CHARGE

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

SKILLED NURSING CARE

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.

SKILLED NURSING FACILITY (SNF) OR EXTENDED CARE FACILITY

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; and
- c. Maintains daily clinical records on each patient and has available the services of a Physician under the established agreement; and
- d. Provides appropriate methods of dispensing and administering Drugs and medicines; and
- 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; and
- 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.

SPECIALIST

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

SPINAL MANIPULATION AND CHIROPRACTIC CARE

The Treatment rendered for the correction of structural imbalance, distortion, misalignment or subluxation of or in the vertebral column by manual or mechanical means.

SOUND AND NATURAL TEETH

A tooth which is free of decay or periodontal disease, contains a live nerve and root, and has never been capped or crowned.

SURGERY

Any of the following medical procedures:

- a. To incise, excise, or electro-cauterize 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 or the Usual, Customary and Reasonable amount 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 or the full Usual, Customary and Reasonable amount of the primary procedure, and at fifty percent (50%) of the negotiated rate agreed upon between BCBSAZ and the Network Provider or Usual, Customary and Reasonable amount of each of the lesser procedure(s) that are through their own separate incision(s).

SURGICAL CENTER, FREESTANDING OR AMBULATORY

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.

TOTAL DISABILITY

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

TREATMENT

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.

URGENT CARE FACILITY

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.

USUAL, CUSTOMARY AND REASONABLE (UCR)

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.

VISIT

An in person interview/consultation between a Physician or other eligible health care Practitioner and a Covered Person.

SECTION XVIII—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.

A. Purpose

Your Employer 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.

B. Effective Date

The revised Effective Date of the Plan is July 01, 2013 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.

C. 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 this Summary Plan Description.

D. 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.

E. 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.

F. 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.

G. 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.

H. 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.

I. 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 and in accordance with all state and federal laws, including HIPAA. 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.

SECTION XIX—MISCELLANEOUS PLAN PROVISIONS

A. Filing of Information

Each Covered Person is responsible to file with the Claims Administrator and/or the Plan 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.

B. 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.

C. Interpretation of Plan Provisions

The Claims Administrator shall have the discretion to interpret and apply the provisions of this Plan, subject to review by the Pinal County EBT Board of Trustees. Trustees shall have sole discretion to maintain and/or amend the Plan as well as in appeal and/or other review processes.

D. Preferred 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. All other Plan restrictions and limitations will remain the same.

E. 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.

F. Managed Care Recommendations

The Plan, together with the Utilization Review firm and the Claims Administrator, have the option to override certain Plan limitations, exclusions or pre-certification requirements when it is in the best interest of the Plan to allow a more cost-effective type of alternative care. Subject to all other terms and conditions of this Plan as set forth in this Summary Plan Document, if a covered person suffers from a covered Injury or Illness which requires treatment for which there is no "In-network" provider, as confirmed by the Utilization Review firm and approved by the reinsurance carrier, the Plan may elect to pay for treatment by an Out-of-network provider at the In-network provider level.

G. 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.

H. 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.

I. 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 Dependent, 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.

SECTION XX—REIMBURSEMENT AND RECOVERY PROVISION

A. 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.

All funds recovered by a Plan Participant, or held in trust for the benefit of the Plan, exist separately from the property and estate of the Plan Participant.

B. Subrogation and Reimbursement - Rules for the Plan

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

1. 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.
2. 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.
3. 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.
4. 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.

5. 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.
6. 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.
7. 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.
8. 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.
9. 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.
10. 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.
11. 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.
12. 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.

C. Additional Recovery Sources

The right of Refund, Recovery and/or Subrogation applies to all first and third party sources that a Plan Participant may receive payment from, including, but not limited to: (1) the responsible party, its insurer, or any other source on behalf of the responsible party; (2) any first party insurance through medical coverage, personal Injury protection, or no-fault coverage; (3) any insurance policy or guarantor of a third party; (4) workers' compensation or other liability coverage; (5) crime victim restitution funds; (6) medical disability; (7) any other source, including, but not limited to, school coverage.

D. 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, 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. No such action may be brought unless brought within one year after the date of such determination.

E. 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.

F. Regulatory Reporting

The Plan Administrator shall be responsible for filing all reports and accounting which governmental regulatory bodies may require. It shall be the Trustee'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.

G. 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.

SECTION XXI—PRIVACY OF PROTECTED HEALTH INFORMATION

(As required by 45 Code of Federal Regulations Parts 160 & 164)

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.

If you have any questions about this Notice please contact:

Pinal County Employee Benefit Trust's Privacy Officer
c/o Pinal County Human Resources
Administration Bldg. A
31 North Pinal Street
P.O. Box 1590
Florence, AZ 85232
(p) 520.886.6594 (f) 520.866.6401
Email: Jeanette.Grady@pinalcountyaz.gov

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out Treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or Mental Health conditions and the provision or payment of related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. We will provide you with any revised Notice of Privacy Practices upon your request to the Privacy Officer identified above. Requests may be sent to the Privacy Officer via telephone, fax, email or mailing to the numbers or addresses shown above. Alternatively, you may request any revised Notice of Privacy Practices by contacting your Employer's Personnel or Human Resources Department.

A. Uses and Disclosures of Protected Health Information Without Your Consent or Authorization

Pinal County Employee Benefit Trust (PCEBT) may have access to and use your protected health information for reasons consistent with applicable provisions of federal and state law. These uses will be confined to reasons related to Treatment, payment and operations. Following are examples of the types of uses and disclosures of your protected health care information that PCEBT is permitted to make without your consent. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by PCEBT in the course of administering the employee benefits provided to you by your Employer through its membership in PCEBT.

1. **Treatment:** PCEBT may use and disclose your protected health information for purposes of determining the eligibility of proposed benefits for reimbursement through PCEBT and, where such Treatments are in fact covered under PCEBT's plan of benefits, paying any and all resulting claims as presented to PCEBT through its third party administrator (TPA) and in accordance with the applicable summary plan description.
2. **Payment:** Your protected health information will be used, as needed, to make payment to providers who have cared for you in accordance with the provisions of the benefit plan provided through PCEBT. This may include certain activities that PCEBT may undertake before it approves or pays for the health care services your Physician recommends for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to

you for medical necessity, undertaking utilization review activities and resolving appeals related to benefit and/or claims payment denials.

3. **Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of PCEBT. These activities include, but are not limited to, placement of contracts of insurance or reinsurance, seeking reimbursement of eligible medical payments from PCEBT insurers or reinsurers, seeking reimbursement or repayment from third parties via subrogation, auditing the appropriateness of claims processing or payment activity of PCEBT vendors, developing and implementing health and wellness promotion programs and conducting or arranging for other PCEBT business activities.

In completing Treatment, payment and operational activities, PCEBT may share your protected health information with third party "business associates" that perform various activities (e.g. Pre-certification of certain medical procedures and Hospital admissions, payment of claims and reimbursement-related activities with insurers and reinsurers) for PCEBT. Whenever an arrangement between PCEBT and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that seek to protect the privacy of your protected health information. Further uses and disclosure of PHI without your consent or authorization is permitted for the following public policy purposes:

1. **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
2. **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, Injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.
3. **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process, but only if reasonable efforts have been made by the person requesting the information to tell you about the request or to obtain an order protecting the disclosure of the information requested.
4. **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (A) legal processes and otherwise required by law;(B) limited information requests for identification and location purposes;(C) pertaining to victims of a crime;(D) suspicion that death has occurred as a result of criminal conduct;(E) in the event that a crime occurs on the premises of any medical practice through which you are receiving care or Treatment; and (F) medical Emergency and it is likely that a crime has occurred.
5. **Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
6. **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (A) for activities deemed necessary by appropriate military command authorities; (B) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (C) to foreign military authority if you are a member of that foreign military services. We may also

disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

7. **Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.
8. **Organ and Tissue Donation:** If you are an organ donor, we may disclose Protected Health Information about you to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ tissue donation and transplantation.
9. **Psychotherapy Notice:** We will not use or disclose Protected Health Information about you contained in psychotherapy notes without your authorization except for limited circumstances to carry out the following Treatment, Payment, or Health Care Operations: (a) use by the originator of the psychotherapy notes for Treatment; (b) use or disclosure by a health care provider in training programs in which students, trainees, or Practitioners in Mental Health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; (3) use or disclosure by the Plan to defend a legal action or other proceeding brought by you against the Plan; or (d) as permitted by the applicable HIPAA regulations.

B. Permitted Disclosures to Family Members or Other Relatives Unless You Object

We may disclose PHI about you to family members, other relatives, and your close personal friends if: (a) the information is directly relevant to the family or friend's involvement with your care or payment for that care; and (b) you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

C. Disclosure upon Your Request

Upon your request, we are required to give you access to certain Protected Health Information in order for you to inspect and copy it.

D. Other Uses of Your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us written authorization to use or disclose Protected Health Information about you, you may revoke that written authorization, in writing, at any time. If you revoke your written authorization, we will no longer use or disclose Protected Health Information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your written authorization.

E. Our Efforts to Safeguard Your Protected Health Information

PCEBT will implement processes and procedures in an effort to safeguard your protected health information including at least:

1. Limiting access to protected health information to the minimum number of PCEBT-staff members and/or vendors who need such access in the course of PCEBT operations;
2. Installing alarms and physical barriers in PCEBT facilities where such information is stored;

3. Limiting the number of people from PCEBT member entities who may have access to protected health information;
4. Conducting periodic training of PCEBT staff and Trustees on their responsibilities relative to protected health information; and
5. Requiring PCEBT vendors to execute agreements relative to their obligations pertaining to protected health information.

F. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

1. You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as PCEBT maintains the protected health information. A "designated record set" contains medical and billing records and any other records that your Physician and the practice uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to have this decision reviewed. Please contact PCEBT's Privacy Officer if you have questions about access to your medical record.
2. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of Treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. PCEBT is not required to agree to a restriction that you may request. If PCEBT believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If PCEBT does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide Emergency Treatment. With this in mind, please discuss any restriction you wish to request with your Physician. You may request a restriction by contacting PCEBT's Privacy Officer at the address, phone or fax number shown on the first page of this notice.
3. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to the Privacy Officer.
4. You may have the right to have your Physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as PCEBT maintains this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact the Privacy Officer to determine if you have questions about amending your PCEBT medical records.

5. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than Treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.
6. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

G. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by PCEBT. You may file a complaint with PCEBT by notifying the Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact the Privacy Officer at (p) 520.886.6594 (f) 520.866.6401 for further information about the complaint process.

This amended notice was published and becomes effective on July 01, 2013.

SECTION XXII—FEDERAL NOTICES

A. Women’s Health And Cancer Rights Act (WHCRA)

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

- a. All stages of reconstruction of the breast on which the mastectomy was performed;
- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- c. Prostheses; and
- d. Treatment of physical complications of the mastectomy, including lymphedema.

This coverage is subject to the same Deductibles and Copayments consistent with those established for other benefits under this Plan.

B. Notice Of Prescription Drug Coverage and Medicare

Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription Drug coverage with the Pinal County Employee Benefit Trust (hereafter PCEBT) and about your options under Medicare’s prescription Drug coverage. It also tells you where to find more information to help you make decisions about your prescription Drug coverage. You may ask for another copy of this notice from the PCEBT at any time.

Key points for you to remember:

- a. Medicare prescription Drug coverage (sometimes called Medicare Part D) is available to everyone with Medicare.
 - b. The prescription Drug coverage offered to you by PCEBT is generally better than the standard Medicare prescription Drug coverage.
 - c. If you decide to keep your coverage through PCEBT’s Plan, you do not have to do anything.
 - d. If you keep your prescription Drug coverage through PCEBT and then later decide to buy prescription Drug coverage through Medicare, you will not have to pay a penalty (that is, pay a higher Medicare premium).
 - e. If you have questions about this Notice or would like more information about your coverage options, please contact Pinal County Human Resources.
-

For the upcoming year, you have several coverage options:

1. You may stay with your current plan offered by PCEBT. Because PCEBT’s coverage is, on average for all Plan Participants, expected to pay out more than standard Medicare Part D prescription Drug coverage will pay, you can keep this coverage and not pay a higher premium (that is, there is no penalty) if you later decide to Enroll in a Medicare Part D plan. If you decide to keep your existing coverage through PCEBT’s plan, you do not have to do anything. You will continue to be enrolled in PCEBT’s plan and receive the same benefits you currently have.
2. You may Enroll in a stand-alone Medicare prescription Drug plan to obtain Medicare Part D coverage. All Medicare Prescription Drug plans will provide at least a standard

level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

If you want to Enroll in a Medicare prescription Drug plan, open enrollment for the Medicare prescription Drug plans runs from October 15th through December 7th of each year. Before enrolling in a Medicare prescription Drug plan, please contact your Human Resources Department to discuss what health insurance coverage you have through PCEBT to avoid duplicate coverage.

You should also know that if you drop or lose your prescription plan with PCEBT and don't Enroll in a Medicare prescription Drug plan or another plan that is at least as good within 63 days after your coverage with PCEBT ends, you will pay more (that is, pay a penalty) to Enroll in Medicare prescription Drug coverage. When you Enroll in a Medicare prescription Drug plan, your monthly premium will be increased at least 1% for every month you did not have coverage. For example, if you go 19 months without coverage, your premium for a Medicare prescription Drug plan will always be at least 19% higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare prescription Drug coverage. In addition, you may have to wait until the next November to Enroll and until the next January to receive benefits.

3. You may decide not to have any prescription Drug coverage from either PCEBT's plan or from a Medicare prescription Drug plan. If you decide not to have any prescription Drug coverage, you will have to pay a higher premium later (that is, pay a penalty), when you decide to Enroll in a Medicare prescription Drug plan. Later when you Enroll in a Medicare prescription Drug plan, your monthly premium will be increased at least 1% for every month you did not have coverage. For example, if you go 19 months without coverage, your premium for Medicare prescription Drug plan will always be at least 19% higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare prescription Drug coverage. In addition, you may have to wait until next November to Enroll and until next January to receive benefits.

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

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

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

- Visit www.medicare.gov for personalized help.
- Call 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 plans is available. Information about this extra help can be obtained from the Social Security Administration (SSA) online at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

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

Date: July 01, 2013
Name of Entity/Sender: Pinal County Employee Benefit Trust
Address: c/o Pinal County Human Resources
Administration Bldg. A
31 N. Pinal Street
P.O. Box 1590
Florence, AZ 85232
Phone Number: (520) 866-6594

C. Newborns' And Mothers' Health Protection Act Statement Of Rights

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., the Member's Physician, Nurse Midwife, or Physician's assistant), after consultation with the mother, discharges the mother and/or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). Pre-certification is still required for the delivery and for newborn placement in an intensive care Nursery. Pre-certification is also required for any length of stay period in excess of the minimum (48 or 96 hours), even though not required for the minimum length of stay period.

D. Mental Health Parity

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental Employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the Employer, rather than provided through a health insurance policy. The Pinal County Employee Benefit Trust (PCEBT) has elected exemption from the following requirement:

Parity in the application of certain limits to mental health benefits. Group health plans (of Employers that employ more than 50 employees) that provide both medical and surgical benefit and Mental Health or substance use disorder benefits must ensure that financial requirements and Treatment limitations applicable to Mental Health or substance use disorder benefits are no more restrictive than the predominant financial requirements and Treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The exemption from this Federal requirement will be in effect for the Plan Year beginning July 01, 2013 and ending June 30, 2014. This election may be renewed for subsequent Plan Years.

HIPAA also requires the Plan to provide Covered Employees and dependents with a “certificate of creditable coverage” when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another Employer’s health plan, or if you wish to purchase individual health insurance policy.

If you have any questions regarding PCEBT’s election to exempt the Trust from the requirements of Mental Health parity, please feel free to contact the County’s Human Resources Office at (520) 866-6231.

If you have questions regarding the certificate of creditable coverage please contact AmeriBen’s Customer Care Department at (877) 955-1548.

SECTION XXIII—PLAN ADOPTION

A. Adoption

Pinal County Employee Benefit Trust, hereby adopts the provisions of this Plan, and its duly authorized officer has executed this Plan Document and summary plan description effective the first day of July 2013.

By: 

Date: 8/15/13

Title: CHAIRMAN

If you have questions about your *Plan* benefits, please contact the *Third Party Administrator* at 1-800-786-7930.



PO Box 7186
Boise ID 83707

