

YUMA AREA BENEFIT CONSORTIUM (YABC)

*MEDICAL PLAN (including Prescription Drugs),
DENTAL AND VISION PLANS
PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION*

Amended, restated and effective July 1, 2005

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INTRODUCTION

What This Document Tells You

This document describes the medical and dental benefits for participants of the Yuma Area Benefit Consortium (herein referred to as the “Consortium”). The plan described in this document is restated and effective as of **July 1, 2005**. Since this document will help you understand the health benefits offered by the Consortium, you should review it and also show it to those members of your family who are or will be covered by the Plan. It will give you an understanding of:

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

Be sure to read the Schedule of Medical Benefits, the Schedule of Dental Benefits, the Exclusions sections and the Definitions section of this document, as they set forth the coverages and limitations of this Plan.

Remember, not every expense you incur for health care is covered by the Plan. Keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find them.

This Plan is not governed by the Employment Retirement Income Security Act of 1974 (ERISA).

The self-funded benefits offered by this Plan do not constitute the act of insurance. The self-funded benefits of this Plan are not guaranteed and may be amended or withdrawn at any time by a participating employer of the Consortium, without the consent of any participant or other party. As the Plan is amended from time to time, the Consortium will alert you with information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Suggestions For Using This Document

This document provides a great deal of detail about your Plan. We suggest that you and your covered family members take the following steps to be familiar with what is included in this document:

1. Read through this **Introduction** and look at the **Table of Contents** that immediately precedes it. The Table of Contents provides you with an outline of the chapters. As you look through the chapters, you will notice that there are examples, charts and tables to help clarify the key provisions and more technical details of the coverages.
2. **The Quick Reference Chart** in the Introduction chapter of this document contains the names, addresses and phone numbers of the key vendors with whom this Plan contracts.
3. **Refer to the Definitions section at the back of the document.** Words that appear throughout the text have specific meanings that are set forth in the Definitions section. You may also encounter technical terms that are also defined in the Definitions section.
4. **Refer to the Schedule of Medical Benefits, the Schedule of Dental Plan Benefits and the Schedule of Vision Plan Benefits** for information regarding your coverage of medical, dental and vision services.
5. **Refer to the Claims Information section** to find out what you must do to file a claim and how to seek review if you are dissatisfied with a claims decision.
6. **Refer to the section on Coordination of Benefits (COB)** for information regarding the handling of situations where you have coverage under more than one group health care plan, Medicare and other government plans, or where you can recover your health care expenses from a third party who wrongfully caused the injury or illness giving rise to those expenses.
7. **If coverage ends for you or a covered spouse or dependent child, see the section on COBRA Continuation of Coverage.** This section explains when your coverage may temporarily be extended or continued.

Your Contributions For Coverage

Your contributions for coverage are commonly based on the type of dependent coverage selected, if any. Contributions are subject to change each Plan year, so you should consult your personnel/payroll department to determine the actual contributions required for the current Plan year.

COBRA General (Initial) Notice

It is the Plan’s intention for the COBRA chapter in this document to serve as the General (Initial) COBRA Notice to you and your covered family members describing your COBRA rights. Look for the COBRA chapter in the Table of Contents and read it carefully. If you have any questions contact the Plan Administrator named in the Quick Reference Chart below.

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

QUICK REFERENCE CHART	
If you need information on:	Contact the following:
Claims Administration <ul style="list-style-type: none"> • Medical claims and appeals • Eligibility and Benefits • COBRA Administration • Certificate of Creditable Coverage 	Professional Benefit Services, Inc. (PBS) 2255 N. 44th St., Suite 250 Phoenix, AZ 85008 1-602-231-8896 or 1-866-365-9198
PPO Network Providers	Arizona Foundation for Medical Care 326 E. Coronado Road Phoenix AZ 85004 1-602-253-5029 or 1-800-624-4277 www.azfmc.org
Utilization Management (UM) <ul style="list-style-type: none"> • Case Management • Precertification and Medical Review • Appeal of a Denied UM request 	American Health Group (AHG) 2152 S. Vineyard Ave, Suite 103 Mesa, AZ 85210 1-602-265-3800 or 1-800-847-7605
Dental Plan Administrator <ul style="list-style-type: none"> • Dental claims and appeals 	Professional Benefit Services, Inc. 2255 N. 44th St., Suite 250 Phoenix, AZ 85008 1-866-365-9198
Prescription Drug Program <ul style="list-style-type: none"> • Retail Pharmacies • Mail Order Service • Specialty Drugs • Appeal of a denied Drug request 	RxAmerica Retail Pharmacy <i>Customer Service:</i> 1-800-770-8014 Mail Order: <i>Customer Service</i> 1 877-889-3402 American Diversified Pharmacy (ADP) P. O. Box 340940 Sacramento ca 95834-0940 Specialty Drugs <i>Customer Service:</i> 1-866-516-7611 www.reamerica.com
Vision Plan Administrator <ul style="list-style-type: none"> • Vision claims and appeals • Vision network providers 	Vision Service Plan (VSP) 3333 Quality Drive Rancho Cordova, CA 95670 1-800-877-7195 www.vsp.com
Employee Assistance Program (EAP) <ul style="list-style-type: none"> • Appeal of a denied EAP request 	CONTACT Behavioral Health 4645 E. Cotton Blvd. Bldg 1, Suite 200 Phoenix, AZ 85040 (800) 309-2242 www.contactbhs.com
Level Two Claim Appeals	Board of Trustees for YABC regarding Claim Appeal c/o PBS 2255 N. 44 th St., Suite 250 Phoenix, AZ 85008 1-602-231-8896 or 1-866-365-9198
COBRA Administrator	Professional Benefit Services, Inc. (PBS) 2255 N. 44th St., Suite 250 Phoenix, AZ 85008 1-602-231-8896 or 1-866-365-9198

QUICK REFERENCE CHART

If you need information on:	Contact the following:
Plan Administrator	Plan Administrator c/o Chief Financial Officer, AZ Western College P. O. Box 929 Yuma, AZ 85366-0929 1-928-344-7515 YABC Website: www.yabc.net
Privacy Officer Security Officer	Arizona Western College Office of Human Resources P. O. Box 929 Yuma, AZ 85366-0929 1-928-344-7505
Privacy Officer Security Officer	Yuma Elementary School District No.1 Payroll Supervisor 450 6 th Street Yuma AZ 85364 1-928-343-0800 x 331
Privacy Officer Security Officer	Crane Elementary School District No. 13 Director, Human Resources 4250 W. 16 th Street Yuma AZ 85364 1-928-373-3420
Privacy Officer Security Officer	City of Yuma Accounting Supervisor One City Plaza Yuma, AZ 85364 1-928-373-5085

ELIGIBILITY

HOW AND WHEN COVERAGE BEGINS, IS MAINTAINED, AND ENDS

WHO IS ELIGIBLE FOR COVERAGE?

Your Eligibility: Employees, and former employees of a participating employer in the Yuma Area Benefit Consortium (called a Retiree), may be eligible for benefit coverage with this Plan as described below:

- **Crane Elementary School District No. 13:** Eligible employees include contracted and non-contracted employees who are full-time and work thirty-seven and one-half (37.5) hours or more per week in a position approved by the Governing Board.
- **Yuma School District No.1:** Contracted and benefited employees are eligible if they work a minimum of twenty-one (21) hours or more per week in a position approved for benefits by the Governing Board. Non-contracted and non-benefited employees are eligible if they work a minimum of twenty (20) hours or more per week in a position approved as benefited by the Governing Board (and make any required contribution for coverage).
- **Arizona Western College:** Contracted employees are eligible if they are full time working a minimum of thirty (30) hours or more per week in a position approved by the Governing Board. Non-contracted employees are eligible if they work a minimum of thirty-seven (37) or more hours per week in a position approved by the Governing Board.
- **City of Yuma:** Employees are eligible if they are working in a position designated by the City as a regular full-time employee. Employees participating in the City's job sharing program are also eligible.

Your Dependents' Eligibility: Your dependents become eligible for benefit coverage with this Plan on the **later** of the day you become eligible for your own benefit coverage **or** the day you acquire an eligible dependent, either by marriage, birth, adoption or placement for adoption, provided that benefit coverage is in effect for you on that day.

Your eligible dependents include your lawful spouse and your dependent child(ren). See the Definitions section of this document for definitions of "dependent child(ren)" and "spouse." **Any person who does not qualify as a dependent child or spouse as those terms are defined by this Plan has no right to any coverage for Plan benefits or services under this Plan.**

Eligible Retirees and When Coverage Begins:

- **For Crane Elementary School District No. 13,** eligible retirees are those former employees who are 50 years or older with at least 15 years of service with Crane or are 55 years or older with at least 10 years of service with Crane. To maintain retiree eligibility, the retiree may provide substitute services to Crane Elementary School District each year, without pay. The number of days required will be calculated on an individual basis. Retiree coverage begins on the first day of the month following the employee's retirement date, as long as the retiree pays any required contribution or begins substitute teaching and retiree pays for his/her dependent's coverage. Coverage is also available to those who do not substitute, at their own expense, less any state retirement subsidy. **Retirees** are eligible until the earlier of age 65 or Medicare eligibility.
- **For Arizona Western College,** eligible retirees are those former employees who are 50 years or older with at least 5 years of service with the college. Retiree coverage begins on the first day of the month following the employee's retirement date, as long as the retiree pays any required contribution. The retiree pays the full cost of retiree coverage (less any State retiree subsidy). **Retirees** are eligible until the earlier of age 65 or Medicare eligibility.
- **For Yuma School District No.1,** eligible retirees are those former employees who are 50 years or older with at least 10 years of service with the District. To maintain retiree eligibility, the retiree is required to perform one day of substitute service with the District each year, with pay. Retiree coverage begins on the first day of the month following the employee's retirement date. The District pays the full cost of retiree coverage (less any State retiree subsidy) and the retiree pays for his/her dependent coverage. **Retirees** are eligible to the end of the Yuma School District No.1 fiscal year ending June 30 in which the retiree attains the earlier of age sixty-five or Medicare eligibility.
- **For the City of Yuma,** eligible retirees are those former City employees with at least 10 years of service with the City and drawing retirement benefits from the Arizona State Retirement System, Public Safety Personnel Retirement System or Elected Officials Retirement System. Retirees pay the full cost of retiree and dependent coverage less any state retirement subsidy. **Retirees** are eligible until the earlier of age 65 or Medicare eligibility.

Individuals who are enrolled under this Plan as retirees must enroll in Medicare Part A and B when eligible and when entitled to Medicare will no longer be eligible for Plan benefits. See the subsection of this chapter titled “Events Causing Coverage to End” and the Definitions chapter for information on Entitled to and Eligible for Medicare.

Employees who are entitled to Medicare are not eligible to enroll or continue to be enrolled in this Plan as retirees.

PROOF OF DEPENDENT STATUS

Specific documentation to substantiate Dependent status will be required by the Plan and may include proof of the same principal place of abode and any of the following:

- **Marriage:** copy of the certified marriage certificate.
- **Birth:** copy of the certified birth certificate.
- **Adoption or placement for adoption:** court order paper signed by the judge.
- **Foster Child:** a copy of the foster child placement papers from a qualified state agency and any proof of any state provided health coverage.
- **Legal Guardianship:** a copy of your court-appointed legal guardianship documents and a copy of the certified birth certificate.
- **Disabled Dependent Child:** Current written statement from the child’s physician indicating the child’s diagnoses that are the basis for the physician’s assessment that the child is currently mentally or physically Handicapped (as that term is defined in this document) and is incapable of self-sustaining employment as a result of that handicap; and dependent chiefly on you and/or your spouse for support and maintenance. The plan may require that you show proof of initial and ongoing disability and that the child meets the Plan’s definition of Dependent Child.
- **Qualified Medical Child Support Order (QMCSO):** Valid QMCSO document or National Medical Support Notice.

ENROLLMENT PROCEDURE

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

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

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

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

Proper enrollment is required for coverage under this Plan. **A person who has not properly enrolled by completing the above noted steps, in a timely manner, has no right to any coverage for Plan benefits or services under this Plan.**

Coverage may be subject to the Pre-Existing Condition limitation as described later in this chapter under the heading Pre-Existing Conditions.

DECLINING MEDICAL COVERAGE

- **Employees may decline** medical expense coverage under this Plan for yourself, your spouse and/or dependent child(ren), but to do so you must submit the completed written portion of the enrollment form that pertains to declining coverage. If you decline coverage because you or any of your eligible dependents have other medical and/or dental coverage, you must complete that portion of the enrollment form related to that other coverage. If, at

a later date, you want the coverage you declined for yourself, your spouse and/or dependent child(ren), you may enroll under the Special or Open Enrollment provisions appearing later in this section.

- **Retirees may decline** coverage upon becoming eligible for retirement or during an Open Enrollment period, but there is no late/subsequent enrollment opportunity for the retiree or their dependents. If you decline coverage for yourself, you will not be allowed to enroll your spouse or dependent children under the coverage you declined. Once a retiree declines (opts-out of) coverage under this Plan, the retiree will not be eligible to re-enroll in a YABC-sponsored program again.
- **Note that no compensation is made to individuals who waive/decline/opt out of benefit coverage.**

INITIAL ENROLLMENT

Enrollment: You must enroll within **30** days of the date on which you become eligible for coverage. If you want dependent coverage, you must enroll your eligible dependents at the same time. Your coverage will be subject to exclusions for any pre-existing condition as described later in this chapter under the heading Pre-existing Conditions.

When Coverage Begins:

- **Crane Elementary School District No. 13:** For contracted and non-contracted employees coverage becomes effective on the first day of the month following your date of employment. When the date of employment is the first day of the month coverage will be effective on the date of full-time employment.
- **Yuma School District No.1:** For contracted employees coverage becomes effective on the first day of the month following the date of employment. For non-benefited employees coverage becomes effective on the first day of the month following ninety (90) days of employment, provided you make any required financial contribution for coverage.
- **Arizona Western College:** For contracted and non-contracted employees, coverage becomes effective on the first day of the month following the date of full-time employment. When the date of employment is the first day of the month coverage will be effective on the date of employment.
- **City of Yuma:** For benefits eligible City employees, coverage becomes effective on the first day of the month following one month of full-time employment. Retiree coverage becomes effective on the first of the month following the employee's retirement from the City.

Coverage of your enrolled spouse and/or dependent child(ren) begins on the date your coverage begins. The coverage provided will be subject to exclusions for any pre-existing condition as described in this section.

Failure To Enroll During Initial Enrollment: CAUTION: If you do not enroll yourself or your eligible dependents within 30 days of the date on which they first become eligible for coverage, unless your eligible dependent(s) qualify for Special Enrollment described in this section, you will have to follow the Subsequent (late) Enrollment procedure and the coverage will be subject to exclusions for any pre-existing condition, as described in this section.

OPEN ENROLLMENT

Open enrollment is the period of time during the spring of each year to be designated by your employer during which eligible employees may make the elections specified below. Enrollment forms may be obtained from your personnel/payroll department.

Elections Available During Open Enrollment: During the open enrollment period, you may elect, for yourself and your eligible dependents to:

1. enroll in the medical, dental and vision coverage offered by the Plan; or
2. add eligible dependents to the medical, dental and vision coverage; or
3. discontinue medical, dental and vision coverage for yourself and/or any of your eligible dependents.

Restrictions on Elections During Open Enrollment: No dependent may be covered unless you are covered. All relevant parts of the enrollment form must be completed and the form must be submitted before the end of the Open Enrollment period.

Start of or Changes to Coverage Following Open Enrollment: If you or your spouse or dependent child(ren) are enrolled for the **first** time during an Open Enrollment period, that person's coverage will begin on the first day of the Plan year following the Open Enrollment period. All other changes in or discontinuance of coverage will become effective on the first day of the Plan year following the Open Enrollment period.

Failure to Make a New Election During Open Enrollment: If you have been enrolled for coverage and you fail to make a new election during the Open Enrollment period, you will be considered to have made an election to retain the

same medical, dental and vision coverage you had during the preceding Plan year. However, you will not have any part of your pay reduced to cover your contribution toward the cost of coverage and/or to be allocated to the Plan's flexible spending account for a Plan year unless you affirmatively elect to do so for that Plan year, even if that was part of your medical coverage for the previous year.

Failure to Enroll During Open Enrollment (Very Important Information): If you fail to enroll yourself and/or any of your eligible dependents within 30 days after the date on which you or they become eligible for Open Enrollment, unless your eligible dependents qualify for the Special Enrollment described in this section of this document, you will have to follow the Subsequent Late Enrollment procedure described in the this section, and the coverage provided may be subject to an 18-month exclusion for any pre-existing condition as described later in this section under the heading Pre-Existing Conditions.

SPECIAL ENROLLMENT

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

1. **If you are enrolled for individual coverage** and if you acquire a spouse by marriage, or if you acquire any dependent children by birth, adoption or placement for adoption, you may request enrollment for your newly acquired spouse and/or dependent child(ren) and any other eligible dependents, within 30 days after the date of marriage, birth, adoption or placement for adoption.
2. **If you are not enrolled for individual coverage** and if you acquire a spouse by marriage, or if you acquire any dependent children by birth, adoption or placement for adoption, you may request enrollment for yourself and your newly acquired spouse and/or dependent child(ren) and any other eligible dependents within 30 days after the date of marriage, birth, adoption or placement for adoption.
3. **If you did not enroll your spouse for coverage** within 30 days of the date on which he or she became eligible for coverage, and if you subsequently acquire a dependent child by birth, adoption or placement for adoption, you may request enrollment for your spouse together with your newly acquired dependent child, and any other eligible dependents, within 30 days after the date of your newly acquired dependent child's birth, adoption, or placement for adoption.
4. Except with respect to special enrollment for newborn or newly adopted dependent children, the coverage provided will be subject to exclusions for pre-existing conditions as described in this section. To request Special Enrollment follow the procedures described under the section titled "Enrollment Procedure" earlier in this chapter.

B. Loss of Other Coverage: When You, Your Spouse Or Dependent Child(ren) Lose Other Coverage (Special Enrollment Opportunity)

1. If you did not request enrollment under this Plan for yourself, your Spouse and/or any Dependent Child(ren) within 30 days after the date on which coverage under the Plan was previously offered because you or they had health care coverage under any other health insurance policy or program or employer plan including COBRA continuation coverage, individual insurance, Medicare, Medicaid, or other public program; and
2. If your spouse and/or any dependent child(ren) cease to be covered by that other health insurance policy or plan, you may enroll that spouse and/or dependent child(ren) within 30 days after the termination of their coverage under that other health insurance policy or plan, either as a result of:
 - of loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause); or
 - of termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
 - the health insurance was provided under COBRA Continuation Coverage, and the COBRA coverage was "exhausted" or
 - of moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
 - of the other plan ceases to offer coverage to a group of similarly situated individuals; or
 - of the loss of dependent status under the other plan's terms; or
 - of the termination of a benefit package option under the other plan, unless substitute coverage offered; or
 - of the loss of eligibility due to reaching the lifetime benefit maximum on all benefits under the other plan. For Special Enrollment that arises from reaching a lifetime benefit maximum on all benefits, an individual will be allowed to request Special Enrollment in this Plan within 30 days after a claim is denied due to the operation of a lifetime limit on all benefits.

NOTE: However, you may not avail yourself of this opportunity for special enrollment unless, unless when coverage under this Plan was previously offered, you indicated in writing that the reason you, your spouse and/or your dependent child(ren) were not enrolled was because they had coverage under another health insurance policy or plan.

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

Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options (when such options exist) at the same costs and the same enrollment requirements, including any pre-existing condition limitations the Plan may require, as are available to similarly-situated employees at Initial Enrollment.

Failure To Enroll During Special Enrollment: If you fail to enroll any of your eligible dependents within 30 days of the date on which they first become eligible for Special Enrollment, you will have to follow the Subsequent (Late) Enrollment procedure described in this section, and their coverage will be subject to exclusions for any pre-existing condition as described in this section.

NEWBORN DEPENDENT CHILDREN (*Special Rule for Coverage*)

Your newborn dependent child(ren) will be covered from the date of birth, only if you properly enroll the newborn dependent child within 30 days of the child’s date of birth by following the enrollment procedure listed earlier in this chapter.

ADOPTED DEPENDENT CHILDREN (*Special Rule for Coverage*)

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

- **A Newborn Child who is Placed for Adoption** with you within 30 days after the child was born will be covered from birth if you comply with the Plan’s requirements for obtaining coverage for a Newborn Dependent Child, described above in this chapter.
- **A Dependent Child adopted more than 30 days after the child’s date of birth** will be covered from the date that child is adopted or “Placed for Adoption” with you, whichever is earlier, if you submit a completed written enrollment form to the District **and** provide proof of Dependent status **and** pay any required contribution for that Dependent Child’s coverage, within 30 days of the child’s adoption or placement for adoption.
- If the adopted Dependent child is not properly enrolled in a timely manner, you must wait until the next Open Enrollment period, if applicable.

However, if a child is Placed for Adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child. Remember that you may not enroll an adopted Child or a Child Placed for Adoption for coverage unless you, the employee, are also enrolled for coverage. See also the Special Enrollment provisions in this chapter.

SUBSEQUENT (LATE) ENROLLMENT (For Your Eligible Dependents)

Late enrollment means enrollment of an individual in this Plan other than at the Initial Enrollment period (the earliest date on which coverage can become effective under this Plan) or Special Enrollment.

If your eligible dependents are **not** entitled to Special Enrollment as provided in this section, you must wait and enroll them during the once a year Open Enrollment period. Enrollment should be coordinated through the personnel/payroll department of your employer. Coverage of your enrolled spouse and/or dependent child(ren) related to this subsequent (late) enrollment begins on the first day of the month of July. **However, coverage provided will be subject to an 18-month exclusion for any pre-existing condition.** See also, the special rules for coverage of newborn and adopted dependent children in this section.

PRE-EXISTING CONDITIONS (*Special Rule for Coverage*)

Definition Of “Pre-Existing Condition”: A “pre-existing condition” is any illness or injury (whether physical or mental) regardless of its cause, for which medical advice, diagnosis, care, or treatment was recommended or received within the three (3) month period ending on the enrollment date. Treatment includes an individual taking a prescribed drug within the 3-month period.

When a Pre-existing Condition Limitation Does NOT apply: However, genetic information (in the absence of a diagnosis of a resulting condition) including family history and the results of genetic testing, and pregnancy are not Pre-Existing Conditions for the purposes of this Plan. Pre-existing condition limitations are not applied to the following Plan benefits: outpatient retail or mail order prescription drug benefits, the dental plan and the vision plan. No exclusion of a Pre-Existing Condition may apply with respect to any condition of a newborn child who is enrolled for creditable coverage (as defined below) under this Plan within 30 days of birth, or an adopted child who was enrolled within 30 days of adoption or placement for adoption.

“Enrollment Date,” as it pertains to pre-existing conditions, means the earlier of the first day of coverage or the first day of the “waiting period” (defined below) for that coverage. It is the date that will be used to measure the 3-month period prior during which medical advice, diagnosis, care, or treatment for a Pre-Existing Condition was recommended or received (also called the look-back period), and to measure the 12 or 18-month period during which the Plan may exclude coverage of expenses related to a Pre-Existing Condition.

- With respect to **Initial Enrollment**, the Enrollment Date is the first day of the waiting period for coverage when you are in a benefits-eligible position.
- With respect to **Special Enrollment**, the Enrollment Date is the date on which the Plan receives the request for Special enrollment.
- With respect to any **person newly enrolled during an Open Enrollment**, the Enrollment Date is the first day of the Open Enrollment period.
- With respect to **Late Enrollment** other than during an Open Enrollment, the Enrollment Date is the Plan receives the completed written enrollment form.

A **“Waiting Period”** is the period that must pass before coverage for an employee or dependent otherwise eligible to enroll under the terms of the Plan can become effective.

Maximum Period Of Exclusion Of Coverage For Pre-Existing Conditions After Initial, Open, Special Or Subsequent (Late) Enrollment:

- If, after you or your eligible dependents have completed an Initial, Open, or Special Enrollment, the Plan Administrator or its designee determines that you or any of your covered dependents has a pre-existing condition, no expenses related to that pre-existing condition will be covered before the earliest of **twelve (12) consecutive months**.
- For subsequent (late) enrollment applicants, the period during which the Plan will exclude coverage of expenses related to a pre-existing condition is **eighteen (18) consecutive months**.

Credit For Previous Coverage: This Plan may require you to submit evidence of the period of creditable coverage (often called a Certificate of Creditable Coverage) under any other health care plan or insurance policy in order to prove that you are entitled to credit for the time you were covered under that plan or policy that will reduce the maximum period of exclusion of coverage for this Plan’s pre-existing conditions and that there has been no break in coverage.

A “break in coverage” means a period of 63 consecutive days or more between the date coverage ended under any other health care plan or insurance policy as described below and the date enrollment for coverage under this Plan is received by the Plan. Your previous employer, insurer or plan will be required by law to provide such certification to you on request.

- If there HAS been a break in coverage, **no credit will be provided for any periods of coverage prior to the break in coverage**. A leave of absence under the provisions of the Family and Medical Leave Act or the Uniformed Service Employment and Reemployment Act will **not** be counted as a break in coverage.
- **If there has been NO break in coverage**, the maximum period of exclusion of coverage for pre-existing conditions described in the paragraphs above will be reduced by the period of time that your spouse and/or any of your dependent children were covered under any creditable coverage.

“Creditable coverage” includes most types of health insurance such as COBRA or any group health plan or insurance policy (whether or not it is employer-sponsored), any individual health insurance policy or program, Medicare, Medicaid, military-sponsored health care, program of the Indian Health Service, state health benefits risk pool, State Children’s Health Insurance Program (SCHIP), foreign plans and US government plan, the federal employees health benefit program, a public health plan, and/or any health benefit plan provided under the Peace Corps.

WHEN YOU AND ANY OF YOUR DEPENDENTS BOTH WORK FOR AN EMPLOYER WITHIN THE CONSORTIUM

(Special Rule for Enrollment)

1. No individual may be covered under this Plan both as an employee and as a dependent, nor may any dependent child be covered as the dependent of more than one employee.
2. **If both you and your spouse are eligible employees of a participating employer in the Consortium:**
 - Each of you may be designated as the eligible employee who can file his or her own medical coverage choices. However, only one of you may elect dependent coverage, in order for your dependent children to be covered.
 - The Plan's out of pocket maximum limits and family deductibles will be combined, if the Plan is informed that the employee who did not elect dependent coverage is your spouse.

If either employee's employment terminates or if there is a reduction in hours that would ordinarily result in a termination of coverage, the employee whose coverage would be terminated will immediately be deemed to be covered as a spouse of the employee whose coverage has not terminated, and any dependent children covered by the employee whose coverage would be terminated will immediately be deemed to be covered as dependent children of the employee whose coverage has not terminated. Contributions for family coverage will be deducted from the pay of the employee-spouse who is now considered the eligible employee. As a result, neither employee will sustain a loss of coverage as a result of termination of employment or reduction in hours.

If, in the judgment of the Plan administrator or its designee, because of the change in the family's circumstances as a result of the termination of employment or reduction in hours, the employee-spouse who is then deemed to be the eligible employee will have the option to terminate the coverage of the spouse or any dependent child or otherwise elect alternative coverage available under the plan for the family members.

3. If, at any time, any of your dependent children become an employee of a participating employer of the Consortium and are now eligible for coverage as an employee, that child will cease to be a dependent child and may enroll for coverage as an employee, in which case coverage as a dependent child will terminate on the date coverage as an employee begins.

If the employee-child terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, and still qualifies as a dependent child, the employee-child will immediately be deemed to be covered as a dependent child of the employee-parent. As a result, the employee-child will not sustain a loss of coverage because of termination of employment or reduction in hours. Contributions for dependent coverage will be deducted from the pay of the employee-parent and will be adjusted as may be required when a dependent child becomes an employee and ceases to have coverage as a dependent child, or when the employee-child ceased to be an employee and resumes coverage as a dependent child.

EVENTS CAUSING COVERAGE TO END (TERMINATION PROVISIONS)

Employee coverage ends on the earliest of the last day of the month in which:

1. Your employment ends; or
2. Your contract ends; or
3. You are no longer eligible to participate in the Plan; or
4. You reach your lifetime maximum; or
5. You cease to make any contributions required for your coverage.

Coverage of an employee or retiree's covered Dependents ends on the earliest of the last day of the month in which:

1. Employee or retiree coverage ends (except for Yuma #1 as noted below); or
2. The employee or retiree's covered spouse or dependent child(ren) no longer meet the definition of spouse or dependent child(ren); or
3. The expiration of the period of coverage stated in a QMCSO; or
4. You cease to make any contributions required for dependent coverage; or
5. The dependent reaches their lifetime maximum.

Retiree coverage ends on the earliest of the last day of the month in which the retiree:

1. is no longer eligible to participate in the Plan (such as if the retiree fails to maintain their eligibility for retiree coverage by completing any required substitute services as outlined in this Eligibility chapter or the retiree dies); or
2. becomes entitled to Medicare Part A or B; or

3. reaches their lifetime maximum; or
4. fails to make any contributions required for coverage; or
5. meets any provision set forth in each District's or the City's personnel policies related to termination of retiree health coverage; or
6. for the City of Yuma, the retiree reaches age 65.

Retiree Termination Provisions For Yuma #1: Retiree coverage ends at the end of the month for the retiree termination provisions noted above or the end of the Plan year in which the retiree turns age 65, whichever is earlier. The spouse of a retiree who turns age 65 is covered to the end of the month in which the retiree loses coverage under the retiree termination provisions noted above or the spouse turns age 65, whichever is earlier. A dependent child of a retiree is covered to the end of the month in which the dependent meets the dependent termination provision noted above or the end of the Plan year in which the retiree turns age 65, whichever is earlier.

CERTIFICATE OF CREDITABLE COVERAGE

When your coverage ends, you and/or your covered Dependents are entitled by law to and will automatically be provided (free of charge) with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. Such a certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your covered Dependent(s) has ended. You can present this certificate to your new employer/health plan to offset a pre-existing condition limitation that may apply under that new plan or use this certificate when obtaining an individual health insurance policy to offset a similar limitation.

Procedure for Requesting and Receiving a Certificate of Creditable Coverage: A certificate will be provided upon receipt of a written request for such a certificate that is received by the Plan's Claims Administrator within two years after the date coverage ended under this Plan. The written request must be mailed to the Claims Administrator and should include the names of the individuals for whom a certificate is requested (including spouse and dependent children) and the address where the certificate should be mailed. The address of the Claims Administrator is on the Quick Reference Chart in the front of this document. A copy of the certificate will be mailed to the address indicated. See the COBRA chapter for an explanation of when and how certificates of coverage will be provided after COBRA coverage ends.

NOTICE REQUIRED TO THE PLAN

You, your spouse, or any of your dependent child(ren) must notify the Plan no later than 60 days after the date of:

1. a Spouse ceases to meet the Plan's definition of a Spouse such as with a divorce;
2. a dependent child reaches the Plan's limiting age, which is age 25; or ceases to meet the Plan's definition of a dependent;
3. the existence of any physical or mental handicap of a dependent child or ceases to have any physical or mental handicap;

Failure to give such a notice in a timely manner may cause the loss of rights to obtain COBRA coverage. See the Other Information section in this document for information regarding other notices you must furnish to the Plan.

WHEN THE PLAN CAN END YOUR COVERAGE FOR CAUSE

The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered dependents for cause 30 days after it gives you written notice of its finding that:

1. you or your covered dependent made a fraudulent statement, a material misrepresentation, or omitted material information in any enrollment, claim or other form in order to obtain coverage, services or benefits under the Plan; or
2. you or your covered dependent allowed anyone else to use the identification card that entitles you or your covered dependent to coverage, services or benefits under the Plan; or
3. you or your covered dependent altered any prescription furnished by a physician; or
4. the Plan administrator or its designee determined that your conduct or the conduct of your covered dependent was abusive, obstructive, or otherwise detrimental to the participating physician network.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

If a court has issued an order with respect to the provision of health care coverage for any of the employee's dependent children, the Plan administrator or its designee will determine if the court order is a Qualified Medical Child Support

Order (QMCSO) as defined by federal law, and that determination will be binding on the employee. An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an employee who is not covered by the Plan to provide coverage for a dependent child, except as required by a state's Medicaid-related child support laws.

If an order is determined to be a QMCSO and if the employee is covered by the Plan, the Plan Administrator or its designee will so notify the parents and each child and advise them of the Plan's procedures that must be followed to provide coverage of the dependent child(ren). However, no coverage will be provided for any dependent child under a QMCSO unless the applicable employee contributions for that dependent child's coverage are paid, and all of the Plan's requirements for coverage of that dependent child have been satisfied.

For additional information regarding QMCSOs and the procedures for payment of claims under them, see the Claims Information section of this document.

CHANGING YOUR COVERAGE DURING THE YEAR (Mid-Year Change of Status)

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

- 1) **Change in legal marital status**, including marriage, divorce, legal separation (where permissible by state family law), annulment or death of a Spouse.
- 2) **Change in number of Dependents**, including birth, adoption, placement for adoption, or death of a Dependent Child.
- 3) **Change in employment status or work schedule**, including the start or termination of employment by you, your Spouse or any Dependent Child, a strike or lockout, **or** the start of or return from an unpaid leave of absence. In addition, any change in the employment status of you, your spouse, or your Dependent that results in that individual losing or gaining eligibility under this Plan will constitute a change in status affecting your benefit needs.
- 4) **Change in Dependent status under the terms of this Plan**, including becoming or ceasing to be a "dependent" as that term is defined in the Definitions chapter of this document.
- 5) **Change of residence or worksite** that impairs the ability of you, your Spouse or any Dependent Child to access the services of In-Network Health Care Providers.
- 6) **Change required under the terms of a Qualified Medical Child Support Order (QMCSO)**, including a change to add coverage for the child, to provide the coverage specified in the order, or to cancel coverage for the child if the order requires your former spouse to provide coverage for the child.
- 7) **Change consistent with your right to Special Enrollment** as described in the section dealing with Loss of Coverage under Special Enrollment in the Eligibility chapter.
- 8) **Cancellation of your coverage or coverage of your Spouse or any Dependent Child who becomes entitled to coverage under Medicaid or Medicare** (except for coverage solely under the program for distribution of pediatric vaccines).
- 9) **Change in cost**
 - a) **Automatic changes for cost.** If the cost of this Plan increases or decreases during a Plan year and under the terms of the Plan you are required to make a corresponding change in your payments, the Plan may on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in your elective contributions for the Plan.
 - b) **Significant changes in cost.** If the cost of a benefit package option significantly increases during a Plan Year, you may either make a corresponding prospective increase in your payments, or revoke your elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option providing similar coverage.
- 10) **Significant changes in coverage.**
 - a) **Significant curtailment.** If the coverage under the Plan is significantly curtailed or ceases during a Plan Year, you may revoke your elections under the Plan. In that case, you may make a new election on a prospective basis for coverage under another benefit package providing similar coverage. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to participants under the Plan so as to constitute reduced coverage to participants generally.

- b) **Addition or elimination of a benefit package option providing similar coverage.** If during a Plan Year the Plan adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option) you may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.

11) **Changes in Spouse's, Former Spouse's or Dependent child's coverage.** You may make a change in coverage if it is on account of and corresponds with a change made under a plan of Your Spouse, Former Spouse or Dependent Child for one of the following reasons:

- a) If the change is permitted under federal cafeteria plan regulations; or
b) If the plan of the Spouse, Former Spouse, or Dependent child's employer permits participants to make an election for a period of coverage that is different from the Plan Year under this Plan.

These rules apply to making changes to your benefit coverage(s) during the year:

1. Any change you make to your benefits must be determined by the Plan Administrator or its designee to be necessary, appropriate to and consistent with the change in status; and
2. You must notify the Plan in writing within 31 days of the qualifying change in status, otherwise, the request will not be considered to be made on account of your change of status and you will have to wait until the next Open Enrollment period to make your changes in coverage; **and**
3. If benefits are not pre-tax you may drop coverage at any time; however you may not re-enroll unless eligible at Open Enrollment or Special Enrollment times and any pre-existing limitation conditions not yet completed will continue to apply.
4. If you have a qualifying change in status, you are only allowed to make changes to your coverage that are consistent with the change of status event. Generally only coverage for the individual who has lost eligibility as a result of a change of status (or who has gained eligibility elsewhere and actually enrolled for that coverage) can be dropped mid-year from this Plan; and
5. Coverage changes associated with a mid-year qualifying change of status opportunity are effective the first day of the month following the qualifying change provided you submit a completed written change form to your personnel/payroll department, except for:
 - Newborns, who are effective on the date of birth;
 - Children adopted or placed for adoption, who are effective on the date of adoption/ placement for adoption and
 - New spouse, who is effective on the date of marriage.

FAMILY AND MEDICAL LEAVE (FMLA)

If you have worked for your employer for at least twelve months and a minimum of 1,250 hours within the last 12 months of employment, you are entitled by law to up to 12 weeks each year of unpaid family or medical leave for specified family or medical purposes, such as the birth or adoption of a child, or to provide care of a spouse, child or parent who is seriously ill, or for your own serious illness. For the calculation of the 12-month period used to determine employee eligibility for FMLA, Arizona Western College, City of Yuma and Crane Elementary use a rolling 12-month period measured backward in time from the date the employee uses any FMLA leave while Yuma School District #1 uses a fiscal year.

While you are officially on such a family or medical leave, your employer is required to continue the employer contribution toward employee coverage. You can keep your dependent benefit coverage in effect during that family or medical leave period by continuing to pay your contributions during that period. Since you may not be paid while you are on a family or medical leave, you may pay your dependent contributions as they come due on the dates you would have paid had you not taken family or medical leave, in which case your contributions will be made on an after-tax basis.

Whether or not you keep your dependent coverage while you are on family or medical leave, if you return to work promptly at the end of that leave, your dependent benefit coverage will be reinstated without any additional limits or restrictions imposed on account of your leave. Any changes in the Plan's terms, rules or practices that went into effect while you were away on that leave will apply to you and your dependents in the same way they apply to all other employees and their dependents. For additional questions on FMLA and benefits contact your personnel/payroll department.

LEAVE FOR MILITARY SERVICE

If you go into active military service for up to 31 days, you can continue your medical and dental coverage during that leave period if you continue to pay your contributions for that coverage during the period of that leave.

If you go into active military service for more than 31 days, you should receive military health care coverage at no cost; however, you may also continue this group health plan coverage under the provisions of USERRA, at your own expense, as follows:

- If you elect USERRA continuation coverage **before** December 10, 2004 the maximum period for this coverage is up to 18 months.
- If you elect USERRA continuation coverage **on or after** December 10, 2004 the maximum period for this coverage is up to 24 months.

When your coverage under this Plan terminates because of your reduction in hours due to your military service, you and your eligible dependents may also have COBRA rights. See also the COBRA chapter of this document. Questions regarding your entitlement to this leave and to the continuation of benefit coverage should be referred to your personnel/payroll department.

REINSTATEMENT OF COVERAGE AFTER LEAVES OF ABSENCE

If your coverage ends while you are on an approved **leave of absence other than family, medical, or military leave**, your coverage will be reinstated on the first day of the month following your return to active service if you return immediately after your leave of absence ends, subject to any applicable exclusions or limitations for pre-existing conditions as well as all accumulated overall and annual maximum plan benefits that were incurred prior to the leave of absence. If your coverage ends while you are on an approved leave of absence other than family, medical, or military leave and is not reinstated within 62 days, the period of leave will be counted as a break in coverage as defined in this section.

If your coverage ends while you are on an approved **leave of absence for family, medical or military leave**, your coverage will be reinstated on the day you return to active service if you return immediately after your leave of absence ends, subject to any limitations for pre-existing conditions that existed before the start of the leave of absence, and subject to all accumulated overall and annual maximum benefits that were incurred prior to the leave of absence.

Any period related to any approved leave of absence including a leave of absence under the provisions of the Family and Medical Leave Act or the Uniformed Service Employment and Reemployment Rights Act will **not** be counted as a break in coverage. Questions regarding your entitlement to such a leave and to the continuation of benefit coverage should be referred to your personnel/payroll department.

This Plan does allow an employee on an approved leave of absence to continue group medical coverage as long as with any applicable contributions toward that coverage are paid.

NOTE: There is **no extension of medical benefit provisions under this Plan** other than the COBRA benefit described in the COBRA Continuation of Coverage section of this document.

MEDICAL EXPENSE COVERAGE

ELIGIBLE MEDICAL EXPENSES

You are covered for expenses you incur for most, but not all, medical services and supplies that are determined by the Plan administrator or its designee to be “**medically necessary,**” but only to the extent that the Plan administrator or its designee determines that the charges for them are “**usual and customary.**” See the Definitions section for a definition of “medical necessity” and “usual and customary.” This section explains which expenses for medical services and supplies are covered (that is, are eligible medical expenses) and which are not. **Generally, the Plan will not reimburse you for all eligible medical expenses.** Usually, you will have to satisfy some **deductibles**, pay some **coinsurance**, or make some **copayments** toward the amounts you incur that are eligible medical expenses.

EXPENSES THAT ARE NOT ELIGIBLE MEDICAL EXPENSES

The Plan will not reimburse you for any expenses that are not eligible medical expenses. That means you are responsible for paying the full cost of all expenses that are not covered by the Plan, as well as any charges for eligible medical expenses that exceed the amount determined by the Plan to be usual and customary.

SERVICES OF NETWORK (PPO) HEALTH CARE PROVIDERS

If you receive medical services or supplies from a health care provider that is a member of the Plan’s PPO, you will be responsible for paying less money out of your pocket. While you must meet an annual deductible this will be less than if you used a non-PPO provider. For some PPO services you will only have to pay a small copay. The coinsurance you pay when you use a PPO provider is less than if you use a non-PPO provider. The PPO health care providers have agreed to provide services to plan participants at a discount. After you pay your copay or coinsurance, PPO providers will accept the Plan’s payment as “payment in full” and will not bill you for any difference between the amount allowed by the Plan and their billed charges. **See also the Preferred Provider Organization subsection in the Medical Network and Utilization Management section of this document.**

OVERVIEW OF THE DEDUCTIBLE, COINSURANCE, COPAYMENT, OUT-OF-POCKET MAXIMUM, AND LIFETIME MAXIMUMS				
Annual Deductible	Coinsurance	Copayment	Annual Out-of-Pocket Maximum	General Overall (Lifetime) Maximum Plan Benefit
What you must pay each Plan year before the Plan pays benefits.	How you and the Plan will split the cost of covered expenses.	A set dollar amount you pay for certain services while the Plan may pay the rest or most of the rest of the cost of that service.	The amount you are responsible to pay each Plan year, in addition to the deductible, before the Plan pays 100% of your covered expenses.	The most this Plan will pay for all covered expenses for one person.
In-Network: \$250 individual \$500 family Out of Network: \$400 individual \$800 family	In-Network: Plan: 85% You: 15% Out of Network: Plan: 60% You: 40%	See the Schedule of Medical Benefits for copayment amounts.	In-Network: \$1,500/person Out of Network: \$3,000/person	\$1 million per eligible plan participant.

All annual deductibles and annual maximum Plan benefits are determined during the Plan year beginning July 1 and ending June 30.

DEDUCTIBLES

For the use of in-network and out-of-network services, each year you are responsible for paying all of your eligible medical expenses until you satisfy the annual **Plan year** deductible. Then, the Plan begins to pay benefits. There are two types of deductibles: Individual and Family. **NOTE:** These deductibles are NOT interchangeable, thus you may not use any portion of an in-network deductible to meet an out-of-network deductible and vice versa.

1. The individual deductible is the maximum amount one covered person has to pay before Plan benefits begin. **The Plan’s individual deductible is \$250 in-network and \$400 out-of-network.**
2. The family deductible is the maximum amount that a family of two or more is responsible for paying before Plan benefits begin. **The Plan’s family deductible is \$500 in-network and \$800 out-of-network, but at least one family member must incur the individual deductible.**

Common Accident Deductible: When 2 or more covered persons in a family are injured in the same accident, only one deductible must be met before the Plan will consider benefits for expenses as a result of the accident.

COINSURANCE

Once you have met your annual deductible, the Plan generally pays a percentage of the eligible medical expenses and you are responsible for paying the rest. The part you pay is called the coinsurance.

1. **Coinsurance When You Use The Plan's PPO:** If you use the services of a health care provider who is a member of the Plan's PPO, you may have a reduced coinsurance or just a copay for those expenses. Refer to the Schedule of Medical Benefits for a more detailed explanation of financial responsibility by type of service.
2. **Coinsurance When You Don't Comply With The Utilization Management Programs:** If you fail to follow certain of the Plan's Utilization Management programs, the Plan may pay a smaller percentage of the cost of those services, and you will have to pay a greater percentage of those costs, or a larger coinsurance. These features are described in the Medical Networks and Utilization Management section of this document.

COPAYMENT

A copayment (copay) is a set dollar amount you are responsible for paying when you incur an eligible medical expense. When copayments apply, there are no deductibles or coinsurance unless the Plan specifically provides otherwise. The copayments applicable to this Plan are listed in the Schedule of Medical Benefits.

OUT-OF-POCKET EXPENSES

Out-of-pocket expenses are the expenses for medical services and supplies that you are responsible for paying yourself. **Each Plan year**, after an individual incurs a maximum out-of-pocket cost of \$1,500 for in-network services or \$3,000 for out of network services, no further coinsurance will apply to covered eligible medical expenses. As a result, the Plan will pay 100% of all covered eligible medical expenses that are incurred during the remainder of the Plan year after the out-of-pocket maximum has been reached. Under the Plan, the following expenses are **not** applicable to the out-of-pocket maximum, and each year you will be responsible for paying them out of your own pocket:

1. Your individual or family deductible.
2. Any applicable copayment.
3. All expenses for medical services or supplies that are not covered by the Plan.
4. All charges in excess of the usual and customary charge determined by the Plan.
5. All charges in excess of the Plan's general overall, limited overall and/or annual maximum benefits, or in excess of any other limitation of the Plan.
6. Any additional coinsurance applicable because you failed to comply with the Utilization Management programs set forth in the Medical Network and Utilization Management section of this document.
7. Expenses for Behavioral health and outpatient prescription drugs.

MAXIMUM PLAN BENEFITS

General Overall (Lifetime) Maximum Plan Benefit: The general overall (lifetime) maximum plan benefit payable for all medical expenses incurred by any individual covered under this Plan and any previous medical expense plan provided to that individual by a participating employer of the Consortium is \$1 million for you and \$1 million for each of your covered dependents.

Limited Overall Maximum Plan Benefits: Some medical benefits have a limited overall maximum on the type of service payable within a lifetime, such as with hospice. Please refer to the Schedule of Medical Benefits for a more detailed description.

Annual Maximum Plan Benefits: Plan benefits for certain medical expenses are subject to annual maximums (e.g., dollar and/or visits) per covered person or family during each Plan year, such as with spinal manipulation services. Please refer to the Schedule of Medical Benefits for a more detailed description.

SCHEDULE OF MEDICAL BENEFITS

A chart outlining a description of the Plan's medical benefits and explanations of them appears on the following pages. The chart is arranged listing hospital services first, followed by physician and other practitioner's services, and then all other service types are listed **alphabetically**.

SCHEDULE OF MEDICAL BENEFITS

See also, the Exclusions and Definitions sections of this document for important information. This chart notes what this Plan pays. In-network deductibles may not be used to meet any out-of-network deductibles and vice versa. The allowable coinsurance on out-of-network benefits is based on usual and customary charges.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Hospital Services (Inpatient)</u></p> <ul style="list-style-type: none"> • Room & board in semiprivate room with general nursing services. • Specialty care units (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related medically necessary ancillary services (e.g., prescriptions, supplies). • Newborn care. • Circumcision for newborn males ages birth to 10 weeks of age. • Hospitalization for dental services is covered only if the Plan administrator or its designee determines it to be medically necessary to safeguard the health of the patient. 	<ul style="list-style-type: none"> • Elective hospitalization is subject to precertification. All hospitalization is subject to concurrent review. See the Medical Network and Utilization Management section for details. • Private room is covered only if medically necessary. • Charges for a newborn will be considered part of and payable under the mother's delivery admission charges until the mother is discharged. If the newborn cannot be discharged with the mother and needs continued confinement, the newborn's charges from the date of birth will be considered as separate from the mother. See the Eligibility chapter for guidelines on what must occur in order to enroll a newborn under this Plan. 	<p>85% after Deductible is met</p>	<p>60% after Deductible is met</p>
<p><u>Physician & Other Health Care Practitioner Services</u></p> <ul style="list-style-type: none"> • Office visits. • Hospital, emergency room, and other health care facility visits of physicians and other covered health care practitioners. • Surgeon fees. • Assistant surgeon (only if medically necessary). • Anesthesia fees from physicians and Certified Registered Nurse Anesthetists (CRNA). • Pathologist fees, Radiologist fees. • Physician assistant, nurse practitioner and nurse midwife fees. 	<ul style="list-style-type: none"> • Services by a physician assistant, nurse practitioner and/or nurse midwife are covered if they are medically necessary and provided under the supervision of a physician. • Some physician services are subject to precertification. See the Medical Network and Utilization Management section for details. • The Plan administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of "surgery" in the Definitions section. • Assistant surgeon fees will be reimbursed for services provided by a physician only to a maximum of 20% of the eligible expenses payable to the primary surgeon. • Lab tests obtained and performed within the physician's office are payable under the office visit copay if an office visit occurs on the same date of service. All other lab services subject to coinsurance. • The coinsurance for "All other fees" applies to professional fees performed in a non-office setting such as surgeon's fees, anesthesia, assistant surgeon, pathologist/radiologist interpretation fees, etc. 	<p>If the place of service is the Physician office, charges are not subject to the Deductible and the Plan pays 100% after a \$20 copay for the office visit code and all other services performed are paid at 85%.</p> <p>All other fees: 85% after Deductible is met</p>	<p>Office Visit: 60% after Deductible is met</p> <p>Anesthesia fees: 85% after Deductible is met</p> <p>All other fees: 60% after Deductible is met</p>

SCHEDULE OF MEDICAL BENEFITS

See also, the Exclusions and Definitions sections of this document for important information. This chart notes what this Plan pays. In-network deductibles may not be used to meet any out-of-network deductibles and vice versa. The allowable coinsurance on out-of-network benefits is based on usual and customary charges.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Allergy Services</u></p> <ul style="list-style-type: none"> Allergy sensitivity testing, including skin patch or Rast/Mast blood tests. Desensitization and hyposensitization (allergy shots given at periodic intervals). 	<ul style="list-style-type: none"> Covered only when ordered by a physician. Desensitization injections are covered only when provided by a licensed health care practitioner. 	<p>Testing: 100% after a \$20 copay, (not subject to the Deductible)</p> <p>Desensitization Injections: 100% (not subject to the Deductible)</p>	<p>Testing: 60% after Deductible is met</p> <p>Desensitization Injections: 60% after Deductible is met</p>
<p><u>Behavioral Health Services</u> (Mental Health and Substance Abuse Treatment)</p> <ul style="list-style-type: none"> EAP program: <ul style="list-style-type: none"> For all participating employers except the City of Yuma, up to 3 free counseling sessions/person/year. For the City of Yuma, up to 10 free counseling sessions/year. Outpatient: Up to 25 visits/person/year. Inpatient: Up to 30 days confinement/person/year. 	<ul style="list-style-type: none"> The Employee Assistance Program (EAP) provides free confidential counseling sessions per person per year for you and your eligible dependents. Refer to the Quick Reference Chart in the front of this document for the EAP telephone number. See the specific exclusions related to behavioral health services, including mental retardation and learning disability in the Exclusions section. Benefits are payable only for services of behavioral health practitioners listed in the Definitions section. Psychological (psychiatric) testing is not payable under this Plan. Coverage for substance abuse treatment is limited to 2 programs of outpatient care per person per lifetime. The program must be completed before Plan benefits are payable. Behavioral health expenses are not subject to the out-of-pocket maximum. 	<p>EAP Visits: 100% (not subject to the Deductible)</p> <p>Outpatient and Inpatient: 50% after Deductible is met</p>	<p>EAP Visits: 100% (not subject to the Deductible)</p> <p>Outpatient and Inpatient: 50% after Deductible is met</p>
<p><u>Blood Transfusions</u></p> <ul style="list-style-type: none"> Blood transfusions and blood products and equipment for its administration 	<ul style="list-style-type: none"> Covered only when ordered by a physician. 	85% after Deductible is met	60% after Deductible is met
<p><u>Chemotherapy</u></p> <ul style="list-style-type: none"> Chemotherapy services and supplies payable when ordered by a Physician. 	<ul style="list-style-type: none"> For chemotherapy performed in a physician's office, the coinsurance applies to the chemotherapy and supplies while the copay applies to the office visit, when such an office visit is billed. 	85% after Deductible is met	60% after Deductible is met

SCHEDULE OF MEDICAL BENEFITS

See also, the Exclusions and Definitions sections of this document for important information. This chart notes what this Plan pays. In-network deductibles may not be used to meet any out-of-network deductibles and vice versa. The allowable coinsurance on out-of-network benefits is based on usual and customary charges.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Corrective Appliances</u> (Prosthetic & Orthotic Devices, Other Than Dental)</p> <ul style="list-style-type: none"> • Coverage is provided for rental or purchase of standard models at the option of the Plan, subject to Annual Maximum plan benefits shown in the Explanations and Limitations column. • Rental is payable only up to the allowed purchase price of the corrective appliance. • Benefits are payable for medically necessary repair, adjustment and servicing of corrective appliances. Benefits are payable for medically necessary replacement of these devices due to a change in the covered person's physical condition or if the device cannot be satisfactorily repaired. • Colostomy or ostomy (orthotic) supplies. • Insulin Pump 	<ul style="list-style-type: none"> • See the specific exclusions related to corrective appliances in the Exclusions section. To help determine what prosthetic or orthotic appliances are covered, see the definitions of "prosthetics" and "orthotics" in the Definitions section. • Corrective appliances are covered only when ordered by a physician. • Prosthetic devices overall maximum plan benefit is \$10,000 per person per limb or device for the appliance, including necessary supplies, repair, and servicing. • Orthotics (except for feet) annual maximum plan benefit is \$3,000 per person for the device, including necessary supplies, repair and servicing. • Foot orthotics (orthopedic or corrective shoes and other supportive appliances for the feet) are limited to once in a period of 12 months for adults and once in a period of six months for children under age 19 when replacement is required due to growth. The annual maximum plan benefit for foot orthotics is \$500 per person. • Orthotic devices used to assist an individual in performing activities of daily living are not payable under this Plan. 	85% after Deductible is met	60% after Deductible is met

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Drugs and Medicines</u></p> <ul style="list-style-type: none"> Coverage is provided only for FDA approved pharmaceuticals requiring a prescription and FDA approved for the condition, dose, route, duration and frequency if prescribed by a physician or other health care practitioner authorized by law to prescribe them. Insulin, insulin syringes, test strips, prenatal vitamins, oral contraceptives and injectables are payable. Injectable contraceptives (e.g. DepoProvera, Lunelle) are payable. Contact the Prescription Drug Program (whose phone number is listed on the Quick Reference Chart in the front of this document) for the following: <ul style="list-style-type: none"> The list of Formulary Brand Drugs. Information on drugs needing pre-approval by the clinical staff of the Prescription Drug Program. Information on which drugs have a limit to the quantity payable by this Plan. Specialty drugs are available on an outpatient basis when ordered through and managed by the Prescription Drug Program. Specialty drugs are products derived from living organisms used by individuals with unique health concerns and includes items such as injectables for multiple sclerosis, rheumatoid arthritis or hepatitis. These drugs need precertification by the clinical staff of the Prescription Drug Program and are managed because they often require special handling, are date sensitive and are usually available only in a 30-day quantity. Drugs not yet approved by the FDA are not covered. New FDA-approved drugs will be covered by the Plan unless an amendment states otherwise or the class of drug is excluded. Note that if the cost of the drug is less than the copay you pay just the drug cost. 	<ul style="list-style-type: none"> Retail prescriptions are available through pharmacies participating with the Prescription Drug Program whose name is listed on the Quick Reference Chart in the Introduction section. The Plan pays for generic drugs, unless specified otherwise by the provider. If no generic drug is available, the Plan will pay for the brand name drug. If you choose to have your prescription filled with a brand name even though a generic is available, you must pay the difference between the cost of the brand drug and the generic drug. Mail Order prescriptions are provided only through the Prescription Drug Program whose name is listed on the Quick Reference Chart in the front of this document. Note: insulin, diabetic supplies, immunosuppressants and anti-depressants are not available via the mail order program, please refer to the retail program. No coverage for: over-the-counter (OTC) medication, smoking cessation, weight control, cosmetic, or fertility/infertility drugs. Only contraceptive birth control pills and injectable contraceptives are payable under this Drug benefit. For other contraceptive coverage see the Family Planning section of this table. Direct Member Reimbursement for use of an Out of Network Retail Pharmacy: If you fill a prescription at an out of network pharmacy location, you will need to pay for the drug at the time of purchase and later, send your drug receipt to the Prescription Drug Program using the Direct Member Reimbursement (DMR) process as listed on the Quick Reference Chart. DMR forms may be obtained from the Prescription Drug Program. For eligible prescriptions, you will be reimbursed according to the amount that would have been allowed had you used an in-network retail pharmacy minus the appropriate copay/coinsurance. See also the specific exclusions related to Drugs and Medicines in the Exclusions section and the definition of "experimental and/or investigational" in the Definitions section. Outpatient prescription drugs are not applied to meet the medical plan's deductible and out-of-pocket maximum. 	<p><u>Retail Pharmacy and Specialty Drugs:</u> (up to a 30 day supply)</p> <p><u>Generic:</u> \$10 copay or cost of the drug if less than \$10.00.</p> <p><u>Formulary Brand (no generic available):</u> \$10 copay or 30%, whichever is greater to a maximum of \$150 per fill.</p> <p><u>Non-Formulary Brand (generic is available):</u> \$10 copay or 40% whichever is greater to a maximum of \$150 PLUS you pay the difference between the cost of the brand versus generic drug.</p> <p><u>Specialty Drugs:</u> You pay 25% of the cost of the drug to a maximum of \$150 per 30-day supply.</p> <p><u>Mail Order:</u> (up to a 90 day supply) <u>Generic:</u> \$20 copay <u>Formulary Brand:</u> \$40 copay <u>Non-Formulary Brand:</u> \$60 copay</p>	<p><u>Retail:</u> (up to a 30 day supply) <i>See the description of Direct Member Reimbursement under the Explanations column.</i></p> <p><u>Mail Order:</u> Not available.</p>

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Durable Medical Equipment (DME)</u></p> <ul style="list-style-type: none"> • Coverage is provided for rental or purchase of standard models at the option of the Plan, subject to an annual maximum plan benefit (described to the right). • Rental is payable only up to the allowed purchase price of the durable medical equipment. • Benefits are payable for medically necessary repair and servicing of durable medical equipment. Benefits for replacement of durable medical equipment are payable when replacement is medically necessary due to a change in the physical condition of the covered person or if the equipment cannot be satisfactorily repaired. • Benefits are payable for medically necessary oxygen, along with the medically necessary equipment and supplies required for its administration. 	<ul style="list-style-type: none"> • See the specific exclusions related to durable medical equipment in the Exclusions section. To help determine what durable medical equipment is covered, see the definition of “durable medical equipment” in the Definitions section. • Durable medical equipment is covered only when its use is medically necessary and it is ordered by a physician. • Annual maximum plan benefit for durable medical equipment is \$5,000 per person. 	<p>85% after Deductible is met</p>	<p>60% after Deductible is met</p>

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Emergency & Ambulance Transportation Services</u></p> <ul style="list-style-type: none"> • Hospital emergency room. • Urgent care facility. • Ambulance: Ground transportation (<i>e.g.</i>, ambulance) to nearest appropriate facility as medically necessary for treatment of medical emergency or non-emergency ambulance transport for inter-facility transfer. Air transportation only as medically necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the health status of the patient for treatment of a medical emergency. 	<ul style="list-style-type: none"> • Emergency room covered only when services are for an emergency. See definition of “emergency (medical)” in the Definitions section. • Emergency room (ER) visit is subject to a \$50 copayment per visit after the deductible is met. The copay will be waived if subsequent immediate hospitalization is required. • Urgent care facility visit is subject to a \$50 copayment per visit (no deductible applies). The copay will be waived if subsequent immediate hospitalization is required. 	<p>Emergency room visit: 85% after a \$50 copayment per visit. (Deductible applies to ER visits.)</p> <p>Urgent care facility visit: 85% after a \$50 copayment per visit. (Deductible does not apply to urgent care.)</p> <p>Emergency or non-emergency transportation: 85% after in-network Deductible is met</p>	<p>Emergency room visit: 60% after a \$50 copayment per visit and out of network Deductible met.</p> <p>Urgent care facility visit: 60% after a \$50 copayment per visit. (Deductible does not apply to urgent care.)</p> <p>Emergency transportation: 85% after In-network Deductible met.</p> <p>Non-emergency transportation: 60% after Out of Network Deductible is met.</p>
<p><u>Family Planning Services</u></p> <ul style="list-style-type: none"> • Surgical sterilization (<i>e.g.</i>, vasectomy, tubal ligation). • Contraceptives prescribed by a physician, including birth control pills (payable under the prescription Drug benefits of this Plan), injectable contraceptives, IUD, diaphragms and implantable birth control devices and services. Injectable contraceptives (<i>e.g.</i> Depo-Provera, Lunelle) are available as follows: <ul style="list-style-type: none"> • The injectable may be purchased at a retail pharmacy allowing you to return to the physician’s office for administration of the injectable; or • You may have the physician administer the injectable from the physician’s medication supply, however, the Plan will only consider as the allowable charge, the fee for the injectable that would have been incurred had you purchased the injectable at the retail pharmacy. 	<ul style="list-style-type: none"> • See the specific exclusions related to Family Planning in the Exclusions section. • No coverage for fertility and infertility services, including drugs and medicines related to those services. • Birth control pills are covered only when prescribed by a physician, and subject to payment under the Prescription Drug Program. See the Drugs and Medicine section of this Schedule of Medical Benefits. 	<p>100% for sterilization after Deductible is met</p> <p>See also Drugs and Medicines and Physicians Services in this chart.</p>	<p>100% for sterilization after Deductible is met</p> <p>See also Drugs and Medicines and Physicians Services in this chart.</p>

SCHEDULE OF MEDICAL BENEFITS

See also, the Exclusions and Definitions sections of this document for important information. This chart notes what this Plan pays. In-network deductibles may not be used to meet any out-of-network deductibles and vice versa. The allowable coinsurance on out-of-network benefits is based on usual and customary charges.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Home Health Care and Home Infusion Services</u></p> <ul style="list-style-type: none"> • Part-time, intermittent skilled nursing care services and medically necessary supplies to provide home health care or home infusion services, subject to a maximum plan benefit (described to the right). • Home services other than skilled nursing care are not covered. 	<ul style="list-style-type: none"> • See the specific exclusions related to home health care and custodial care (including personal care and childcare) in the Exclusions section of this document. • Covered only when ordered by a physician. • Maximum plan benefit for skilled nursing care services and supplies to provide home health care and home infusion services is 60 days per person per Plan year. • Home hospice coverage is described below under Specialized Health Care Facilities benefits. Home physical therapy services coverage is described below under the Rehabilitation Services benefits. Prescription drug and medicine coverage is described above under the Drugs and Medicine benefits. 	<p>85% after Deductible is met</p>	<p>60% after Deductible is met</p>
<p><u>Laboratory Services (Outpatient)</u></p> <ul style="list-style-type: none"> • Technical and professional fees. 	<ul style="list-style-type: none"> • Covered only when ordered by a physician. • Lab tests obtained and performed within the physician's office are payable under the office visit copay when an office visit is billed on the same date of service. All other lab services subject to coinsurance. 	<p>85% after Deductible is met</p>	<p>60% after Deductible is met</p>

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Maternity Services</u></p> <ul style="list-style-type: none"> • Hospital and birthing center charges and physician fees for medically necessary maternity services and newborn care while mother is confined. • Amniocentesis or chorionic villus sampling (CVS) for pregnant women only if the procedure is medically necessary as determined by the Plan administrator or its designee. • Nurse midwife. 	<ul style="list-style-type: none"> • See the specific exclusions related to Family Planning in the Exclusions section. Expenses for pre-planned home births are not payable under this Plan. See also the special rule for coverage of newborn dependent children in the Eligibility section. • No coverage for maternity care and delivery expenses for a pregnant dependent child. • Copayments are waived for pregnancy-related OB/GYN charges of PPO OB/GYN physicians when the mother begins care within first trimester of pregnancy. • This Plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section; or requiring a health care practitioner to obtain authorization from the Plan (or its UM company) for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending health care practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable). • Charges for a newborn will be considered part of and payable under the mother's delivery admission charges until the mother is discharged. If the newborn cannot be discharged with the mother and needs continued confinement, the newborn's charges from the date of birth will be considered as separate from the mother. See the Eligibility chapter for guidelines on what must occur in order to enroll a newborn under this Plan. 	<p>85%, after Deductible is met</p> <p>Copays waived if OB/GYN care begins in first trimester of pregnancy.</p>	<p>60% after Deductible is met</p> <p>No waiver of copays if OB/GYN care begins in first trimester of pregnancy.</p>
<p><u>Nondurable Medical Supplies</u></p> <ul style="list-style-type: none"> • Coverage is provided for: <ul style="list-style-type: none"> • Sterile surgical supplies used immediately after surgery. • Supplies needed to operate or use covered durable medical equipment or corrective appliances. • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services. • Insulin syringes and test strips for diabetics are covered under the Prescription drug program. 	<ul style="list-style-type: none"> • To determine what nondurable medical supplies are covered, see the definition of "nondurable medical supplies" in the Definitions section. 	<p>85% after Deductible is met</p>	<p>60% after Deductible is met</p>

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Oral and Craniofacial Services</u></p> <ul style="list-style-type: none"> Injury to teeth. Oral and/or craniofacial surgery. 	<ul style="list-style-type: none"> See the exclusions related to dental services in the Exclusions section. Treatment of Accidental Injuries to the Teeth: This medical plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan Administrator or its designee, all of the following conditions are met: <ul style="list-style-type: none"> The accidental injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and The dental treatment will return the person's teeth to their pre-injury level of health and function. See also the definition of Injury to Teeth in the Definitions chapter of this document Surgical or nonsurgical treatment of TMJ dysfunction/syndrome, including appliances, is excluded. Refer to the dental plan. Oral or craniofacial surgery is limited to cutting procedures for removal of tumors, cysts, abscess, acute injury, or as medically necessary for the treatment of conditions not related to impacted teeth, root canal, gingivectomy, dental abscess or orthognathic procedures. 	85% after Deductible is met	60% after Deductible is met
<p><u>Preadmission Testing</u></p> <ul style="list-style-type: none"> Laboratory tests, x-rays and other medically necessary tests performed on an outpatient basis prior to a scheduled hospital admission or outpatient surgery. 	<ul style="list-style-type: none"> Covered only when ordered by a physician. Not subject to deductible. 	100% no Deductible	100% no Deductible
<p><u>Radiology (X-ray), Nuclear Medicine and Radiation Therapy Services (Outpatient)</u></p> <ul style="list-style-type: none"> Technical and professional fees associated with diagnostic and curative services, including radiation therapy. 	<ul style="list-style-type: none"> Covered only when ordered by a physician. 	85% after Deductible is met	60% after Deductible is met

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Reconstructive Services</u></p> <ul style="list-style-type: none"> Includes expenses for reconstructive surgery, procedures or treatment intended to improve bodily function and or correct a deformity resulting from disease, trauma, infection, congenital anomalies that cause a functional defect or prior covered therapeutic procedure. This Plan complies with the Women’s Health and Cancer Rights Act of 1998 and provides medical and surgical benefits in connection with a mastectomy and for certain reconstructive surgery, as follows: <ul style="list-style-type: none"> Reconstruction of breast on which the mastectomy was performed. Surgery on the other breast to produce a symmetrical appearance. Prostheses and physical complications of all stages of mastectomy, including lymphedemas. 	<ul style="list-style-type: none"> See the specific exclusions related to cosmetic services and reconstructive surgery in the Exclusions section. Most cosmetic and dental (including orthognathic) services are excluded from coverage. 	85% after Deductible is met	60% after Deductible is met
<p><u>Rehabilitation Services (Cardiac and Pulmonary)</u></p> <ul style="list-style-type: none"> Cardiac Rehabilitation is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or MI). Pulmonary Rehabilitation is available to those individuals who are able to actively participate in a pulmonary rehabilitation program that is likely to improve their pulmonary condition, as determined by the Plan administrator or its designee. 	<ul style="list-style-type: none"> Cardiac or pulmonary rehabilitation programs must be ordered by a physician. Overall maximum plan benefit for cardiac rehabilitation is limited to services provided during a maximum of 12 weeks, not to exceed \$3,000 per person per cardiac incident. Overall maximum plan benefit for pulmonary rehabilitation is limited to services provided during a maximum of 12 weeks not to exceed a total of \$1,500 per person during the duration of coverage by the Plan. 	85% after Deductible is met	60% after Deductible is met

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Rehabilitation Services</u> (Occupational, Physical, and Speech Therapy)</p> <ul style="list-style-type: none"> Short-term active, progressive rehabilitation services (occupational, physical, or speech therapy) performed by licensed or duly qualified therapists as ordered by a physician. Inpatient rehabilitation services in an acute hospital, rehabilitation unit or facility or skilled nursing facility for short term, active, progressive, rehabilitation services that cannot be provided in an outpatient or home setting. 	<ul style="list-style-type: none"> Maintenance rehabilitation and coma stimulation services are not covered. See specific exclusions relating to rehabilitation therapies in the Exclusions section. Rehabilitation services are covered only when ordered by a physician. The Overall maximum plan benefit for all combined inpatient and outpatient rehabilitation services (occupational, physical, and speech therapy), including facility charges, is \$40,000 per person per injury or illness. Within this overall maximum there are some specific maximums: <ul style="list-style-type: none"> Inpatient rehabilitation services benefits are limited to 60 consecutive days per person per injury or illness. Outpatient rehabilitation benefit is payable to \$5,000 per person per injury or illness. Speech therapy is covered if the services are provided by a licensed or duly qualified speech therapist to restore normal speech or to correct dysphagic or swallowing defects and disorders lost due to illness, injury or surgical procedure. Speech therapy for functional purposes including, but not limited to, stuttering, stammering and conditions of psychoneurotic origin, is excluded from coverage. Outpatient physical therapy in conjunction with spinal manipulation services is subject to the Plan's limitations for spinal manipulation services. 	<p>85% after Deductible is met</p>	<p>60% after Deductible is met</p>
<p><u>Second and Third Physician Opinions</u></p> <ul style="list-style-type: none"> Includes up to three opinions per person per diagnosis. 	<ul style="list-style-type: none"> See the section on Medical Network and Utilization Management for details of the second and third opinion program. Additional medically necessary tests are covered under other Plan provisions. 	<p>100% when required by the Plan (not subject to the Deductible); otherwise 85% after Deductible is met</p>	<p>100% when required by the Plan (not subject to the Deductible); otherwise 60% after Deductible is met</p>

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Specialized Health Care Facilities</u></p> <ul style="list-style-type: none"> Ambulatory/outpatient surgical facility. Birthing center. Hospice. Skilled Nursing Facility (SNF). Subacute care facility. 	<ul style="list-style-type: none"> Admission to a specialized health care facility is subject to precertification. See the section on Medical Network and Utilization Management for details. Specialized health care facility services must be ordered by a physician. To determine if a facility is a “specialized health care facility,” see the Definitions section. Hospice overall maximum plan benefit for combined inpatient and outpatient care, including bereavement counseling for family within 6 months after death, is \$10,000. Skilled nursing facility benefit for confinement is limited to 60 days per year. Subacute care facility benefit for confinement is limited to 60 days per injury or illness. Reimbursement for facility charges will not exceed 50% of the prevailing semiprivate hospital room rate in the geographic area. 	<p>Facility Fees: 85% after Deductible is met</p>	<p>Facility Fees: 60% after Deductible is met</p>
<p><u>Spinal Manipulation Services</u></p> <ul style="list-style-type: none"> Spinal manipulation services, including ancillary and related services (e.g., visit, x-rays, physical therapy) from a physician or chiropractor, subject to an annual maximum plan benefit shown in the Explanations and Limitations column. 	<ul style="list-style-type: none"> Covered services are for back-related care only, for adults 18 years or older. Annual maximum plan benefit for all spinal manipulations is 25 visits per individual payable to a maximum of \$20 per visit. 	<p>25 visits/year, not to exceed payment of \$20/visit, in- or out-of-network. This benefit is not subject to the Deductible.</p>	
<p><u>Transplantation (Organ and Tissue)</u></p> <ul style="list-style-type: none"> Coverage is provided only for eligible services directly related to transplantation of the following human organs or tissue: bone marrow, cornea, heart, intestine, kidney, liver, lung(s), pancreas, skin, or stem cells harvested from peripheral blood, including, facility and professional services, FDA approved drugs, medically necessary equipment and supplies. All transplantation benefits are subject to overall maximum plan benefits shown in the Explanations and Limitations column. Organ or tissue procurement/acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor. Eligible donor expenses, not payable by their own health plan, will be payable without application of this Plan’s deductibles, copays or coinsurance. 	<ul style="list-style-type: none"> See the specific exclusions related to experimental and investigational services and transplantation in the Exclusions section. Transplantation services are subject to precertification. See the section on Medical Network and Utilization Management for details. Benefits are payable only if services are provided in a hospital or specialized health care facility approved by the Plan administrator or its designee. Overall maximum plan benefit for all transplantation-related services, including donor expenses and organ or tissue procurement/acquisition fees, from date of recipient work-up and organ acquisition through 18 months after transplant surgery is \$300,000. 	<p>85% after Deductible is met</p>	<p>No coverage</p>

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Weight Management Benefit</u></p> <ul style="list-style-type: none"> Coverage is available for gastrointestinal bypass surgery and any complications thereof to participants who are determined by the Plan Administrator or its designee to be morbidly obese (as defined in this Plan) to a maximum of \$30,000 per person per lifetime for facility and professional fees associated with this procedure. 	<ul style="list-style-type: none"> Covered only when ordered and performed by a physician. Morbidly Obese is defined in the Definitions chapter of this document. Surgical procedures to remove excessive skin resulting from weight loss are not considered payable by this Plan. Participant must have been employed by a member of the Consortium and covered under this Plan for 1 or more years or if a dependent, the person is over the age of 18 and the participant has met the 1-year continuous employment timeframe. 	85% after Deductible is met	No coverage
<p><u>Wellness Programs: Well Child Examinations and Immunizations</u></p> <ul style="list-style-type: none"> Routine outpatient newborn and well child visits and routine childhood immunizations. 	<ul style="list-style-type: none"> Deductible and coinsurance do not apply to in-network benefits. Nine well child visits from the age of one week to 18 months, to a maximum of \$100/visit for health exams and immunizations. 	100% up to \$100 per visit. (Not subject to the Deductible)	No coverage
<p><u>Wellness Programs: Adult Health Maintenance Examinations (Age 18 and up)</u></p> <p><i>These benefits are available for employees only.</i></p> <ul style="list-style-type: none"> Routine exam. Adult immunizations. 	<ul style="list-style-type: none"> Deductibles and coinsurance do not apply to in-network benefits. Coverage is provided to an employee only, for one exam (visit), including testing, and immunizations, reimbursed at 100% to a maximum of \$100 per year. Bills must be clearly marked as applicable to this wellness benefit. Additional diagnostic exams and tests that are medically necessary because of the patient's condition are covered, subject to the Plan's deductibles, coinsurance or copayments and all other Plan provisions. 	100% up to \$100 per year. (Not subject to the Deductible).	No coverage

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Wellness Programs: Adult Well Woman Care (Age 18 and up)</u></p> <ul style="list-style-type: none"> Gynecology exam and pap smear lab test. Mammogram (age 35 and up). 	<ul style="list-style-type: none"> Deductible does not apply to in-network benefits. The following coverage is provided to all female plan participants age 18 years and older: <ul style="list-style-type: none"> One gynecology exam per year payable with a \$20 copay per visit. One pap smear lab test per year at 100% coinsurance. One mammogram per year for women age 35 and older, payable at 100%. Additional mammograms and diagnostic exams and tests that are medically necessary because of the patient's condition are covered, subject to the Plan's deductibles, coinsurance or copayments and all other Plan provisions. 	<p>GYN office visit: 100% after a \$20 per visit.</p> <p>Pap smear lab test: 100%. (not subject to the Deductible)</p> <p>Mammogram: 100%. (not subject to the Deductible)</p>	<p>All services 60% after Deductible is met.</p>
<p><u>Wellness Programs: Adult Well Man Care (Age 50 and up)</u></p> <ul style="list-style-type: none"> Office visit for digital rectal exam. Prostatic Specific Antigen (PSA) blood test. 	<ul style="list-style-type: none"> Deductible does not apply to in-network benefits. The following coverage is provided to all male plan participants age 50 and older: <ul style="list-style-type: none"> one office visit for digital rectal exam per year. PSA blood test. Additional diagnostic exams and tests that are medically necessary because of the patient's condition are covered, subject to the Plan's deductibles, coinsurance or copayments and all other Plan provisions. 	<p>Office visit: 100% after a \$20 copay per visit.</p> <p>PSA Blood test: 85%.</p>	<p>All services 60% after Deductible is met</p>

MEDICAL NETWORK AND UTILIZATION MANAGEMENT

MEDICAL NETWORK: PREFERRED PROVIDER ORGANIZATION (PPO)

The Plan's Preferred Provider Organization (PPO) is a medical network of hospitals, physicians, pharmacies, medical laboratories and other health care providers who have agreed to provide health care services and supplies for favorable negotiated fees applicable only to plan participants. Using the services of a PPO provider is considered "in-network" services. Plan participants may obtain health care services from in-network or out-of-network health care providers.

- **IN-NETWORK SERVICES:** In-network health care providers have agreements with the Plan's PPO which means they provide health care services and supplies for a favorable discounted negotiated fee for plan participants. When a plan participant uses the services of an in-network health care provider, the participant's financial responsibility is less. After you meet your deductible, you will pay just a copay or a lower coinsurance than if you received those medically necessary services or supplies from a health care provider who is not a PPO provider. The PPO provider has agreed to accept the Plan's payment plus any applicable coinsurance or copayment that you are responsible for paying as payment in full. Please refer to the Schedule of Medical Benefits for specific financial information by type of service.
- **OUT-OF-NETWORK SERVICES:** Out-of-network health care providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will reimburse the plan participant for the usual and customary charge for medically necessary services or supplies which are payable by the plan, subject to the Plan's deductibles, coinsurance, copayments, limitations and exclusions. Plan participants must submit proof of claim before any such reimbursement will be made. **NOTE: Non-network health care providers may bill the plan participant for any balance due in addition to the amount payable by the Plan, commonly referred to as "balance billing."**

DIRECTORIES OF PPO PROVIDERS

Physicians and health care providers who participate in the Plan's PPO are added and deleted during the year. At any time, you can find out if a health care provider is a member of the PPO by using the website or calling the PPO Network phone number listed on the Quick Reference Chart. A directory of local health care providers who are members of the Plan's PPO is available free of charge. Visit the website of the PPO Network or the YABC website, as listed on the Quick Reference Chart in the front of this document.

GENERAL INFORMATION ABOUT THE UTILIZATION MANAGEMENT (UM) PROGRAM

Purpose Of the Utilization Management Program

Your Plan is designed to provide you and your eligible family members with financial protection from significant health care expenses. The development of new medical technology and procedures and the ever-increasing cost of providing health care may make it difficult for a participating employer of the Consortium to afford the cost of maintaining your Plan. To enable your Plan to provide coverage in a cost-effective way, your Plan has adopted a UM program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the participating employer of the Consortium is better able to afford to maintain the Plan and all its benefits.

If you follow the procedures of the Plan's UM program, you may avoid some out-of-pocket costs. However, if you do not follow these procedures, your Plan provides reduced benefits and you will be responsible for paying more out of your own pocket.

Utilization Management Program

The Plan's UM program consists of:

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

may therefore benefit from professional assistance to guide them through the maze of choices of health care services, providers and practices.

The Plan's UM program is administered by an independent professional UM organization operating under a contract with the Plan (herein referred to as the UM organization). The health care professionals in the UM organization focus their review on the necessity and appropriateness of hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical or surgical services.

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

VERY IMPORTANT INFORMATION ABOUT THE UTILIZATION MANAGEMENT PROGRAM

1. The fact that your physician recommends surgery, hospitalization, confinement in a specialized health care facility, or that your physician or other health care provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be considered medically necessary for determining coverage under the medical plan.
2. The Utilization Management program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of plan benefits. The UM organization'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:
 - a. the UM organization does not certify a proposed surgery or other proposed medical treatment as medically necessary; or
 - b. the Plan will not pay regular plan benefits for a hospitalization or confinement in a specialized health care facility because the UM organization does not certify a proposed confinement.

The benefits payable by the Plan may, however, be affected by the determination of the UM organization.

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

PRECERTIFICATION REVIEW

How Precertification Review Works

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

WHAT SERVICES MUST BE PRECERTIFIED (Approved Before They Are Provided)

1. **All elective hospital admissions.** Note: for pregnant women, precertification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section;
2. **All elective admissions to any specialized health care facility such as a skilled nursing facility, subacute care, hospice, etc.;**
3. **All elective surgery to be performed in a hospital or ambulatory surgical facility;**
4. All admissions to any hospital or specialized health care facility for **rehabilitation therapy;**
5. All **home health care and all home infusion services.**

What Services May Be Precertified (Approved Before They Are Provided)

You may request precertification of any health care service recommended by your physician or other health care provider that are not required to be precertified under the preceding section in order to be assured that the service is medically necessary and appropriate for the individual patient's circumstances.

How To Request Precertification

You or your physician must call the UM organization at the telephone number shown on the Quick Reference Chart in the Introduction section of this document. Calls for elective services should be made at least **seven (7) days** before the expected date of service. The caller should be prepared to provide **all of the following information**:

1. the employer's name;
2. the employee's name;
3. the patient's name;
4. the physician's name and tax identification number;
5. the name of any hospital, specialized health care facility or any other health care provider that will be providing services;
6. the reason for the health care services or supplies; and
7. the proposed date for performing the services or providing the supplies.

If additional information is needed, the UM organization will advise the caller. The UM organization will review the information provided, and will let you, your physician and the hospital, specialized health care facility, any other health care provider, and the claims administrator know whether or not the proposed health care services have been certified as medically necessary. The UM organization will usually respond to your treating physician or other health care provider **by telephone within three (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.

Appeal Of A Denial Of Precertification

Regular Appeal: If the UM organization determines that the proposed health care service is not medically necessary, you and/or your physician may submit a written appeal of the decision, accompanied by any additional information to support the need for the proposed health care service. The appeal, with supporting information, should be sent to the UM organization at the address or fax number shown in the latest version of the Quick Reference Chart in the Introduction section of this document. You can expect that the UM organization will respond in **writing within 30 days after it receives the request and any required medical records and/or information**.

Expedited Appeal: If a covered individual is under treatment by a physician, and if the UM organization determines that the proposed health care service is not medically necessary, the treating physician may telephone the UM organization at the telephone number shown in the latest version of the Quick Reference Chart in the Introduction section of this document to request an expedited appeal with the medical director or a physician designated by the UM organization to provide the necessary review. The UM organization will usually respond to your physician by telephone within 24 working hours, and its determination will then be confirmed in writing to you and your physician and the claims administrator.

Independent Review Of A Denial Of Precertification

If the UM organization confirms its initial determination that the proposed health care service is not medically necessary, you and/or your physician may submit a written request for an independent medical review of the determination of the appeal of a denial of precertification by the UM organization. Contact the Claims Administrator at the telephone number shown in the latest version of the Quick Reference Chart in the Introduction section of this document. The independent medical reviewer will consider all information presented by your physician and the UM organization. You can expect a **written response regarding this review within 60 days after your request for such a review is received**.

CONCURRENT (CONTINUED STAY) REVIEW

How Concurrent (Continued Stay) Review Works

When you are receiving medical services in a hospital or specialized health care facility, the UM organization may contact your physician or other health care providers to **assure that continuation of medical services is medically necessary and help coordinate your medical care with the benefits available under the Plan**. See also "Very Important Information About the Utilization Management Program" in this section. Concurrent review may include such services as:

1. coordinating home health care or durable medical equipment needs;
2. assisting with discharge plans;

3. determining the need for continued medical services; and/or
4. advising your physician or other health care providers of the various options and alternatives available under this Plan for your medical care.

Emergency Hospitalization

If an emergency requires hospitalization, there may be no time to contact the UM organization before you are admitted. If this happens, the UM organization must be notified of the hospital admission **within 48 hours after your admission**. Your physician, a family member or friend can make that phone call. This will enable the UM organization to assist with discharge plans, determining the need for continued medical services, and/or advising your physician or other health care providers of various benefits, options and alternatives for your medical care.

Appeal Of A Denial Of A Concurrent Review

If the UM organization determines that continued health care services are not medically necessary, you and/or your physician will be notified and have the opportunity to appeal if your physician disagrees with that determination. **If you and/or your physician disagree with the determination, the obligation to appeal rests entirely with you and your physician. In the absence of an appeal, the Plan has no obligation to provide any review of that decision.**

If you are not hospitalized or confined in any other specialized health care facility, to appeal a determination that continued health care services are not medically necessary, you and/or your physician should follow the procedures set forth in the section of the previous section regarding precertification review.

If, while you are hospitalized or confined in any other specialized health care facility, you or your physician receive a notice that continued stay is **not certified**, you or your physician may request an expedited appeal by calling the UM organization at the telephone number shown in the latest version of the Quick Reference Chart in the Introduction section of this document. The UM organization will usually respond to your physician by telephone within 24 working hours, and its determination will then be confirmed in writing to you, your physician, the hospital or other specialized health care facility, and the claims administrator.

No benefits will be paid for any charges related to days of confinement to a hospital or other specialized health care facility that have not been determined to be medically necessary by the UM organization.

SECOND AND THIRD OPINIONS

How The Second And Third Opinion Process Works

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

1. there may be a question regarding the effectiveness or reliability of a proposed service; or
2. the proposed service involves a high risk in relation to the anticipated benefit; or
3. there appear to be conflicting diagnoses, vague indications, or possible inadequate clinical management.

If a second opinion is required, **you** will need to arrange an examination by a physician who:

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

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

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

Patient-Requested Second And Third Opinions

If the UM organization does not require a second opinion, but you or your covered dependent requests one, it will be provided in the manner described in the preceding section, except that you or your covered dependent may get the second opinion from any physician. You will note there is a difference in coinsurance for use of network versus non-network providers. If the second opinion differs from the treating physician's recommendation, you may request a third opinion in the manner described above.

Appeal Of A Second Or Third Opinion That Disagrees With A Recommended Procedure

If the second or third opinion disagrees with the procedure recommended by the treating physician, and the disagreement cannot be resolved by discussion between the treating and reviewing physicians, you and/or your physician may submit a written appeal of the decision, accompanied by any additional information to support the need for the proposed health care service. The appeal, with supporting information, should be sent to the UM organization at the office or to the fax number shown in the Quick Reference Chart in the Introduction section of this document. The UM organization will respond **in writing within 30 days after it receives the request and any required medical records and/or information.**

Cost Of The Second And Third Opinions

The Plan will pay the full cost for any second and third opinion **required** by the UM organization. If a second opinion is **requested** by a covered person, the Plan will pay a percentage for in-network or out-of-network expenses for the opinion. See also the Schedule of Medical Benefits.

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 Claims Information section of this document.**

CASE MANAGEMENT

How Case Management Works

Case management is a process administered by the UM organization. Its medical professionals work with the patient, family, caregivers, health care providers, claims administrator and the participating employer with the Consortium to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential health care providers.

Working With The Case Manager

Any plan participant, physician or other health care provider can request services by calling the UM organization at the telephone number shown in the latest version of the Quick Reference Chart in the Introduction section of this document. However, in most cases, the UM organization will be actively searching for those cases where the patient could benefit from case management services, and it will initiate case management services automatically.

The case manager of the UM organization will work directly with your physician, hospital, and/or other specialized health care facility to review proposed treatment plans and to assist in coordinating services and obtaining discounts from health care providers as needed. From time to time, the case manager may confer with your physician or other health care providers, and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services.

You, your family, or your physician may call the case manager at any time at the UM telephone number shown in the latest version of the Quick Reference Chart in the Introduction section of this document to ask questions, make suggestions, or offer information.

WHAT HAPPENS IF YOU DON'T FOLLOW THE UTILIZATION MANAGEMENT PROCEDURES?

If you don't follow the precertification review, concurrent (continued stay) review, or case management procedures, or if you fail to obtain a required second or third opinion before incurring medical expenses, or if you undergo a medical procedure that has not been determined to be medically necessary under the second or third opinion program, the claims administrator will refer your claim to the UM organization for a retrospective review to determine **if** the services were medically necessary.

- If the UM organization determines that the services **were not medically necessary**, no plan benefits will be payable for those services.
- If the UM organization determines that the services **were medically necessary**, the benefits payable by the Plan will be reduced by an additional 10% coinsurance. This additional coinsurance will **not** be applied to meet your out-of-pocket maximum.

MEDICAL EXCLUSIONS

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

GENERAL EXCLUSIONS

1. **Autopsy:** Expenses for an autopsy and any related expenses, except as required by the Plan administrator or its designee.
2. **Complications:** Expenses for complications of any non-covered service/procedure/treatment.
3. **Costs of Reports, Bills, etc.:** Expenses for preparing medical reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken appointments, telephone calls and/or photocopying fees.
4. **Educational Services:** Expenses for educational services, supplies or equipment, including, but not limited to, computers, software, printers, books, tutoring, visual aides, auditory aides, speech aids, etc., even if they are required because of an injury, illness or disability of a covered individual.
5. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any plan benefit limitation, annual maximum plan benefits, or overall (lifetime) maximum plan benefits as described in the Medical Expense Coverage section of this document.
6. **Expenses Exceeding Usual and Customary Charges:** Any portion of the expenses for covered medical services or supplies that are determined by the Plan administrator or its designee to exceed the usual and customary charge as defined in the Definitions section of this document.
7. **Expenses for Which a Third Party is Responsible:** Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party, as applicable. See the provisions relating to Third Party Liability in the Coordination of Benefits (COB) section of this document for an explanation of the circumstances under which the plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
8. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the medical plan or after the date the patient's coverage ends, except under those conditions described in the COBRA section.
9. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan administrator or its designee to be experimental and/or investigational as defined in the Definitions section of this document.
10. **Illegal Act:** Expenses incurred by any covered individual for injuries resulting from or sustained as a result of commission, or attempted commission by the covered individual, of an illegal act that the Plan administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the covered individual. The Plan administrator's discretionary determination that this exclusion applies shall not be affected by any subsequent official action or determination with respect to prosecution of the covered individual (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.
11. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a covered individual.
12. **Travel and Related Expenses:** Expenses for and related to travel or transportation (including lodging, meals and related expenses), unless those expenses have been preapproved by the Plan administrator or its designee.
13. **Physical Examinations or Tests for Employment, School, etc.:** Expenses for physical examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, or by any third party, except as provided under the Schedule of Medical Benefits.
14. **Private Room in a Hospital or Specialized Health Care Facility:** The use of a private room in a hospital or other specialized health care facility, unless its use is certified as medically necessary by the Plan administrator or its designee.
15. **Services Covered by Workers' Compensation:** Expenses for the treatment of conditions covered by workers' compensation or occupational disease law.
16. **Services for Patient Convenience:** Expenses for patient convenience, including, but not limited to, care of family members while the covered individual is confined to a hospital or other specialized health care facility or to bed at home, guest meals, television, VCR, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

17. **Services for Pre-Existing Conditions:** Expenses arising from a pre-existing condition during the period described in the Eligibility section.
18. **Services Not Medically Necessary:** Services or supplies determined by the Plan administrator or its designee not to be medically necessary as defined in the Definitions section of this document.
19. **Services Not Prescribed by a Physician:** Expenses for services rendered or supplies provided that are not recommended or prescribed by a physician, except for covered services provided by a behavioral health practitioner, midwife or nurse midwife, chiropractor or podiatrist.
20. **Services Performed by Medical Students, Interns or Residents:** Expenses for the services of a medical student, intern or resident.
21. **Services Provided by Employer:** Expenses for services rendered through a medical/health department, clinic or similar facility provided or maintained by the Consortium, or if benefits are otherwise provided under this plan or any other plan that the Consortium contributes to or otherwise sponsors, such as HMOs.
22. **Services Provided by Government:** Expenses for services when benefits for them are provided to the covered person under any plan or program established under the laws or regulations of any government, including the federal state, or local government or the government of any other political subdivision of the United States, or of any other country or any political subdivision of any other country; or under any plan or program in which any government participates other than as an employer, unless the governmental program provides otherwise.
23. **Services Provided by Relatives:** Expenses for services provided by any physician or other health care practitioner who is the parent, spouse, sibling (by birth or marriage) or child of the patient or covered employee.
24. **Services Provided Outside the United States:** Expenses for medical services or supplies rendered or provided outside the United States, except for treatment in Mexico or for a medical emergency as defined in the Definitions section of this document.
25. **Services Provided Without Cost to Recipient:** Expenses for services rendered or supplies provided for which a covered person is not required to pay or which are obtained without cost or there would be no charge if the person receiving the treatment were not covered under this Plan.
26. **Services Required Because of Failure to Follow Medical Advice:**
 - a. **Failure to Comply with Medically Appropriate Treatment:** Expenses incurred by any covered individual who fails to comply with medically appropriate treatment, as determined by the Plan administrator or its designee.
 - b. **Leaving a Hospital Contrary to Medical Advice:** Hospital or other specialized health care facility expenses if you leave the facility against the medical advice of the attending physician within 72 hours after admission.
 - c. **Travel Contrary to Medical Advice:** Expenses incurred by any covered individual during travel if a physician or other health care provider has specifically advised against such travel because of the health condition of the covered individual.
27. **Telephone Calls:** Any and all telephone calls between a physician or other health care provider and any patient, other health care provider, UM organization, or any representative of the plan for any purpose whatsoever, including, without limitation:
 - a. Communication with any representative of the plan or it's UM organization for any purpose related to the care or treatment of a covered individual.
 - b. Consultation with any health care provider regarding medical management or care of a patient;
 - c. Coordinating medical management of a new or established patient;
 - d. Coordinating services of several different health professionals working on different aspects of a patient's care;
 - e. Discussing test results;
 - f. Initiating therapy or a plan of care that can be handled by telephone;
 - g. Providing advice to a new or established patient; or
 - h. Providing counseling to anxious or distraught patients or family members.
28. **War:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, except as required by law.

SPECIFIC MEDICAL EXCLUSIONS

29. **Alternative Health Care Services Exclusions**
 - a. Acupuncture and/or Acupressure.
 - b. Chelation Therapy: Expenses for chelation therapy, except as may be medically necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.
 - c. Faith or Spiritual Healing: Expenses for prayer, religious healing, or spiritual healing.

- d. Naturopathic and/or Homeopathic Services: Expenses for naturopathic and/or homeopathic services or supplies.

30. Assistant Surgeon Fees

Assistant surgeon expenses are only payable when it is determined by the Plan or its designee that the services of an assistant surgeon were medically necessary.

31. Behavioral Health Care Exclusions

- a. Expenses for diagnosis, treatment and prevention of behavioral health disorders, including substance abuse, except as provided under the Schedule of Medical Benefits section of this document.
- b. Expenses for residential care services for behavioral health care.
- c. Expenses for hypnosis, hypnotherapy, biofeedback and/or psychological/psychiatric testing.
- d. Expenses for behavioral health care services related to adoption counseling, attention deficit disorders (with or without hyperactivity), autism, court-ordered behavioral health care services, custody counseling, developmental disabilities, dyslexia, family planning counseling, learning disorders/disability, marriage, couples, and/or sex counseling, mental retardation, pregnancy counseling, transsexual counseling, and vocational disabilities, **except** office visits to a Physician for medication management of the diagnosis of attention deficit disorder with or without hyperactivity. Medications for this diagnosis are payable under the Drug benefits of the Plan.

32. Corrective Appliances And Durable Medical Equipment Exclusions

- a. Expenses for replacement of lost, missing, or stolen corrective appliances, including orthotic devices and/or prosthetic appliances, or durable medical equipment.
- b. Expenses for duplicate corrective appliances, including orthotic devices, and/or prosthetic appliances, or durable medical equipment.
- c. Expenses for services or supplies designed to personalize or characterize any corrective appliance, including orthotic devices, and/or prosthetic appliance, or durable medical equipment.
- d. Expenses for corrective appliances and durable medical equipment to the extent they exceed the cost of standard models of such appliances or equipment.

33. Cosmetic Services Exclusions

- a. Surgery or medical treatment to improve or preserve physical appearance, but not physical function, as distinguished from medically necessary surgery or treatment to correct defects resulting from trauma, infection or other diseases, or the consequences of treatment of trauma, infection or other diseases, or to correct a congenital disease or anomaly of a covered dependent child that causes a functional defect. Cosmetic surgery or treatment includes, but is not limited to removal of tattoos, breast augmentation, or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan administrator or its designee.
- b. However, the medical plan **does** cover medically necessary reconstructive surgery or treatment if it is required to correct damage caused by accidental traumatic injury such as Reconstructive surgery when it follows surgery covered by the plan that results from trauma, infection or other disease; and Reconstructive surgery to correct the effects a congenital disease or a gross developmental anomaly of a covered dependent child that causes a functional defect and Breast reconstruction as required by the Women's Health and Cancer Rights Act.
- c. Covered individuals should use the plan's precertification procedure to determine if a proposed surgery will be considered cosmetic surgery or reconstructive.

34. Custodial Care Exclusions

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

35. Dental Services Exclusions

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

36. Drugs, Medicines And Nutrition Exclusions

- a. Pharmaceuticals requiring a prescription that:
 1. have not been approved by the U.S. Food and Drug Administration (FDA); or
 2. are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed; or
 3. are experimental and/or investigational as defined in the Definitions section of this document.
- b. Non-prescription (over-the-counter) drugs or medicines.
- c. Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins (except prenatal) and minerals, except when provided during a stay in a health care facility covered by this Plan.
- d. Naturopathic or homeopathic services and substances.
- e. Drugs, medicines or devices for hair growth, infertility and fertility, smoking cessation, weight control/anorexiant, cosmetic drugs, or syringes (except for insulin syringes and diabetic supplies).
- f. Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal or state law.
- g. Take-home drugs or medicines provided by a hospital, emergency room, ambulatory surgical center, or other health care facility.

37. Family Planning (Fertility and Reproductive Care) Services Exclusions

- a. Expenses for the diagnosis and treatment of infertility and complications thereof, including, but not limited to, services, drugs and procedures or devices to achieve fertility; in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, adoption, and reversal of sterilization procedures.
- b. Expenses for medical or surgical treatment of sexual dysfunction or inadequacy, and any complications thereof, except medications are payable.
- c. Expenses for medical or surgical treatment related to transsexual (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.
- d. Expenses related to condoms or implantable birth control devices, such as Norplant. Certain contraceptives are payable by the Plan as noted under Family Planning and Drugs and Medicine in the Schedule of Medical Benefit.
- e. Expenses for genetic services, tests and/or procedures performed only for the purpose of detecting, evaluating or treating chromosomal abnormalities or genetically transmitted characteristics in pregnant women, except amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein analysis in pregnant women; and tests for sperm function and quality in men.

- f. Expenses for pre-planned home delivery.
- g. Expenses for elective termination of pregnancy (abortion), unless the attending physician certifies that the health of the woman would be endangered if the fetus were carried to term or where medical complications arise from an abortion.
- h. Expenses for the maternity care and delivery expenses for a pregnant dependent child and complications of the pregnancy.

38. Foot Care Exclusion

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

39. Hair Replacement Procedures, Medications And Devices (Wigs)

Expenses for hair removal or hair transplantation and other procedures to replace lost hair or to promote the growth of hair, for the use of Rogaine or other prescription drugs or medicines used to promote the growth of hair, or for hair replacement devices including but not limited to, wigs, toupees and/or hairpieces.

40. Hearing Care Exclusion

Expenses for the purchase, servicing, fitting and/or repair of hearing aid devices and cochlear implants.

41. Home Health Care Exclusions

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

42. Nursing Care Exclusion

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

43. Rehabilitation Therapies (Inpatient or Outpatient) Exclusions

- a. Expenses for educational, job training and/or vocational rehabilitation.
- b. Expenses for massage therapy, rolfing and related services.
- c. Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan administrator or its designee, is otherwise incapable of participating in a purposeful manner with the therapy services, including, but not limited to coma stimulation programs and services.
- d. Expenses for maintenance rehabilitation as defined in the Definitions section of this document.
- e. Expenses for speech therapy for functional purposes including, but not limited to, stuttering, stammering and conditions of psychoneurotic origin.

44. Smoking Cessation Or Tobacco Withdrawal Exclusion

Expenses for nicotine gum, patches, or other products, services or programs intended to assist a person to stop smoking.

45. Spinal Manipulation Exclusion

Expenses for spinal manipulation for individuals under 18 years of age or for manipulation not related to the back.

46. Transplantation (Organ and Tissue) Exclusions

- a. Expenses for human organ and/or tissue transplants not listed in the Schedule of Medical Benefits or that are experimental and/or investigational, and all complications thereof.
- b. Expenses related to nonhuman (Xenografted) organ and/or tissue transplants or implants, except heart valves.
- c. Expenses incurred by the person who donates the organ or tissue, unless the person who receives the transplant is the person covered by this Plan.

47. Vision Care Exclusions

- a. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK), Laser In Situ Keratomileusis (LASIK) and Automated Keratoplasty (ALK).
- b. Expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies, except one pair of eyeglasses or contact lenses provided as a prosthetic device following lens removal surgery, except as provided by the Consortium's vision plan described separate from this document.
- c. Vision therapy (orthoptics) and supplies.

48. Weight Management And Physical Fitness Exclusions

- a. Expenses for medical or surgical treatment of obesity, including, but not limited to, gastric restrictive procedures, gastric/intestinal bypass and reversal procedures, weight loss programs, dietary instructions, and any complications thereof unless the treatment is for Morbid Obesity as defined. See the Definitions chapter for a definition of Morbid Obesity.
- b. Expenses for medical or surgical treatment of severe underweight, including, but not limited to high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by physicians to determine normal body weight.
- c. Expenses for health clubs, exercise programs, gymnasium memberships, exercise equipment, and/or other facility for physical fitness programs.

DENTAL EXPENSE COVERAGE

ELIGIBLE DENTAL EXPENSES

You are covered for dental expenses you incur for most, but not all, dental services and supplies that are provided by a dental care provider and are determined by the Plan administrator or its designee to be **“medically necessary”** but only to the extent that the Plan administrator or its designee determines that the services are the most cost effective ones that meet acceptable standards of dental practice and would produce a satisfactory result **and** the charges for them are **“usual and customary.”** See also the Definitions section for the definitions of “medically necessary” and “usual and customary.” This section of the document explains which expenses for dental services and supplies are covered (that is, are eligible dental expenses) and which are not. Generally, the Plan will not reimburse you for all eligible dental expenses. Usually, you will have to satisfy some deductible and pay some coinsurance toward the amounts you incur that are eligible dental expenses.

EXPENSES THAT ARE NOT ELIGIBLE DENTAL EXPENSES

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

OVERVIEW OF DENTAL DEDUCTIBLE, PLAN MAXIMUMS, AND COINSURANCE			
Annual Deductible	Annual Dental Plan Maximum	General Overall (Lifetime) Maximum Plan Benefit	Coinsurance
What you must pay each year before the Plan pays benefits	The most the Plan will pay for covered expenses in one year.	The most this Plan will pay for all covered expenses for one person.	How you and the Plan will split the cost of covered expenses.
Individual: \$50 Family: \$100	\$1,500 per person per year.	\$1,500 for orthodontia \$350 for non-surgical TMJ services	Preventive: 100% Basic: 80% Major: 50% Orthodontia: 50% (All services are subject to the deductible except preventive.)

All annual deductibles and annual maximum plan benefits are determined during the Plan year beginning July 1 and ending June 30.

DEDUCTIBLES

Each year, you are responsible for paying all your eligible dental expenses until you satisfy the annual deductible, then the Plan begins to pay benefits. There are two types of deductibles: Individual and Family. **NOTE:** Eligible dental expenses incurred for preventive services are **not** subject to the deductible. The individual deductible is the maximum amount one covered person has to pay before Plan benefits begin. **The Plan’s individual deductible is \$50.** The family deductible is the maximum amount that a family of two or more has to pay before Plan benefits begin. **The Plan’s family deductible is \$100.**

COINSURANCE

Once you have met your annual deductible, the Plan pays a percentage of the eligible dental expenses, and you are responsible for paying the rest. The part you pay is called the coinsurance. **NOTE:** Eligible dental expenses incurred for preventive services are not subject to coinsurance.

OVERALL MAXIMUM PLAN BENEFITS

- **Annual Maximum Plan Benefits:** The Plan’s annual maximum plan benefits payable on account of dental services, except for TMJ or orthodontia services, for any individual covered under this Plan is **\$1,500.**
- **Orthodontia Services:** The overall lifetime maximum plan benefits payable for dental expenses incurred on account of orthodontia services for any individual covered under this Plan and any previous dental expense plan or program provided to that individual by your employer is **\$1,500.**
- **Temporomandibular Joint Syndrome/Disorder (TMJ) Services:** The overall lifetime maximum plan benefits payable for expenses incurred on account of non-surgical TMJ for any individual covered under this Plan and any previous dental expenses plan or program provided to that individual by your employer is **\$350.**

SCHEDULE OF DENTAL BENEFITS

See also the Dental Exclusions and Definitions chapters of this document. This chart shows what the dental plan pays.
The deductible applies to all benefits except where noted.

Benefit Description	Explanations	Deductible	Plan Pays
<p><u>Preventive Services</u></p> <ul style="list-style-type: none"> • Oral examination. • Prophylaxis (cleaning of the teeth). • Examination in connection with emergency palliative treatment. • Examination for consultation purposes. • Bite-wing x-rays. • Full mouth x-rays. • Topical application of sodium or stannous fluoride. • Periodontal prophylaxis. • Space maintainers. 	<ul style="list-style-type: none"> • Preventive services are subject to the annual and overall maximum plan benefits. • Oral examination limited to twice in a 12-month period. • Prophylaxis, scaling, cleaning and polishing limited to twice in a 12-month period. • Bite-wing x-rays limited to once in a period of 12 consecutive months. • Full mouth x-rays limited to once in a period of 24 consecutive months. • Fluoride limited to family members under the age of 19 and limited to not more than twice in a 12-month period. • Periodontal prophylaxis limited to once every 3 months not to exceed 4 times in a 12-month period. • Space maintainers for the premature loss of posterior primary teeth, limited to children under the age of 14. 	No	100%
<p><u>Basic Services</u></p> <ul style="list-style-type: none"> • Dental x-rays as required for diagnosis of a specific dental condition. • Application of sealants on bicuspid and posterior teeth (molars). • Injection of necessary antibiotic drugs by the attending dentist. • Amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration for decayed or broken teeth. • Treatment of periodontal and other diseases of the gums and supporting structures of the mouth (gingiva and/or alveolar bone). • Occlusal adjustment, only in connection with periosurgery. • Oral surgery, including tooth extractions and surgical procedures. • Endodontic treatment, including root canal therapy. • Administration of local, general anesthesia and/or intravenous sedation in connection with oral surgery and covered dental services. • Non-surgical treatment of temporomandibular joint syndrome/disorder (TMJ). • Laboratory services, including cultures necessary for diagnosis and/or treatment of a specific dental condition. • Drugs and medicines that are FDA-approved pharmaceuticals requiring a prescription and FDA approved for the condition, dose, route, duration and frequency that were prescribed by a dentist. 	<ul style="list-style-type: none"> • Basic services are subject to annual and overall maximum plan benefits. • Application of sealants limited to permanent bicuspids and molars, once in a period of 36 consecutive months, for children under the age of 19. • Periodontal scaling and root planing is payable once per quadrant per 24 month period and the pocket depth must be greater than 4mm to qualify for this procedure. • Oral surgery is limited to removal of impacted teeth or as necessary for: <ul style="list-style-type: none"> • teeth covered partially or totally by bone; • root canal treatment; or • gingivectomy. • Non-surgical treatment of TMJ limited to \$350 per person per lifetime. 	Yes	80%

SCHEDULE OF DENTAL BENEFITS

See also the Dental Exclusions and Definitions chapters of this document. This chart shows what the dental plan pays.
The deductible applies to all benefits except where noted.

Benefit Description	Explanations	Deductible	Plan Pays
<p><u>Major Services</u></p> <ul style="list-style-type: none"> • Installation of fixed bridgework, dentures and cast inlays. • Onlays and crowns, including porcelain for the front teeth only. • Repair or re-cementing of crowns, inlays or onlays. • Adjusting, relining or re-basing of removable dentures. • Replacement of an existing partial or full removable denture or fixed bridgework; addition of teeth to an existing partial or removable denture; bridgework to replace teeth that were extracted if evidence, satisfactory to the Plan administrator or its designee, is presented that the conditions shown to the right have been satisfied. • Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace natural teeth that were lost or extracted. Expenses on account of adjustments to fixed bridgework are covered only for the 6-month period following initial installation. • Precision or semi-precision attachments for prosthetic devices. • Gold restorations. 	<ul style="list-style-type: none"> • Major services are subject to annual and overall maximum plan benefits. • Installation of fixed bridgework must be completed within 12 months of the extraction. • When porcelain is used for onlays or crowns on posterior teeth, plan benefits are limited to the amount payable for metal onlays or crowns. • For replacement of an existing partial or full removable denture: <ul style="list-style-type: none"> • The replacement or addition of teeth is necessary to replace one or more teeth extracted after the existing denture or bridgework was installed and the addition of teeth is completed within 12 months of the extraction. • The existing denture or bridgework cannot be made serviceable and was installed at least 5 years prior to the replacement date, and the patient was covered by the dental plan for at least 2 years. • The existing denture is an immediate temporary denture replacing one or more natural teeth extracted. Replacement by a permanent denture is required. The replacement must take place within 12 months from the placement of the temporary denture. • The replacement is due to accidental injury requiring oral and the replacement takes place within 15 months of the accident. 	Yes	50%
<p><u>Orthodontia Services</u></p> <ul style="list-style-type: none"> • Necessary services related to an active course of orthodontia treatment include diagnosis, evaluation and pre-care. • The initial installation of orthodontic appliances for an active course of orthodontia treatment. • Adjustment of active orthodontia appliances. • This orthodontia benefit is for nonsurgical services provided to correct malocclusion (alignment of the teeth and or jaws) that significantly interferes with their function. • Expenses related to orthodontia will be covered only when one or more of the conditions shown to the right have been satisfied. 	<ul style="list-style-type: none"> • Orthodontia services are subject to an overall maximum plan benefit. • Payment for orthodontia benefits will not continue if treatment ceases for any reason. • Repair or replacement of orthodontia appliances are not covered. • Conditions required for coverage of orthodontia: <ul style="list-style-type: none"> • The existence of an extreme buccolingual version of the teeth, either unilateral or bilateral. (The teeth are pushed out toward the cheek or in toward the tongue on one or both sides.) • A protrusion of the upper teeth of more than 3 millimeters. • A protrusion or retrusive relation of the maxillary or mandibular arch. 	Yes	50%, to the lifetime orthodontia maximum.

DENTAL PLAN EXCLUSIONS

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

GENERAL EXCLUSIONS

1. **Costs of Reports, Bills, etc.:** Expenses for preparing dental reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken appointments, telephone calls and/or photocopying fees.
2. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any plan benefit limitation, annual maximum plan benefits, or overall maximum plan benefits as described in the Dental Expense Coverage section of this document.
3. **Expenses Exceeding Usual and Customary Charges:** Any portion of the expenses for covered dental services or supplies that are determined by the Plan administrator or its designee to exceed the usual and customary charge as defined in the Definitions section of this document.
4. **Expenses for Orthodontia That Started Before Coverage Began:** Expenses for any dental services relating to any active course of orthodontia treatment that began before the effective date of coverage under this Plan, even if those services are provided after the effective date of coverage under this Plan.
5. **Expenses for Which a Third Party Is Responsible:** Expenses for dental services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party, as applicable. See the provisions relating to Third Party Liability in the Coordination of Benefits (COB) section of this document for an explanation of the circumstances under which the plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
6. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the dental plan or after the date the patient's coverage ends.
7. **Expenses Related to Teeth Lost Before Coverage Began:** Expenses for the initial installation of dentures or bridgework replacing a tooth or a group of teeth lost while the individual was covered under this Plan but were finally installed or delivered more than 31 days after termination of coverage.
8. **Experimental and/or Investigational Services:** Expenses for any dental services and supplies that are determined by the Plan administrator or its designee to be experimental and/or investigational as defined in the Definitions section of this document.
9. **Illegal Act:** Expenses incurred by any covered individual for injuries resulting from or sustained as a result of commission, or attempted commission by the covered individual, of an illegal act that the Plan administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the covered individual. The Plan administrator's discretionary determination that this exclusion applies shall not be affected by any subsequent official action or determination with respect to prosecution of the covered individual (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.
10. **Travel and Related Expenses:** Expenses for and related to travel or transportation (including lodging, meals and related expenses), unless those expenses have been preapproved by the Plan administrator or its designee.
11. **Services Covered by Workers' Compensation:** Expenses for the treatment of conditions covered by workers' compensation or occupational disease law.
12. **Services Not Medically Necessary:** Services or supplies determined by the Plan administrator or its designee not to be medically necessary as defined in the Definitions section of this document.
13. **Services Not Performed by a Dentist or Dental Hygienist:** Expenses for dental services not performed by a dentist (except for services of a dental hygienist that are supervised and billed by a dentist and are for cleaning or scaling of teeth or for fluoride treatments).
14. **Services Provided by Government:** Expenses for dental services when benefits for them are provided to the covered person:
 - a. under any plan or program established under the laws or regulations of any government, including the federal state, or local government or the government of any other political subdivision of the United States, or of any other country or any political subdivision of any other country; or
 - b. under any plan or program in which any government participates other than as an employer, unless the governmental program provides otherwise.

15. **Services Provided by Relatives:** Expenses for dental services provided by any dentist or other dental care practitioner who is the parent, spouse, sibling (by birth or marriage) or child of the patient or covered employee.
16. **Services Provided Outside the United States:** Expenses for dental services or supplies rendered or provided outside the United States, except for treatment in Mexico or for a dental emergency as defined in the Definitions section of this document.
17. **Services Provided Without Cost to Recipient:** Expenses for dental services or supplies for which a covered person is not required to pay or which are obtained without cost or there would be no charge if the person receiving the treatment were not covered under this Plan.
18. **War:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, except as required by law.

SPECIFIC DENTAL CARE EXCLUSIONS

19. **Analgesia, Sedation, Hypnosis, etc.:** Expenses for analgesia, sedation, hypnosis and/or related services provided for apprehension or anxiety.
20. **Cosmetic Services:** Expenses for dental surgery or dental treatment for cosmetic purposes, as determined by the Plan administrator or its designee, including but not limited to veneers and facings. However, the following will be covered if they otherwise qualify as covered dental expenses and **are not covered** under your medical expense coverage:
 - a. Reconstructive dental surgery when that service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part.
 - b. Surgery or treatment to correct deformities caused by sickness.
 - c. Surgery or treatment to correct birth defects outside the normal range of human variation.
 - d. Reconstructive dental surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional disorder.
21. **Drugs and Medicines:** Expenses for prescription drugs and medications that are covered under your medical expense coverage, and for any other dental services or supplies if benefits are otherwise provided under the Plan's medical expense coverage; or under any other plan/program that your employer contributes to or otherwise sponsors; through a medical or dental department, clinic or similar facility provided or maintained by the organization.
22. **Duplicate or Replacement Bridges, Dentures or Appliances:** Expenses for any duplicate or replacement bridge, denture or orthodontic appliance except as covered under the Schedule of Dental Benefits.
23. **Duplication of Dental Services:** If a person covered by this plan transfers from the care of one dentist to the care of another dentist during the course of any treatment, or if more than one dentist renders services for the same dental procedure, the Plan will not be liable for more than the amount that it would have been liable had but one dentist rendered all the services during each course of treatment, nor will the Plan be liable for duplication of services.
24. **Gnathologic Recordings for Jaw Movement and Position:** Expenses for gnathologic recordings for jaw movement and position.
25. **Home Use Supplies:** Expenses for home use supplies, including, but not limited to, toothpaste, toothbrush, water-pick, fluoride, mouthwash, dental floss, etc.
26. **Implantology:** Expenses for implantology (artificial root structure placed into the jaw to support bridgework or dentures).
27. **Mouth Guards:** Expenses for athletic mouth guards and associated devices.
28. **Myofunctional Therapy:** Expenses for myofunctional therapy.
29. **Oral Hygiene and/or Dietary Instruction:** Expenses for oral hygiene and/or dietary instruction or for a plaque control program (a series of instructions on the care of the teeth).
30. **Periodontal Splinting:** Expenses for periodontal splinting.
31. **Personalized Bridges, Dentures, Retainers or Appliances:** Expenses for personalization or characterization of any dental prosthesis, including but not limited to any bridge, denture, retainer or appliance.
32. **Replacement of Lost, Missing or Stolen Bridges, Dentures or Appliances:** Expenses for replacement of a lost, missing or stolen bridge or denture or orthodontic appliance, except as payable under the Schedule of Dental Benefits.
33. **Sealants:** Expenses for sealants (materials other than fluorides painted on the grooves of the teeth to prevent decay), except as payable under the Schedule of Dental Benefits.

34. **Services or Appliances Subject to Orthodontia Benefit:** Expenses for any dental services or appliances including, but not limited to items to increase vertical dimension, restore occlusion, stabilize tooth structure lost by wear or bruxism and harmful habits, except as provided under the orthodontia services benefit outlined in the Schedule of Dental Benefits.
35. **Space Maintainers, Study Models, etc.:** Expenses for anterior space maintainers, study models, molds and/or casts, except as payable under the Schedule of Dental Benefits.
36. **Treatment of Jaw or Temporomandibular Joints:** Expenses for surgical treatment, by any means, of jaw joint problems including temporomandibular joint disorder or syndrome (except non-surgical TMJ treatment as payable under the Schedule of Dental Benefits) and any other craniomandibular disorders or other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues relating to that joint.

VISION EXPENSE COVERAGE

All medical plan participants are eligible for this Vision Plan. This Vision Plan offers services from network or non-network providers.

Network Providers: The Vision Plan is a network of preferred vision providers whose member doctors provide professional vision care for eligible participants covered under the Plan. A current list of member doctors is available when you call the Vision Plan whose name and address are noted on the Quick Reference Chart in the Introduction chapter of this document.

Non-Network Providers: Services may be received from any licensed optometrist, ophthalmologist and/or dispensing optician. The itemized bill reflecting the non-network provider's usual and customary fees must be submitted to the Vision Plan administrator for reimbursement. You will be reimbursed according to the usual and customary fee or the schedule below, whichever is less.

NOTE: Vision claims must be submitted to the Vision Plan Administrator within 6 months of the date of service or payment cannot be considered.

SCHEDULE OF VISION BENEFITS			
Covered Vision Benefits	Explanation See also the Vision Exclusions.	Plan Pays	
		Network Provider (Doctor)	Non-Network Provider
Vision Exam and analysis of visual function.	Payable once every 12 months.	100% after a \$10 copay	Up to \$35 per exam
Eyeglasses (frames and lenses)	<ul style="list-style-type: none"> • A single vision, lined bifocal, lined trifocal lenses or lenticular lenses every 12 months if needed; and/or • A frame not to exceed the frame allowance, every 24 months, if needed. <p>This program provides a wide selection of quality frames. Because of the cosmetic nature of frames and rapidly changing styles, this Plan has a limit (determined by the Vision Plan administrator) on the reimbursement for frames. Covered persons who select frames that exceed the frame allowance will pay the additional cost.</p>	<p>100% after a \$15 copay for lenses and/or frames.</p> <p>Frame of your choice is covered/allowed up to \$120, plus 20% discount off any out of pocket costs for frames.</p>	<p>Single vision (pair)*= Up to \$25</p> <p>Lined bifocal lenses (pair)*= Up to \$40</p> <p>Lined trifocal lenses (pair)*= Up to \$55</p> <p>Lenticular lenses (pair)* = Up to \$80</p> <p>Frame = Up to \$45.</p> <p>*If only one lens is needed, the allowance will be one-half the pair allowance.</p>
Contacts	<ul style="list-style-type: none"> • Once every 12 months. <p>When you choose contacts instead of glasses your \$105 allowance applies to the cost of your contacts and contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts.</p>	100%, the Plan pays up to \$105.	<p>Contacts required for vision correction (as determined by the Vision Plan administrator) = Up to \$210</p> <p>Cosmetic (elective) contact lenses (as determined by the Vision Plan administrator) = Up to \$105.</p>

NOTE: The lens allowance described in this Vision Plan is for a pair of lenses. If only one lens is needed, the allowance will be one-half of the pair allowance.

EXTRA DISCOUNTS AND SAVINGS: When visiting a network doctor you will receive:

- Up to 20% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives.
- 20% off additional prescription glasses and sunglasses.
- 15% discount off the cost of contact lens exam (fitting and evaluation).
- Exclusive pricing on annual supplies of popular brands of contacts.

VISION PLAN EXCLUSIONS

1. The Vision Plan is designed to cover visual needs rather than cosmetic materials. When a covered person selects any of the following extras, the Vision Plan will pay the cost of the allowed vision service/supply and the covered person will pay the additional cost for the extras such as:
 - Oversized lenses (61mm or greater, except with prior authorization);
 - Progressive multi-focal lenses;
 - Blended lenses;
 - Contact lenses, except as otherwise stated in the Schedule of Vision Benefits;
 - Coated lenses;
 - Tinted lenses, except pink #1 and #2;
 - High Index lenses;
 - Aspheric lenses;
 - Laminated lenses;
 - Aniseikonic lenses;
 - Lenses when there is no prescription change;
 - A frame that costs more than the Plan's allowance as noted in the Schedule of Vision Benefits.
2. Orthoptics or vision training, subnormal vision aids and any associated supplemental testing.
3. Plano (non-prescription) lenses.
4. Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available as described in the Schedule of Vision Benefits.
5. Two pair of lenses in lieu of bifocals.
6. Medical or surgical treatment of the eyes.
7. Services or materials provided as a result of any Workers' Compensation Law, or similar legislation or obtained through or required by any government agency or program, whether federal, state or any subdivision thereof.
8. Any service or material provided by any other vision care plan, or group benefit plan containing benefits for vision care.
9. Vision examination required by an employer.

CLAIMS INFORMATION

How Medical And Dental Benefits Are Paid

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

Generally, plan benefits payable on account of expenses for a hospital or specialized health care facility will be paid directly to the institution providing the services. Likewise, plan benefits payable on account of expenses for surgery will be paid directly to the surgeon or anesthesiologist providing the services.

However, if, at the time you submit your claim, you furnish evidence acceptable to the Plan administrator or its designee that you or your covered dependent paid some or all of those charges, plan benefits will be paid to you up to the amount you paid for those services. When deductibles, coinsurance or copayments apply, you are responsible for paying your share of the charges.

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

Qualified Medical Child Support Orders (QMCSOs)

According to federal law, a Qualified Medical Child Support Order, or QMCSO, is a child support order of a court that usually results from a divorce or legal separation, that has been received by the Plan, and that:

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

If a court has issued an order with respect to health care coverage for any of the employee's dependent children, the Plan administrator or its designee will determine if the court order is a QMCSO as defined by federal law, and that determination will be binding on the employee, the other parent, the child and any other party acting on behalf of the child. For additional information regarding the coverage of dependent children under a QMCSO, see the Eligibility section.

The QMCSO may not require that a plan provide any plan benefits that are not otherwise provided under the plan. However, if the employee is a participant in the plan, the QMCSO may require the plan to provide coverage for the employee's dependent child(ren) and to accept contributions for that coverage from a parent who is not a plan participant. The plan will accept a special enrollment of the dependent child(ren) specified by the QMCSO from either the employee or the custodial parent.

Coverage of the dependent child(ren) will become effective as of the date the enrollment is received by the plan and will be subject to all terms and provisions of the plan, including the exclusion of pre-existing conditions, limits on selection of providers and requirements for authorization of services, insofar as is permitted by applicable law.

If the employee is not covered by the plan at the time the QMCSO is received and the QMCSO orders the employee to provide coverage for the dependent child(ren) of the employee, the Plan will accept a special enrollment of the employee and the dependent child(ren) specified by the QMCSO. Coverage of the employee and the dependent(s) will become effective as of the date the enrollment is received by the Plan and will be subject to all terms and provisions of the Plan, including the exclusion of pre-existing conditions, insofar as is permitted by applicable law.

Coverage of a dependent child under a QMCSO will terminate when coverage of the employee-parent terminates, for any reason including failure to pay any required contributions, subject to the dependent child's right to elect COBRA continuation coverage if it applies. Contributions required for coverage under a QMCSO are the total employer

contributions required for coverage of the employee and all members of the employee's family who are enrolled in the Plan, minus the contributions otherwise actually being paid by the employee.

The QMCSO may also require the Plan to pay plan benefits on account of expenses incurred by or on behalf of the dependent child(ren) covered by the plan either to the health care provider who rendered the services or to the custodial parent of the dependent child(ren). If coverage of the dependent child(ren) is actually provided by the plan, and if the Plan administrator or its designee determines that it has received an QMCSO, it will pay plan benefits on account of expenses incurred by or on behalf of the dependent child(ren) to the extent otherwise covered by the Plan as required by that QMCSO.

When You Must Repay Plan Benefits

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

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

the Plan will be entitled to a refund from you or your health care provider of the difference between the amount of plan benefits actually paid by the plan for those expenses and the amount of plan benefits that should have been paid by the plan for those expenses based on the actual facts. For additional information on the procedures that may be followed by the plan to recover these amounts, see the provision regarding third party liability in the section of this document discussing Coordination of Benefits (COB).

HOW TO FILE A CLAIM

You can get claim forms from your personnel/payroll department.

How To Complete A Claim Form

1. Complete the employee part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
2. The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your physician or dentist can complete the health care provider part of the claim form, or you can attach the bill for professional services if it contains **all** of the following information:
 - a. a description of the services or supplies provided and appropriate billing codes;
 - b. details of the charges for those services or supplies;
 - c. diagnosis and appropriate diagnosis code(s);
 - d. date(s) the services or supplies were provided;
 - e. patient's name; and
 - f. provider's name, address, phone number, professional degree or license, and federal tax identification number.
3. Please review your bills to be sure they are appropriate and correct. **Report any discrepancies in billing to the claims administrator.** This can reduce costs to you and the plan.
4. Complete a **separate claim form** for each person for whom plan benefits are being claimed.

Where To Send The Claim Form

Send the completed medical and dental claim forms and any other required information to the claims administrator whose address is listed on the Quick Reference Chart in the Introduction section of this document.

Any prescription drug claims should be sent to the prescription drug program whose address is listed on the Quick Reference Chart in the Introduction section of this document.

REVIEW PROCEDURE IF YOUR CLAIM IS DENIED (CLAIMS APPEAL PROCESS)

Written Notice Of Denial Of Claim

Time Limit For Filing Medical And Dental Claims

NOTE: All medical, dental and prescription claims must be submitted to the plan **within 12 months** after the expenses were incurred.

No plan benefits will be paid for any claim not submitted within this period.

The Plan will notify you in writing if payment of your claim is denied in whole or in part. It will explain the reasons why, with reference to the plan provisions on which the denial was based. When applicable, you will be told what additional information is required from you and why it is needed.

Request For Review Of Denial Of Claim

You may appeal a denial that has been received from any of the claims administrators that are listed on the Quick Reference Chart in the front of this document, such as the medical claims administrator, utilization management firm or the vision claims administrator. To appeal a denied claim, follow the steps below:

Level 1 (Initial appeal level)

1. Your request for review must be made in writing to the office where the claim was originally denied within 60 days after you receive a notice of denial. See the Quick Reference Chart in the front of this document for the address of the various claims administrators.
2. You may be required to submit additional facts, documents or other evidence as needed to make an independent determination of the applicant's eligibility for benefits under this Plan. You have the right to review documents applicable to the denial and to submit your own comments in writing.
3. Your claim will be reviewed by a person at a higher level of management than the one who originally denied the claim.
4. Ordinarily, a decision will be reached within 90 days after receipt of your request for appeal. However, in special circumstances, up to an additional 60 days may be necessary to reach a final decision. You will be advised in writing within the first 90 days after receipt of your request for appeal if an additional period of time will be necessary to reach a final decision.
5. The claims administrator's decision on this first level review of your claim will be given to you in writing. It will explain the reasons for the decision, with reference to the applicable provisions of the plan.

Level 2 Appeal: (Second appeal level)

1. If you are still dissatisfied with the denial of your claim after the level one appeal process, you may submit your written request to the Board of Trustees, at their address listed on the Quick Reference Chart in the front of this document, within 60 days after you receive the Level 1 decision.
2. The Board of Trustees will make a full and fair review of each appeal. The claimant may be required to submit additional facts, documents or other evidence as needed to make an independent determination of the applicant's eligibility for benefits under this Plan. In making its determination, the Board of Trustees will consider the written material and oral statements or presentations submitted by the claimant, any claims administrator's reports, the plan document and the report of any independent medical review firm (as applicable).
3. **Independent Medical Review:** The Board of Trustees reserves the right to utilize the assistance of an independent medical review firm in the research and resolution of a claim appeal. The independent medical review may be requested by the Board of Trustees for issues involving costs of more than \$500 and commonly for the following reasons: issues of medical necessity, issues of experimental or investigational or coverage issues. The cost of such independent review will be paid by the Plan. Independent medical review recommendations are not binding on the Board of Trustees.
4. Ordinarily, the Board of Trustees' decision will be reached within 60 days after receipt of your request for Level 2 appeal. However, in special circumstances, up to an additional 30 days may be necessary to reach a final decision.

You will be advised in writing within the original 60-day period after receipt of your request for appeal if an additional period of time will be necessary to reach a final decision.

5. The Board of Trustee's decision on this appeal of your claim will be given to you in writing, explaining the reasons for the decision, with reference to the applicable provisions of the plan. The decision of the Board of Trustees will be final and conclusive upon all persons.

FACILITY OF PAYMENT

If the Plan administrator or its designee determines that you are comatose, incompetent or incapacitated to the extent that you are incapable for furnishing proof of claim or evidence that you or your covered dependent paid some or all of the charges for health care services covered by the plan, the plan may, at its discretion, make any and all such payment to the health care provider who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment will completely discharge the plan's obligations to the extent of that payment, and neither the plan, Plan administrator, claim administrator nor any other designee of the Plan administrator will be required to see to the application of the money so paid.

COORDINATION OF BENEFITS (COB): DUPLICATE COVERAGE

How Duplicate Coverage Occurs

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

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

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

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

This plan operates under rules that prevent it from paying benefits that, together with the benefits from any other source described in the paragraphs above, would allow you to recover more than 100% of medical and dental expenses you incur. In many instances, you may recover less than 100% of those medical and dental expenses from the duplicate sources of coverage or recovery. In some instances, this plan will not provide coverage if you can recover expenses from some other resource. In other instances, this plan will advance its benefits, but only subject to its right to recover them if and when you or your covered dependent actually recover some or all of your losses from a third party.

COORDINATION OF BENEFITS (COB): COVERAGE UNDER MORE THAN ONE GROUP HEALTH PLAN

When And How Coordination Of Benefits (COB) Applies

1. For the purposes of this Coordination of Benefits (or COB, as it is usually called) section, the word “plan” refers to any group or individual medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical or dental services incurred by the covered person or that provides medical or dental services to the covered person. A “group plan” provides its benefits or services to employees, retirees or members of a group who are eligible for and have elected coverage. An “individual plan” provides its benefits or services to individuals or families who have purchased coverage. The term “this plan” refers to the Yuma Area Benefit Consortium.
2. Many families that have more than one family member working outside the home are covered by more than one medical or dental plan. If this is the case with your family, **you must let this plan (or its insurer) know about all your coverages when you submit a claim.**
3. Coordination of benefits operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan (called the secondary plan) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental expenses incurred.** Sometimes, the combined benefits that are paid will be less than the total expenses.

Which Plan Pays First: Order of Benefit Determination Rules

An individual plan (that is, a plan purchased by an individual), whether provided through a policy, subscriber contract, health care network plan, or group practice or individual practice plan, pays first; and this plan pays second.

Group plans determine the sequence in which they pay benefits or which plan pays first by applying a uniform order of benefit determination rules in a specific sequence. This plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules always pays its benefits first.**

If the first rule does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. The rules are:

Rule 1: Non-Dependent/Dependent

- a. The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the plan that covers the same person as a dependent pays second.
- b. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:
 - (1) secondary to the plan covering the person as a dependent; and
 - (2) primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee);then the order of benefits is reversed, so that the plan covering the person as a dependent pays first and the plan covering the person other than as a dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

- a. The plan that covers the parent whose birthday falls earlier in the calendar year pays first and the plan that covers the parent whose birthday falls later in the calendar year pays second, if:
 - (1) the parents are married;
 - (2) the parents are not separated (whether or not they ever have been married); or
 - (3) a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.
- b. If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first and the plan that has covered the other parent for the shorter period of time pays second.
- c. The word “birthday” refers to the month and day in a calendar year not the year in which the person was born.
- d. If the specific terms of a court decree state that one parent is responsible for the child’s health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does **not** apply during any plan year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.
- e. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:
 - (1) The plan of the custodial parent pays first;
 - (2) The plan of the spouse of the custodial parent pays second; and
 - (3) The plan of the non-custodial parent pays third; and
 - (4) The plan of the spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

- a. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee’s dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee’s dependent, pays second.
- b. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- c. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

- a. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person’s dependent) pays first, and the plan providing continuation coverage to that same person pays second.
- b. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- c. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

- a. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.
- b. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.
- c. The start of a new plan does **not** include a change:
 - (1) in the amount or scope of a plan's benefits;
 - (2) in the entity that pays, provides or administers the plan; or
 - (3) from one type of plan to another (such as from a single-employer plan to a multiple-employer plan).
- d. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

How Much This Plan Pays When It Is Secondary

When this plan pays second, it will pay the same benefits that it would have paid had it paid first, **less** whatever payments were actually made by the plan (or plans) that paid first.

1. When this plan pays second, it will pay, with respect to each claim submitted for payment, 100% of "allowable expenses" **less** whatever payments were actually made by the plan (or plans) that paid first.
2. "Allowable expense" means a health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:
 - a. The difference between the cost of a semi-private room in a hospital or specialized health care facility and a private room, unless the patient's stay in a private hospital room is medically necessary.
 - b. If the coordinating plans determine benefits on the basis of usual and customary charges, any amount in excess of the highest usual and customary charge is not an allowable expense.
 - c. If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
 - d. If one coordinating plan determines benefits on the basis of usual and customary charges and the other coordinating plan provides benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the allowable expense for all plans.
 - e. When benefits are reduced by a primary plan because a covered person did not comply with the primary plan's provisions, such as the provisions related to UM in this plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this plan when it pays second.

Allowable expenses **do not** include expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this plan.

Administration Of COB

1. To administer COB, the plan reserves the right to:
 - a. exchange information with other plans involved in paying claims;
 - b. require that you or your health care provider furnish any necessary information;
 - c. reimburse any plan that made payments this plan should have made; or
 - d. recover any overpayment from your hospital, physician, dentist, other health care provider, other insurance company, you or your dependent.
2. If this plan should have paid benefits that were paid by any other plan, this plan may pay the party that made the other payments in the amount this plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this plan, and this plan will be fully discharged from any liability it may have to the extent of such payment.
3. To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the medical and dental expenses that were incurred. However, any person who claims benefits under this plan must give it all the information the plan needs to apply COB.
4. If this plan is secondary, this plan will pay secondary medical benefits only when the coordinating primary plan pays medical benefits, and it will pay secondary dental benefits only when the primary plan pays dental benefits.

This plan will not pay secondary medical benefits when the coordinating primary plan pays dental benefits, nor will this plan pay secondary dental benefits when the coordinating primary plan pays medical benefits.

5. If this plan is secondary, and if the coordinating primary plan provides benefits in the form of services, this plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan.
6. If this plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this plan will be payable by this plan only to the extent they would have been payable if this plan were the primary plan.
7. If this plan is secondary; if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this plan; and if this plan advances an amount equal to the benefits it would have paid had it been the primary plan, this plan will be subrogated to all rights the plan participant may have against the other plan, and the plan participant will execute any documents required or requested by this plan to pursue any claims against the other plan for reimbursement of the amount advanced by this plan.

Medicare And Other Government Programs

Medicare

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security disability income benefits is also entitled to Medicare coverage after a waiting period.

Medicare Participants May Retain or Cancel Coverage Under This Plan

If you, your covered spouse or dependent child becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, you may either retain or cancel your coverage under this plan. If you and/or any of your dependents are covered by both this plan and by Medicare, as long as you remain actively employed, your medical expense coverage will continue to provide the same benefits and your contributions for that coverage will remain the same. In that case, this plan pays first and Medicare pays second. If you are covered by Medicare and you cancel your coverage under this plan, coverage of your spouse and/or your dependent child(ren) will terminate, but they may be entitled to COBRA continuation coverage. See the COBRA Continuation of Coverage section for further information.

If any of your dependents are covered by Medicare and you cancel that dependent's coverage under this Plan, that dependent will **not** be entitled to COBRA continuation coverage. The choice of retaining or canceling coverage under this plan of a Medicare participant is yours, and yours alone. Neither this plan nor the Consortium will provide any consideration, incentive or benefits to encourage you to cancel coverage under this plan.

Coverage Under Medicare and This Plan When You Are Totally Disabled

If you become totally disabled and entitled to Medicare because of your disability, you will no longer be considered to remain actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this plan pays second.

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

If, while you are actively employed, you or any of your covered dependents become entitled to Medicare because of end-stage renal disease (ESRD), this plan pays first and Medicare pays second for 30 months starting the **earlier** of:

1. the month in which Medicare ESRD coverage begins; or
2. the first month in which the individual receives a kidney transplant.

Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this plan pays second.

How Much This Plan Pays When It Is Secondary to Medicare

When the Plan Participant Is Covered by Medicare Parts A and B: This Plan pays the same Benefits provided for active employees less the amounts paid by Medicare.

When the Plan Participant Is Covered by Medicare Advantage (formerly called Medicare + Choice or Part C):

1. This Plan provides benefits that supplement the benefits you receive from Medicare Part A and B coverage. If a plan participant is covered by a Medicare Advantage and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services in-network when the Medicare Advantage program requires it, this plan will reimburse all applicable copayments and will pay the same benefits provided for active employees less any amounts paid by the Medicare Advantage program.

2. **However, if the plan participant doesn't comply with the rules of the Medicare Advantage program, including without limitation, approved referral, preauthorization, or case management requirements, this plan will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the plan participant receives.**

When the Plan Participant is Not Covered by Medicare:

If the plan participant is eligible for but is not enrolled in Medicare, this plan pays the same benefits provided for active employees less the amounts that would have been paid by Medicare had the plan participant been covered by Medicare Parts A and B, based on the fees that would be allowed by Medicare.

When the Plan Participant Enters Into a Medicare Private Contract

Under Medicare, a participant is entitled to enter into a Medicare private contract with certain health care practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care practitioner. If a Medicare participant enters into such a contract, **this Plan will NOT pay any benefits** for any health care services and/or supplies the Medicare participant receives pursuant to it.

Medicaid

If you are covered by both this plan and Medicaid, this plan pays first and Medicaid pays second.

Tricare/CHAMPUS

If you are covered by both this plan and Tricare/CHAMPUS, this plan pays first and Tricare/CHAMPUS pays second. For an employee called to active duty for more than 30 days, Tricare is primary and this plan is secondary.

Services Received In a U.S. Department Of Veterans Affairs Facility

If you receive services in a U.S. Department of Veterans Affairs hospital or facility on account of a military service-related illness or injury, benefits are not payable by the plan. If you receive services in a U.S. Department of Veterans Affairs hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the plan to the extent those services are medically necessary and the charges are usual and customary.

Motor Vehicle No-Fault Coverage Required By Law

If you are covered for medical and dental benefits by both this plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this plan pays second, where applicable. If you are covered for loss of earnings by both this plan and any motor vehicle no-fault coverage that is required by law, the benefits payable by this plan on account of disability will be reduced by the benefits available to you for loss of earnings pursuant to the motor vehicle no-fault coverage.

Other Coverage Provided By State Or Federal Law

If you are covered by both this plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this plan pays second.

Workers' Compensation

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

THIRD PARTY LIABILITY

A. Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party is required to pay because of a negligent or wrongful act (See the exclusion regarding Expenses for Which a Third Party Is Responsible in the Exclusions chapter), but it will advance payment on account of Plan benefits (hereafter called an "**Advance**"), **subject to its right to be reimbursed to the full extent of any Advance payment from the covered Employee and/or Dependent(s) if and when there is any recovery from any third party. The right of reimbursement will apply:**

1. even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical or dental expenses for which the Advance was made; and
2. even if the recovery is not sufficient to make the ill or injured employee and/or dependent(s) whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule); and

3. without any reduction for legal or other expenses incurred by the employee and/or dependent(s) in connection with the recovery against the third party or that third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and
4. regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule).

B. Reimbursement and/or Subrogation Agreement

The covered Employee **and/or** any covered Dependent(s) on whose behalf the Advance is made, must sign and deliver a reimbursement and/or subrogation agreement (hereafter called the "**Agreement**") in a form provided by or on behalf of the Plan. If the ill or injured Dependent(s) is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor dependent child) or spouse or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Plan Administrator or its designee.

If the Agreement is not executed at the Plan Administrator's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an Agreement, **that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights.**

C. Cooperation with the Plan by All Covered Individuals

By accepting an Advance, regardless of whether or not an Agreement has been executed, the covered Employee and/or covered Dependent(s) each agree to:

1. reimburse the Plan for all amounts paid or payable to the covered Employee and/or covered Dependent(s) or that third party's insurer for the entire amount Advanced; and
2. do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or subrogation rights; and
3. notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party based on any alleged negligent or wrongful act that may have caused or contributed to the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts; and
4. inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

D. Subrogation

1. By accepting an Advance, the covered Employee and/or covered Dependent's jointly agree that the Plan will be subrogated to the covered employee and/or covered dependent's right of recovery from a third party or that third party's insurer for the entire amount Advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule (that would have the effect of prohibiting the Plan from recovering any amount). This means that, in any legal action against a third party who may have wrongfully caused the injury or illness that resulted in the Advance, the Plan may be substituted in place of the covered Employee and/or covered Dependent(s), but only to the extent of the amount of the Advance.
2. Under its subrogation rights, the Plan may, at its discretion:
 - start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the covered Employee and/or covered Dependent(s), but in doing so, the Plan will **not** represent, or provide legal representation for the covered Employee and/or covered Dependent(s) with respect to their damages that exceed any Advance; or
 - intervene in any claim, legal action, or administrative proceeding started by the covered Employee or covered Dependent(s) against any third party or third party's insurer on account of any alleged negligent or wrongful action that may have caused or contributed to the injury or illness that resulted in the Advance.

E. Remedies Available to the Plan

If the covered Employee or covered Dependent(s) does not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

1. apply any future Plan benefits that may become payable on behalf of the covered Employee and/or covered Dependent(s) to the amount not reimbursed; or
2. obtain a judgment against the covered Employee and/or covered Dependent(s) for the amount Advanced and not reimbursed, and garnish or attach the wages or earnings of the covered Employee and/or covered Dependent(s).

COBRA CONTINUATION OF COVERAGE WHEN YOUR MEDICAL AND DENTAL COVERAGE ENDS

Extension And Continuation Of Coverage In General

Your plan does **not** provide plan benefits for any medical, dental, or vision expenses incurred **after** coverage ends. However, under certain circumstances, your dental coverage may be extended for certain expenses after coverage ends and/or continued for a limited period of time (as described below). There is no extension of medical, dental or vision benefits under this plan. See the COBRA provisions outlined in this section for an explanation on how to temporarily continue coverage under COBRA.

This section explains when and how this extension and continuation of coverage occurs. Continuation of coverage applies only to medical, dental and vision coverages and does **not** apply to life insurance, accidental death and dismemberment, short-term disability, long term disability or other income replacement coverages.

Extension Of Dental Coverage

If dental coverage ends your plan will pay dental plan benefits for you or your covered dependents until the end of the month in which coverage ends. The plan will also pay the applicable amounts beyond that date for the following:

1. A prosthesis (such as a full or partial denture), if the dentist took the impressions and prepared the abutment teeth while you were covered, and installs the device within 31 days after coverage ends.
2. A crown, if the dentist prepared the crown while you were covered and installs it within 31 days after coverage ends.
3. Root canal treatment, if the dentist opened the tooth while you were covered and completes the treatment within 31 days after coverage ends.

As an alternative, under certain circumstances, you can choose to continue your coverage if you pay for the cost of that coverage. See the following section on Continuation of Coverage (COBRA) for further information.

CONTINUATION OF COVERAGE (COBRA)

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

- Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.
- This Plan provides no greater COBRA rights than what is required by law and nothing in this chapter is intended to expand a person’s COBRA rights.

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

IMPORTANT:

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

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

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event, that person’s health care coverage ends, either as of the date of the Qualifying Event or as of some later date. A parent or legal guardian may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment.

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

Failure to Elect COBRA Continuation Coverage

In considering whether to elect COBRA, you should take into account that failure to continue your group health coverage will affect your future rights under federal law, as noted below:

- a. You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Electing COBRA may help you not have such a gap; and
- b. You will also lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA coverage for the maximum time available to you.

Special Enrollment Rights

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

Maximum Period of COBRA Continuation Coverage

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

Medicare Entitlement

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

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

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

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

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

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

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

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

Notices Related to COBRA Continuation Coverage

When:

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

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

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

The COBRA Continuation Coverage That Will Be Provided

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

Paying for COBRA Continuation Coverage (The Cost of COBRA)

By law, any person who elects COBRA Continuation Coverage will have to pay the full cost of the COBRA Continuation Coverage. The Consortium is permitted to charge the full cost of coverage for similarly situated active employees and families (including both the Consortium’s and employee’s share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

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

The Trade Act

The **Trade Adjustment Assistance Reform Act of 2002** (also called the Trade Act) creates a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (called eligible individuals).

- Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA.
- If you have questions about these new tax provisions call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282 (TTD/TTY: 1-866-626-4282). See also the information about the Trade Act at: www.doleta.gov/tradeact/2002act_index.cfm

Grace Periods

The initial payment for the COBRA Continuation Coverage is due to the COBRA Administrator 45 days after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After the initial COBRA payment, subsequent payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

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

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

Addition of Newly Acquired Dependents

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

Loss of Other Group Health Plan Coverage

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

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

Notice of Unavailability of COBRA Coverage

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

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

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, become entitled to Medicare, or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected spouse and/or child is extended to 36 months measured from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described

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

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

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

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

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

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

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

1. This extension is available only if:
 - the Social Security Administration determines that the individual's disability began no later than 60 days after the termination of employment or reduction in hours; **and**
 - **Notifying the Plan:** you or another family member follow this procedure (to notify the Plan) by sending a written notification to the COBRA Administrator of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the COBRA Administrator before the end of the 18-month COBRA Continuation period.
2. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage will be higher than the cost for that coverage during the 18-month period.
3. The COBRA Administrator must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

Early Termination of COBRA Continuation Coverage

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

1. The date on which the employee's employer no longer provides group health coverage to any of its employees;
2. The first day of the time period for which the amount due for the COBRA Continuation Coverage is not paid on time;
3. The date, after the date of the COBRA election, on which the covered person first becomes entitled to Medicare;
4. The date the lifetime benefit maximum is exhausted on all benefits;

5. The date, after the date of the COBRA election, on which the covered person first becomes covered under another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a Pre-Existing Condition that the covered person may have;
6. The date the Plan has determined that the covered person must be terminated from the Plan for cause;
7. During an extension of the maximum coverage period to 29 months due to the disability of the covered person, the disabled person is determined by the Social Security Administration to no longer be disabled.

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a qualified beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the qualifying event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the qualified beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the COBRA Administrator determines that COBRA coverage will terminate early.

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

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

COBRA Questions or To Give Notice of Changes in Your Circumstances

- If you have any questions about your COBRA rights, please contact the COBRA Administrator whose address is listed on the Quick Reference Chart in the front of this document.

Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you must notify the COBRA Administrator:

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

FMLA and COBRA

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

Certification Of Coverage When Coverage Ends

When your COBRA coverage ends, the Plan’s Claims Administrator will automatically provide you and/or your covered Dependents (free of charge) with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. If your coverage under this Plan ends, and you and/or your covered Dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered Dependents, a health insurance policy, you may need this certificate (to prove that you did not have a break in coverage of 63 consecutive days or more) in order to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your covered Dependents in that new group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered Dependents) by first class mail shortly after your (or their) coverage under this Plan ends. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage terminated. In addition, a certificate will be provided to you and/or any covered Dependent upon receipt of a written request for such a certificate if that request is received by the Plan’s Claims Administrator within two years after the later of the date your coverage under this Plan ended or the date COBRA coverage ended. See the Eligibility chapter for the procedure for requesting a certificate of coverage.

OTHER INFORMATION

Plan Amendments Or Termination

Yuma Area Benefit Consortium reserves the right to amend or terminate this plan or any part of it at any time. Amendments may be made in writing to a trustee of the Yuma Area Benefit Consortium and it will be reviewed by the trustees. If approved by the trustees, it will become effective on such date as may be specified in the document amending the plan. The plan or any coverage under it may be terminated by the trustees of the Yuma Area Benefit Consortium.

Discretionary Authority Of The Plan Administrator And Its Designees

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

Statement Of The Consortium's Rights

The Yuma Area Benefit Consortium makes no representation that employment with participating employers represents lifetime security or a guarantee of continued employment. An individual's employment may be terminated because of:

1. unsatisfactory job performance;
2. unsatisfactory attendance;
3. violation of rules and policies of a participating employer of the Consortium; or
4. because an individual's services become excess to the staffing needs of a participating employer of the Consortium.

The participating employers of the Consortium, as plan sponsor, intend that the terms of this plan described in this document, including those relating to coverage and benefits, are legally enforceable and that each plan is maintained for the exclusive benefit of participants, as defined by law.

No Liability For Practice Of Medicine

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

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule

Effective April 14, 2003 a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans maintain the privacy of personally identifiable health information (called **Protected Health Information or PHI**).

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

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, and is available from the Privacy Officer listed in the Quick Reference Chart. Information about HIPAA in this document is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.** The Plan may disclose PHI to the plan sponsor for the purpose of reviewing a benefit claim or for other reasons related to the administration of the Plan.

- A. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.
- **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your health care providers.
 - **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:
 - a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;
 - b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing;
 - c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization review, including precertification, concurrent review and/or retrospective review.
 - **Health Care Operations** includes, but is not limited to:
 - a. business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment,
 - b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions,
 - c. Underwriting, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,
 - d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
 - e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.
- B. **When an Authorization Form is Needed:** Generally the Plan will require that you sign a valid authorization form (available from a Privacy Officer shown in the Quick Reference Chart) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.
- C. The Plan will disclose PHI to the plan sponsor only upon receipt of a certification from the plan sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the plan sponsor agrees to:
1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law,
 2. Ensure that any agents, including subcontractors, to whom the plan sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.
 3. Not use or disclose the information for employment-related actions and decisions,
 4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices).
 5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
 6. Make PHI available to the individual in accordance with the access requirements of HIPAA,
 7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,

8. Make available the information required to provide an accounting of PHI disclosures,
 9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA, and
 10. If feasible, return or destroy all PHI received from the Plan that the plan sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.
- D. In order to ensure that adequate separation between the Plan and the plan sponsor is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:
1. The Plan Administrator,
 2. Benefits administration staff designated by the Plan Administrator.
 3. Business Associates under contract to the Plan including but not limited to the those entities listed in the Quick Reference Chart who are responsible for such items as medical claims administrator, preferred provider organization network, COBRA administration.
- E. The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions that the plan sponsor performs for the Plan. If these persons do not comply with this obligation, the plan sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officers whose addresses and phone numbers are listed on the Quick Reference Chart in the front of this document.
- F. Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Plan Sponsor will:
1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
 2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
 3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
 4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI

Information You Or Your Dependents Must Furnish To The Plan

In addition to information you must furnish in support of any claim for plan benefits under this plan, you or your covered dependents must furnish, within **60 days** after the event, any information you or they may have that may affect eligibility for coverage under the plan. This includes, but is not limited to:

1. Change of name.
2. Change of address.
3. Marriage, divorce, or death of you or any covered spouse or dependent child.
4. Any information regarding the status of a dependent child, including, but not limited to:
 - a. The dependent child reaching the plan's limiting age of 25; or
 - b. The existence of any physical or mental handicap.
5. Medicare enrollment or disenrollment.
6. The existence of other medical or dental coverage.

Headings Do Not Modify Plan Provisions

The headings of sections (APPEARING IN BOLD TEXT WITH SOLID CAPITAL LETTERS) and of subsections, paragraphs and subparagraphs (Appearing in Bold Text *or Bold and Italics* with Upper and Lower Case Letters) are included for the sole purpose of generally identifying the subject matter of the substantive text so that a table of contents and index can be constructed for the convenience of the reader. The headings are not part of the substantive text of any provision, and they should not be construed to modify the text of any substantive provision in any way.

DEFINITIONS

The following are medical and dental definitions of specific terms and words used in this document. These definitions do not, and should not be interpreted to, extend coverage under the plan.

Abutment (refers to dental): A tooth or root that retains or supports a fixed or removable bridge. Also see the definition of Double Abutment.

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

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

Active Service: You are considered to be in active service with the participating employer of the Consortium on a day that is one of the participating employer's scheduled or non-scheduled work days if you are performing the regular duties of your employment in the customary manner on a full-time basis on that day, either at one of the participating employer's regular places of business or at some location to which the participating employer's business requires you to travel. **Note that this actively at work provision is not applicable to employees not at work due to a health factor.**

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

Allowable Expense: A health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering a plan participant, except as otherwise provided by the terms of this plan or where a statute applicable to this plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense.

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

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

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

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

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

Behavioral Health Disorders: Disorders, conditions and diseases as defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual, which includes, among other things, autism, depression, schizophrenia, and substance abuse. Certain behavioral health disorders, conditions and diseases are specifically excluded from coverage in the Exclusions section of this document. See also the definition of Substance Abuse.

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

Behavioral Health Treatment Facility: A public or private facility, licensed and operated according to law, that provides a program for diagnosis, evaluation, and effective treatment of behavioral health disorders. The facility must have at least one physician on staff or on call; provide skilled nursing care by licensed nurses under the direction of a

full-time registered nurse (RN); and prepare and maintain a written plan of treatment for each patient, which plan must be based on the medical, psychological and social needs of the patient.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the usual and customary charge, after calculation of all deductibles, coinsurance and copayments, and after determination of the plan's exclusions, limitations and maximums.

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

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

In addition, the facility must accept only patients with low-risk pregnancies, have a written agreement with a hospital for emergency transfers, and maintain medical records on each patient and child.

Bite-wing X-rays (refers to dental): Dental x-rays showing the coronal (crown) halves of the upper and lower teeth when the mouth is closed.

Bridge, Bridgework (refers to dental):

1. **Fixed:** A prosthesis that replaces one or more teeth and is cemented in place to existing abutment teeth. It consists of one or more pontics and one or more retainers (crowns or inlays). The patient cannot remove the prosthesis.
2. **Removable:** A prosthesis that replaces one or more teeth and which is held in place by clasps. The patient can remove the prosthesis.

Buccolingual (refers to dental): A dental term referring to the surfaces of a tooth facing the cheek or mouth (buccal) and the tongue (lingual).

Calendar Year: The 12-month period beginning January 1 and ending December 31. See the definition of Plan Year.

Case Management: A process, administered by the utilization management organization, in which its medical professionals work with the patient, family, care-givers, health care providers, claims administrator and the participating employer of the Consortium to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential health care providers.

Chemical Dependency: See the definitions of Behavioral Health Disorders and Substance Abuse.

Child(ren): See the definition of Dependent.

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Claims Administrator: A person or company retained by the plan to administer the claim payment responsibilities of the plan.

Coinsurance: That portion of eligible medical and dental expenses for which the covered employee has financial responsibility. In most instances, you are responsible for paying a percent of covered medical expenses in excess of the plan's deductible, but, in some instances, you are responsible for paying a higher percentage of those expenses, in other instances, no coinsurance applies.

Concurrent Review: A managed care program designed to assure that hospitalization and specialized health care facility admissions and length of stay, surgery and other health care services are medically necessary by having the utilization management (UM) organization conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or specialized health care facility.

Consortium: The Yuma Area Benefit Consortium located in Yuma, Arizona.

Convalescent Care Facility: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how plan benefits are payable when a person is covered by two or more medical or dental health care plans. See the section on Coordination of Benefits (COB), which sets forth the plan's COB rules and procedures.

Copayment, Copay: The set dollar amount you are responsible for paying when you incur an eligible medical or dental expense for certain services, generally those provided by network health care practitioners, hospitals or emergency rooms of hospitals.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (orthotic) or replace a missing body part (prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Medical Supplies, Orthotic Appliance (or Device) and Prosthetic Appliance or Device (Medical).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function, as distinguished from reconstructive surgery or treatment to correct defects resulting from trauma, infection, or other diseases or the consequences of treatment of trauma, infection, or other diseases, or to correct a congenital disease or anomaly of a covered dependent child that causes a functional defect.

Course of Treatment (refers to dental): The planned program of one or more services or supplies provided by one or more dentists to treat a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment begins when a dentist first renders a service to correct or treat the diagnosed dental condition.

Covered Individual: Any employee, spouse, dependent child, eligible retiree, Governing Board member or ex-Governing Board member who is enrolled for coverage under the plan and is actually covered by the plan.

Covered Medical and/or Dental Expenses: See the definition of Eligible Medical and/or Dental Expenses.

Crown (refers to Dental): The portion of a tooth covered by enamel.

Custodial Care: Care and services (including room and board needed to provide that care or service) given mainly for personal hygiene or to perform the activities of daily living. Custodial care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Some examples of custodial care are training or helping patients to get in and out of bed, as well as help with bathing, dressing, feeding or eating, use of the toilet, ambulating, or taking drugs or medicines that can be self-administered. These services are custodial care regardless of where the care is given or who recommends, provides, or directs the care.

Customary Charge: See the definition of Usual and Customary Charge.

Deductible: The amount of eligible medical or dental expenses you are responsible for paying before the plan begins to pay benefits. **Individual Deductible:** The amount one covered person must pay before the plan begins to pay benefits for that person. **Family Deductible:** The amount that all covered family members must pay before the plan begins to pay benefits for the family members.

Dental: Dental services and supplies are not covered under the medical expense coverage of the plan unless the plan specifically indicates otherwise. As used in this document, dental refers to any services performed by or under the supervision of a dentist, or supplies, including dental prosthetics, including prescription drugs used for dental purposes and prescribed by a dentist, even if the services or supplies are necessary because of symptoms, illness or injury affecting another part of the body. Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection.

Dental Care Provider (refers to dental): A dentist or dental hygienist or other health care practitioner or nurse as those terms are specifically defined in this section who is legally licensed and who is a dentist or performs services under the direction of a licensed dentist; acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Hygienist (refers to dental): A person who is trained and legally licensed and authorized to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed dentist, who acts within the

scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Subspecialty Areas (refers to dental):

Subspecialty Area	Services related to the diagnosis, treatment or prevention of diseases related to:
Endodontics	the dental pulp and its surrounding tissues.
Implantology	attachment of permanent artificial replacement of teeth directly to the jaw using artificial root structures.
Oral Surgery	extractions and surgical procedures of the mouth.
Orthodontics	abnormally positioned or aligned teeth.
Pedodontics	treatment of dental problems of children.
Periodontics	structures that support the teeth (gingivae, alveolar bone, periodontal membrane or ligament, cementum).
Prosthodontics	construction of artificial appliances for the mouth (bridges, dentures, crowns).

Dentist (refers to dental): A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered; acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Denture (refers to dental): A device replacing missing teeth.

Dependent Definitions

Dependent Child(ren):

A. For the purposes of this Plan, a Dependent Child is any of the employee’s or retiree’s unmarried children who have the same principal place of abode as the employee or retiree, including a:

- natural child, stepchild, legally adopted child, or child placed for adoption with the employee or retiree; (proof of adoption or placement for adoption may be requested) or
- child for whom the employee or retiree has legal guardianship under a court order (proof of guardianship may be requested); or
- foster child, lawfully placed with the employee, for whom health coverage is not provided by the State (proof of foster child placement may be requested); or

provided:

1. the Dependent Child depends on the employee or retiree for **more than one-half of their support and is not a “qualifying child” of any other person.**

The term “qualifying child” is defined in the Internal Revenue Code (IRC) in Section 152 (c). In addition, if a child (for whom the employee or retiree is the legal guardian) is not a “relative” as listed in IRC Section 152(d)(2)(A) through (G), the child must also have the same principal place of abode as the employee or retiree for the entire year and be a member of the employee’s or retiree’s household; **AND**

2. the child meets **one** of the following criteria:

- a. The child has not reached his or her 25th birthday; **OR**
- b. The child has reached his or her 25th birthday and the child is mentally or physically Handicapped (as that term is defined in this Plan); the child is incapable of self-sustaining employment as a result of that handicap. This Plan may require initial and periodic proof of handicap.

Proof of the same principal place of abode may be requested by the Plan.

B. A child named in a qualified medical child support order (QMCSO) is also an eligible dependent under this Plan. See the Eligibility chapter for details on QMCSOs.

C. See also the Proof of Dependent Status provisions in the Eligibility chapter.

D. It is the employee’s or retiree’s obligation to inform the Plan promptly if any of the requirements set out in this definition of a Dependent child are NOT met with respect to any child for whom coverage is sought or is being provided.

E. Coverage of a Dependent Child ends at the end of the month in which that child:

- 1. reaches his or her 25th birthday, whichever is applicable; or
- 2. marries; or
- 3. no longer meets the eligibility requirements of the Plan; or
- 4. enters military or similar service anywhere; or

5. becomes employed on a full-time basis by a participating employer of the Consortium or any other employer where coverage is elected.

See also the provisions in the Eligibility chapter on Events Causing Coverage to End

Eligible Dependent: Your lawful spouse and your dependent child(ren). An eligible dependent may be enrolled for coverage under the plan by following the procedures required by the plan. See the Eligibility chapter. Once an eligible dependent is duly enrolled for coverage under the plan, coverage begins in accordance with the terms and provisions of the plan, and that person is a covered dependent, and remains a covered dependent until his or her coverage ends in accordance with the terms and provisions of the plan.

Spouse: The employee's lawful spouse as determined by applicable state law.

Disabled: See the definitions of Handicapped and Totally Disabled.

Double Abutment (refers to dental): Tying two teeth together to help support a bridge. If there is bone loss due to periodontal disease (pyorrhea), this will be considered a form of periodontal splinting.

Durable Medical Equipment: Equipment that:

1. can withstand repeated use; and
2. is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and
3. is not disposable or nondurable.

Durable medical equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds (with safety rails) electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the definitions of Durable Medical Equipment, Nondurable Medical Supplies, Orthotic Appliance (or Device) and Prosthetic Appliance or Device (Medical).

Elective Hospital Admission, Service or Procedure: Any non-emergency hospital admission, service or procedure that can be scheduled or performed at the patient's or physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Dependent: See the definition of Dependent.

Eligible for Medicare: Generally a person is eligible for Medicare if he or she reaches age 65 and has worked for at least 10 years in Medicare-covered employment and is a citizen or permanent resident of the United States. A person might also qualify for coverage if he or she has a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant). Being eligible for Medicare is not the same as being entitled.

Eligible Medical and/or Dental Expenses: Expenses for medical and/or dental services or supplies, but only to the extent that:

1. they are medically necessary, as defined in this Definitions section; and
2. the charges for them are usual and customary, as defined in this Definitions section; and
3. coverage for the services or supplies is not excluded, as provided in the Exclusions sections; and
4. the general overall, limited overall, and/or annual maximum plan benefits for those services or supplies has not been reached.

Emergency (Dental): A sudden unexpected onset of a dental condition that manifests itself by such acute symptoms of sufficient severity that urgent and immediate dental attention is required to provide relief from pain and prevent serious impairment of dental functions or lead to serious and/or permanent impairment or dysfunction of another body organ or part, or because the patient's life may be threatened.

Emergency (Medical): A sudden unexpected onset of a medical condition, not normally treatable in a physician's office, that manifests itself by such acute symptoms of sufficient severity that urgent and immediate medical attention is required without regard to the time of day or night, either to prevent serious impairment of body functions or serious and/or permanent impairment or dysfunction of any body organ or part, or because the patient's life is threatened. A medical emergency that meets the above criteria will be covered at the in-network benefit level when the choice of service providers or facility is out of the member's control.

Emergency Hospitalization or Confinement: A hospital admission that takes place within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

Employee: Unless specifically indicated otherwise, when used in this document, employee refers to a person employed by a participating employer of the Consortium who is eligible to enroll for coverage under the plan.

Employer: A participating employer of the Yuma Area Benefits Consortium.

Entitled to Medicare: Medicare entitlement means that a person who is eligible for Medicare has actually become enrolled in Medicare. Enrollment in some circumstances is automatic and in some circumstances requires action by the eligible person. Information on how to become entitled to Medicare is available online at www.medicare.gov.

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the Schedule of Medical Benefits, Schedule of Dental Benefits and Exclusions sections for which the plan does not provide plan benefits.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Experimental and/or Investigational: The Plan administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as experimental and/or investigational. A service or supply will be deemed to be experimental and/or investigational if, in the opinion of the Plan administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for precertification under the plan's utilization management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

1. The service or supply is described as an alternative to more conventional therapies in the protocols or consent document of the health care provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan administrator or its designee, there is a preponderance of authoritative medical, dental or scientific literature:
 - a. published in the United States; and
 - b. written by experts in the field;
that shows that recognized medical, dental or scientific experts:
 - (1) classify the service or supply as experimental and/or investigational; or
 - (2) indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to services or supplies regulated by the Food and Drug Administration (FDA):
 - a. FDA approval is required in order for the service and supply to be lawfully marketed and it has not been granted at the time the service or supply is prescribed or provided; or
 - b. A current investigational new drug or new device application has been submitted and filed with the FDA.

However, a drug will not be considered experimental and/or investigational if it is:

1. Approved by the FDA as an "investigational new drug for treatment use"; or
2. Classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; or
3. Approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was **not** approved for general use and the FDA has **not** determined that such drug should not be prescribed for a given type of cancer.
4. The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; or Phase III exclusion or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

In determining if a service or supply is or should be classified as experimental and/or investigational, the Plan administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided, or considered for precertification under the plan's Utilization Management program:

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the health care provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer-reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to:
 - a. "United States Pharmacopeia"; and
 - b. "American Hospital Formulary Service";
5. The published opinions of:
 - a. the American Medical Association (AMA), such as "The AMA Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) program, etc.; or
 - b. specialty organizations recognized by the AMA; or
 - c. the National Institutes of Health (NIH); or

- d. the Center for Disease Control (CDC); or
 - e. the Office of Technology Assessment; or
 - f. the American Dental Association (ADA), with respect to dental services or supplies.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
 7. The latest edition of “The Medicare Coverage Issues Manual.”

To determine how to obtain a precertification of any procedure that might be deemed to be experimental and/or investigational, see the section on precertification review in the Medical Network and Utilization Management section of this document. The Plan administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as experimental and/or investigational.

Fluoride (refers to dental): A solution applied to the surface of teeth to prevent dental decay.

Gnathologic Recording (refers to dental): A measurement of force exerted in the closing of the jaws.

Handicap or Handicapped (Physically or Mentally): The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise totally disabled, provided the condition was diagnosed by a physician and accepted by the Plan administrator or its designee as a permanent and continuing condition. See the definition of Totally Disabled.

Health Care Practitioner: A physician, behavioral health practitioner, chiropractor, dental hygienist, dentist, nurse, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, as those terms are defined in this section, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Health Care Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or subacute care facility, as those terms are defined in this Definitions section.

Home Health Care: Intermittent skilled nursing care services provided by a licensed home health care agency as defined below.

Home Health Care Agency: An agency licensed or certified and operating according to law that meets all of the following requirements:

1. it primarily provides skilled nursing and other therapeutic services, such as infusion therapy, under the supervision of physicians or registered nurses; and
2. it is run according to rules established by a group of professional medical providers including physicians and registered nurses; and
3. it maintains clinical records on all patients; and
4. it is licensed by the jurisdiction where it is located if licensure is required, and operates according to the laws of that jurisdiction pertaining to agencies providing home health care; and
5. it is certified by Medicare.

Hospice: A facility or organization licensed and operating according to law and certified by Medicare that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home or in a home-like setting, with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family.

Hospital: A public or private facility or institution, other than one owned by the U.S. government, licensed and operating according to law, that is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and that provides care and treatment by physicians and nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises. A hospital may include facilities for mental, nervous and/or substance abuse treatment that are licensed and operated according to law. Any portion of a hospital used as a subacute care facility, skilled nursing facility, or residential treatment facility or place for rest, custodial care, or the aged will not be regarded as a hospital for any purpose related to this plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a physician and as compared to the person’s previous condition. Pregnancy of a covered employee or covered spouse will be considered to be an illness only for the purpose of coverage under this plan. Infertility is **not** an illness for the

purpose of coverage under this plan. Maternity and delivery expenses of a dependent or a dependent are not an illness covered by this Plan.

Immediate Temporary Denture (refers to dental): A temporary denture that is placed immediately after the extraction of teeth.

Implantology (refers to dental): The science of placing artificial root structures on or within the jaw bones that will act to hold and support a dental prosthesis.

Impression (refers to dental): A negative reproduction of the teeth and gums, from which models of the jaws are made. These models are used to study certain conditions and to make dental appliances and prostheses.

Initial Enrollment: The 30-day period of time following the date on which you become eligible to enroll for coverage with this plan. Refer to the Eligibility section of this document or your personnel/payroll department for further information.

In-Network Services: Services provided by a health care provider that is a member of the plan's preferred provider organization (PPO), as distinguished from out-of-network services that are provided by a health care provider that is **not** a member of the PPO.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth: An injury to the teeth caused by trauma from an external source. This does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing.

Inlay (refers to dental): A restoration made to fit a prepared tooth cavity and then cemented into place.

Inpatient: Services provided in a hospital or other specialized health care facility during the period when charges are made for room and board.

Investigational: See the definition of Experimental and/or Investigational.

Late Enrollment: See the definition of Subsequent (Late) Enrollment.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result.

Maxillary Disorders (refers to dental): Disorders of the upper jaw.

Maximum Plan Benefits: The maximum amount of benefits payable by the plan on account of medical and/or dental expenses incurred by any covered plan participant under this plan and any previous medical and/or dental expense plan provided by a participating employer of the Consortium. Refer to the Schedule of Medical Benefits and the Schedule of Dental Benefits for more information.

- **General Overall (Lifetime) Maximum Plan Benefit** is the maximum amount of benefits payable by the plan during the entire time a plan participant is covered under this plan and any previous medical and/or dental expense plan provided by the Consortium.
- **Limited Overall Maximum Plan Benefits** are the maximum amount of benefits payable on account of certain medical or dental services by the plan during the entire time a plan participant is covered under this plan and any previous medical and/or dental expense plan provided by the Consortium, such as corrective appliances and orthodontia. **Annual**
- **Maximum Plan Benefits** are the maximum amount of benefits payable each plan year on account of certain medical and/or dental expenses incurred by any covered plan participant or family of the plan participant under this plan and any previous medical and/or dental expense plan provided by the Consortium, such as certain wellness benefits.

Medically Necessary: A medical or dental service or supply will be determined to be "medically necessary" by the Plan administrator or its designee if it:

1. is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it, or dentist if a dental service or supply is involved; and
2. is determined by the Plan administrator or its designee to be necessary in terms of generally accepted medical standards; and
3. is determined by the Plan administrator or its designee to meet all of the following requirements:
 - a. it is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
 - b. it is not provided solely for the convenience of the patient, physician, hospital, health care provider, or health care facility; and

- c. it is an “appropriate” service or supply given the patient’s circumstances and condition; and
- d. it is a “cost-efficient” supply or level of service that can be safely provided to the patient; and
- e. it is safe and effective for the illness or injury for which it is used.

A medical or dental service or supply will be considered to be “appropriate” if:

1. It is a diagnostic procedure that is called for by the health status of the patient and is as likely to result in information that could affect the course of treatment as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient’s overall health condition.
2. It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient’s overall health condition.

A medical or dental service or supply will be considered “cost-effective” if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be medically necessary for the medical or dental coverage provided by the plan.

A hospitalization or confinement to a specialized health care facility will not be considered to be medically necessary if the patient’s illness or injury could safely and appropriately be diagnosed or treated while not confined.

A medical or dental service or supply that can safely and appropriately be furnished in a physician’s or dentist’s office or other less costly facility will **not** be considered to be medically necessary if it is furnished in a hospital or specialized health care facility or other more costly facility.

The non-availability of a bed in another specialized health care facility, or the non-availability of a health care practitioner to provide medical services, will **not** result in a determination that continued confinement in a hospital or other specialized health care facility is medically necessary.

A medical or dental service or supply will **not** be considered to be medically necessary if it does not require the technical skills of a health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient’s family, any person who cares for the patient, any health care practitioner, or any hospital or specialized health care facility.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorders.

Midwife: A person legally licensed as a midwife or certified as a certified nurse midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administering intravenous fluids and certain medications, providing emergency measures while awaiting aid, performing newborn evaluation, signing birth certificates, and billing and is paid in his or her own name, and who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient. A midwife may **not** independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the definition of Nurse.

Morbidly Obese, Morbid Obesity: Under this Plan the term means the:

1. Presence of morbid obesity that has persisted for at least 5 years, defined as either:
 - a. body mass index (BMI) exceeding 40; or
 - b. BMI greater than 35 in conjunction with ANY of the following severe co-morbidities:
 - (1) coronary heart disease; or
 - (2) type 2 diabetes mellitus; or
 - (3) clinically significant obstructive sleep apnea; or
 - (4) high blood pressure/hypertension (BP > 140 mmHg systolic and/or 90 mmHg diastolic)

AND
 2. Patient has completed growth (18 years of age or documentation of completion of bone growth);
- AND

3. Patient has participated in a physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record. This physician-supervised nutrition and exercise program must meet ALL of the following criteria:
 - a. Participation in nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dietitians and/or nutritionists; AND
 - b. Nutrition and exercise program must be 6 months or longer in duration; AND
 - c. Nutrition and exercise program must occur within the two years prior to surgery; AND
 - d. Participation in physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who does not perform bariatric surgery. Note: A physician's summary letter is not sufficient documentation.

NOTE: BMI is calculated by dividing the patient's weight (in kilograms) by height (in meters) squared:

$$\text{BMI} = \frac{\text{weight in kilograms}}{(\text{height in meters})^2}$$

or compute using the Obesity Education Initiative website: <http://www.nhlbisupport.com/bmi/>

To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by 0.0254.

Nondurable Medical Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, slings, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the definitions of corrective appliances, durable medical equipment, orthotic appliance (or Device) and prosthetic appliance (or Device).

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), certified nurse midwife or licensed midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Onlay (refers to dental): An inlay restoration that is extended to cover the biting surface of the tooth, but not the entire tooth. It is often used to restore lost and weakened tooth structure.

Orthodontia/Orthodontics (refers to dental): The science of the movement of teeth in order to correct a malocclusion or "crooked teeth."

Orthognathic Services (refers to dental): Services dealing with the cause and treatment of malposition of the bones of the jaw, such as prognathism and retrognathism. See the definitions of Prognathism and Retrognathism.

Orthotic Appliance (or Device): A type of corrective appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the medical plan, this definition does **not** include dental orthotics. See also the definitions for Corrective Appliance, Durable Medical Equipment, Nondurable Medical Supplies, Orthotic Appliance (or Device) and Prosthetic Appliance or Device (Medical).

Out-of-Network Services: Services provided by a health care provider that is **not** a member of the plan's preferred provider organization (PPO), as distinguished from in-network services that are provided by a health care provider that is a member of the PPO.

Out-of-Pocket Maximum: The maximum amount of coinsurance each covered person or family is responsible for paying during a plan year before the coinsurance required by the plan ceases to apply. When the out-of-pocket maximum is reached, the plan will pay 100% of any additional covered expenses for the remainder of the plan year. Certain expenses such as the plan's deductible, expenses for medical services or supplies that are not covered by the plan, and all charges in excess of the usual and customary charges as determined by the Plan administrator or its designee **do not count** toward the out-of-pocket maximum. See also the Medical Expense Coverage section for more information.

Outpatient: Services provided either outside of a hospital or specialized health care facility setting or at a hospital or specialized health care facility when room and board charges are **not** incurred.

Partial Denture (refers to dental): A prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures. The denture may be removable or fixed.

Participating Provider: A health care provider who participates in the plan's preferred provider organization (PPO).

Periodontal Splinting (refers to dental): Tying two or more teeth together when there is bone loss. This is done to gain additional stability for teeth that can no longer stand alone.

Physician: A person legally licensed as a medical doctor (MD) or doctor of osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Plan, This Plan: The program, benefits and provisions described in this document.

Plan Administrator: The legal entity, Yuma Area Benefit Consortium, designated as the party who has the fiduciary responsibility for the overall administration of the plan.

Plan Participant: The employee or individual who has enrolled for coverage under the plan. As used in this document, this term does **not** include the spouse or dependent child(ren) of the plan participant.

Plan Year: The 12-month period from July 1 to June 30. Plan design and/or contribution can be adjusted at the start of a new plan year. **All annual deductibles and annual maximum plan benefits are determined during the plan year beginning July 1 and ending June 30.** See also the definition of Calendar Year.

Podiatrist: A person legally licensed as a doctor of podiatric medicine (DPM) and authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Pontic (refers to dental): The part of a fixed bridge that is suspended between two abutments and replaces a missing tooth.

Practitioner: See the definition of Health Care Practitioner.

Preadmission Testing: Laboratory tests and x-rays and other medically necessary tests performed on an outpatient basis prior to a scheduled hospital admission or outpatient surgery.

Precertification: A managed care program designed to assure that hospital and specialized health care facility admissions and lengths of stay, surgery and other health care services are medically necessary by having the utilization management (UM) organization determine the medical necessity **before** the services are provided.

Preferred Provider Organization (PPO): A group or network of health care providers under contract with the plan to provide health care services and supplies at agreed-upon discounted rates as payment in full, except with respect to a defined copayment for which the covered employee or dependent is responsible.

Pre-Existing Condition: Any illness or injury for which a diagnosis has been made or medical care and/or treatment has been provided (including the prescription of drugs or medicines) during the three months immediately preceding the date coverage begins. See also restrictions on subsequent (late) enrollment in the Eligibility section of this document.

Prognathism (refers to dental): The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Prophylaxis (refers to dental): The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth is performed by a dentist or dental hygienist.

Prosthesis (refers to dental): An artificial replacement of one or more natural teeth and/or associated structures.

Prosthetic Appliance or Device (Medical): A type of corrective appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, corrective lenses needed after cataract surgery. For the purposes of the medical plan, this definition does **not** include dental prostheses or hair replacements including but not limited to, wigs, toupees, hair pieces or hair implants. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Medical Supplies and Orthotic Appliance (or Device).

Provider: See the definition of Health Care Provider.

Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an employee to provide health care coverage for a dependent child, and requiring that benefits payable on account of that dependent child be paid directly to the health care provider who rendered the services or to the custodial parent of the dependent child.

Reconstructive Surgery: A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a mastectomy.

Rehabilitation Therapy: Cardiac, occupational, physical, pulmonary or speech therapy, that is prescribed by a physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license.

1. **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function. Active rehabilitation is covered by the plan, subject to limited overall maximum plan benefits.
2. **Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of active rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. **Maintenance rehabilitation is not covered by the plan.**
3. **Passive Rehabilitation** refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive rehabilitation may be covered by the plan, subject to limited overall maximum plan benefits, but only during a course of hospitalization for acute care, and then only until the patient is capable of being discharged from the hospital because hospitalization for the condition requiring acute hospital care is no longer medically necessary. Continued hospitalization for the sole purpose of providing passive rehabilitation will not be considered to be medically necessary for the purposes of this plan.

Restoration (refers to dental): A broad term applied to any filling, crown, bridge, partial denture or complete denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape and function of part or all of the tooth or teeth.

Retrognathism (refers to dental): The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Retrospective Review: Review of health care services **after** they have been provided to determine if those services were medically necessary and/or if the charges for them are usual and customary charges.

Root Canal (Endodontic) Therapy (refers to dental): Treatment of a tooth having a damaged pulp. The treatment is usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with a sealing material.

Scaling (refers to dental): To remove calculus (tartar) and stains from the teeth with special instruments.

Second Opinion: A consultation and/or examination, preferably by a board-certified physician not affiliated with the primary attending physician, to evaluate the medical necessity and advisability of undergoing a surgery or receiving a medical service.

Skilled Nursing Care: Services performed by a licensed nurse if the services are ordered by and provided under the direction of a physician; are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on a less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of skilled nursing care services include, but are not limited to, the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility: A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets all of the following requirements:

1. it is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a skilled nursing facility or is recognized by Medicare as a skilled nursing facility; and
2. it maintains on its premises all facilities necessary for medical care and treatment; and
3. it provides services under the supervision of physicians; and
4. it provides nursing services by or under the supervision of a licensed registered nurse, with one licensed registered nurse on duty at all times; and

5. it is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
6. it is not a hotel or motel.

Special Enrollment: The period of time pertaining to the enrollment of a spouse or dependent children only under certain circumstances such as marriage, birth, adoption or placement for adoption. **See also the Eligibility section on special enrollment provisions under this plan.**

Specialized Health Care Facilities: For the purposes of this plan, specialized health care facilities include ambulatory surgical facilities, behavioral health treatment facilities, birthing centers, hospices, skilled nursing facilities, and subacute care facilities, as those terms are defined in this Definitions section.

Specialty Care Unit: A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by registered nurses or other highly trained personnel. Examples include intensive care units (ICU) and cardiac care units (CCU).

Specialty Drugs: Generally refers to high-cost, low volume, biotechnology-engineered FDA approved, non-experimental medications used to treat complex, chronic or rare diseases. These medications may also have one or more of the following qualities: are injectable, require an infusion, must be administered by a health care practitioner, have side-effects or compliance issues that need monitoring, require substantial patient education/support before self-administration, and/or unique manufacturing, handling and distribution issues that make them unable to be purchased from a retail and/or mail order service. Specialty drugs are managed by a specialty drug prescription drug program under contract to the Plan. Examples of specialty drugs can include certain medications to treat hemophilia, immune disorders or certain types of cancer.

Spinal Manipulation: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal manipulation is commonly performed by chiropractors, but it can be performed by a physician.

Spouse: See the definition of Spouse under the Dependent Definitions heading.

Subacute Care Facility: A public or private facility, either freestanding, hospital-based or based in a skilled nursing facility, licensed and operated according to law and authorized to provide subacute care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement, to the patient's home or to a suitable skilled nursing facility, and that meets all of the following requirements:

1. it is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a subacute care facility or is recognized by Medicare as a Sub-Acute Care Facility; and
2. it maintains on its premises all facilities necessary for medical care and treatment; and
3. it provides services under the supervision of physicians; and
4. it provides nursing services by or under the supervision of a licensed registered nurse; and
5. it is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
6. it is not a hotel or motel.

Subrogation: The right of the plan (when applicable) to be substituted in place of a covered individual with reference to the covered individual's lawful claim, demand or right of action against a third party who wrongfully caused the covered individual's injury or illness. See the Third Party Liability subsection in the section on Coordination of Benefits (COB) for an explanation of how the plan may use its right of subrogation to recover medical and/or dental benefits paid if the covered individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

Subsequent (Late) Enrollment: The provisions of this plan pertaining to enrollment of your eligible dependents who did not enroll for coverage during initial or special enrollment as detailed in the Eligibility section of this document.

Substance Abuse: Alcohol and/or drug dependency as defined by the current edition of the ICD-CM manual. See the definitions of behavioral health disorders and chemical dependency.

Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining plan benefits.

When the procedures will be considered to be separate procedures, the following percentages of the usual and customary charge will be allowed as the plan's benefit:

1. Allowances for multiple surgeries through the same incision or operative field:

Primary procedure	100% of U&C charge
Secondary and additional procedures	50% of U&C charge per procedure

2. Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

First site primary procedure	100% of U&C charge
First site secondary and additional procedures	50% of U&C charge per procedure
Second site primary and additional procedures	50% of U&C charge per procedure

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Syndrome (refers to dental): The temporomandibular (or craniomandibular) Joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, severe aching pain in and about the TMJ (sometimes made worse by chewing), myofascial pain, limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment, often associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly) or ill-fitting dentures.

Therapist: See the definition of Health Care Practitioner.

Third Opinion: A consultation and/or examination, preferably by a board-certified physician not affiliated with the primary attending physician, to evaluate the medical necessity and advisability of undergoing surgery or receiving a medical service, provided by the plan when the second opinion indicates that the recommended surgery or medical service is not medically necessary.

Topical (refers to dental): Painting the surface of teeth as in a fluoride treatment or application of a cream-like anesthetic formula to the surface of the gum.

Tort, Tortfeasor: A civil wrong or injury, typically arising from a negligent or intentional act of an individual, who is called a tortfeasor.

Total Disability, Totally Disabled: The inability of a covered employee to perform all the duties of his or her occupation with a participating employer of the Consortium as a result of a non-occupational illness or injury, or the inability of a covered dependent to perform the normal activities or duties of a person of the same age and sex. See also the definition of Handicap.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissues or cells (such as bone marrow or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted tissue in the recipient. See the Schedule of Medical Benefits in the Medical Expense Coverage section and the Exclusions section for additional information regarding transplants.

1. **Autologous** refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.
2. **Allogenic** refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are always allogenic.
3. **Xenographic** refers to transplants of organs, tissues or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Xenographic transplants are not covered by this plan.

Urgent Care Facility: A public or private freestanding facility, not located on the premises of or operating in conjunction with a hospital, that is licensed or legally operating; that primarily provides minor emergency and episodic medical care in which one or more physicians, registered nurses, and x-ray technicians are in attendance at all times the facility is open; and that includes x-ray and laboratory equipment and a life support system.

Usual and Customary Charge: The charge for medically necessary services or supplies will be determined by the Plan administrator or its designee to be the **lowest** of:

1. with respect to a PPO health care provider, the usual and customary charge means the charges set forth in the agreement between the PPO health care provider and the PPO, or the plan; or
2. the usual charge by the health care provider for the same or similar service or supply; or
3. no more than 80% of the prevailing charge for medical expenses (and 70% for dental expenses) of most other health care providers in the same or similar geographic area for the same or similar health care service or supply; or

4. the health care provider's actual charge.

The "Prevailing Charge" of most other health care providers in the same or similar geographic area for the same or similar health care service or supply will be determined by the claims administrator who will use proprietary data that is updated no less frequently than annually and provided by a reputable company or entity. The plan will not always pay benefits equal to or based on the health care provider's actual charge for health care services or supplies, even after you have paid the applicable deductible and coinsurance. This is because the plan covers only the usual and customary charge for health care services or supplies. Any amount in excess of the usual and customary charge does not count toward the plan's annual out-of-pocket maximums. The usual and customary charge is sometimes referred to as the U&C charge, and may sometimes be called the reasonable and customary charge, the R&C charge, the usual, customary and reasonable charge, or the UCR charge.

Utilization Management: A managed care procedure to determine the medical necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include, but is not limited to precertification and/or preauthorization; concurrent and/or continued stay review; discharge planning; retrospective review; case management; hospital or other health care provider bill audits; and health care provider fee negotiation. Utilization management services (sometimes referred to as UM services, UM program, utilization review services, UR services, utilization management and review services, or UMR services) are provided by licensed health care professionals employed by the utilization management organization operating under a contract with the plan.

Utilization Management Organization: The independent utilization management organization, staffed with licensed health care professionals, operating under a contract with the plan to administer the plan's utilization management services.

Visit: A personal meeting between the patient and a physician, dentist or other health care provider regarding the health condition or care of the patient, and which is properly classified or coded in accordance with the Current Procedural Terminology (CPT) manual of the American Medical Association.

Well Child/Well Baby: Health care services provided to a healthy newborn or child that are determined by the Plan to be medically necessary even though they are not provided as a result of illness, injury or congenital defect. See the Schedule of Medical Benefits for Well Child/Well Baby coverage.

You, Your: When used in this document, these words refer to the employee who is covered by the plan. They do not refer to any dependent of the employee.

Yuma Area Benefits Consortium (YABC): The participating employers in this consortium include: Arizona Western College, Yuma School District #1, Crane Elementary School District No. 13 and the City of Yuma.

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