

SUMMARY BENEFIT DESCRIPTION
OF THE
Town of Gilbert Medical Benefit Legacy Plan

Amended and Restated July 1, 2016

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INTRODUCTION

Town of Gilbert, the Employer, has established the Town of Gilbert Medical Benefit Legacy Plan (Plan) in order to provide comprehensive healthcare benefits for Eligible Employees, and their Dependents. The Plan was originally established July 1, 2003.

The Town of Gilbert Medical Benefit Legacy Plan is amended and restated in its entirety effective July 1, 2016.

The Town of Gilbert Medical Benefit Legacy Plan is a self-insured public sector plan within the meaning of Arizona Statute 11-981 (hereinafter “Plan”). The Plan is not an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). Any resemblance to an ERISA plan shall not be construed to mean it is an ERISA plan. The Plan is a self-insured medical plan intended to meet the requirements under Sections 105(b), 105(h) and 106 of the Internal Revenue Code of 1986 so the portion of the cost for coverage paid by the Employer is not taxable income to the Subscriber and any benefits received through the Plan are not taxable income to the Subscriber. This Plan is a group health plan for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and shall be administered in a manner consistent with HIPAA.

Effective July 1, 2016, this Plan is no longer a grandfathered plan under Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act (HCERA), collectively referred to as Health Care Reform.

This document is the Summary Benefit Description (SBD) that describes the basic features of the Plan and how the plan operates. It is very important to review this document carefully to confirm a complete understanding of the benefits available, as well as responsibilities, under the Plan. The SBD should be read in its entirety because many of its provisions are interrelated. Capitalized words in this document are defined in the *Definitions* section.

Rescission of Coverage Rules. Under this Plan, coverage may be retroactively cancelled or terminated if you act fraudulently or make material misrepresentations of fact in connection with your coverage under this Plan. It is your responsibility to provide accurate information and to make accurate and truthful statements including information and statements regarding familial status, age, relationships, etc. In addition, it is your responsibility to update previously provided information and statements and to notify the Plan of changes in status, such as a divorce or a child reaching the maximum age for coverage under the Plan. Failure to do so may result in your coverage, including the coverage of those provided coverage through you such as your spouse or children, being cancelled and such cancellation may be retroactive.

The Plan is “self-insured” which means that benefits are paid with assets from a trust established by the Employer to pay benefits under the Plan.

The Employer has contracted with the Claims Administrator to perform certain consultative and management services related to the Plan. The Employer retains ultimate authority for the Plan.

Mayo Clinic Health Solutions is the Claims Administrator and will process medical claims in accordance with the plan document and Mayo Clinic Health Solutions’ internal guidelines and protocols, manage the network of Healthcare Providers, and answer benefit and claim questions. Mayo Clinic Health Solutions will be referred to as the Claims Administrator throughout this SBD.

The Claims Administrator’s customer service representatives are available to answer any questions or concerns regarding the Plan. Phone lines are open from 7 a.m. to 7 p.m. (central time) Monday through Friday (excluding holidays).

For enrollment or eligibility questions, please contact Town of Gilbert.

QUESTIONS	
Customer Service (toll-free)	1-866-465-5148
Online Service Center	www.mayoclinichealthsolutions.com
Customer Service (TDD for hearing impaired)	1-800-407-2442
Town of Gilbert (enrollment or eligibility questions)	1-480-503-6857

Customer Service has access to translation services and is available to meet the needs of many non-English speaking people.

ADMINISTRATIVE INFORMATION

Plan Name	Town of Gilbert Medical Plan
Employer & Agent for Service of Legal Process	Town of Gilbert 50 E. Civic Center Drive Gilbert, AZ 85296 Employer Identification Number: 86-6000246 Contact Person: Human Resources 1-480-503-6859
Participating Employers	Town of Gilbert 50 E. Civic Center Drive Gilbert, AZ 85296 Employer Identification Number: 86-6000246
Claims Administrator	Mayo Clinic Health Solutions PO BOX 211698 Eagan, MN 55121 1-866-465-5148 <i>Please Note:</i> Mayo Clinic Health Solutions performs claims processing services pursuant to a contract, it does not insure benefits under the Plan.
Plan's Fiscal Year	July 1 to June 30

COBRA NOTICE OF RIGHTS

The Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) requires most employers with 20 or more employees to offer employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called “continuation coverage” or “COBRA coverage”) at group rates in certain instances where health coverage under employer-sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage must pay for the continuation coverage. At the end of the maximum coverage period (described below), individual conversion coverage will be offered if it is otherwise available under the Plan, subject to the requirement to pay the premiums required by the individual conversion health plan. There is no conversion opportunity available under this Plan. Therefore, there is no right to convert to an individual policy at the conclusion of COBRA coverage.

This notice is intended to provide a brief overview of a Member’s rights and obligations under the continuation coverage provision of COBRA. It is intended that no greater rights be provided than those required by the law.

Individuals entitled to COBRA continuation (“qualified beneficiaries”) are Subscribers and their Dependents who are covered at the time of a qualifying event which would normally cause coverage to end. In addition, a child born to or placed for adoption with a Subscriber during the COBRA continuation period is also a qualified beneficiary.

Qualifying Events

If a Subscriber’s employment is terminated for any reason other than gross misconduct or if a Subscriber’s hours worked are reduced so that Plan coverage terminates, the Subscriber and his or her covered Dependents may continue coverage under the Plan for up to 18 months.

If the Subscriber should die, become divorced, or become eligible for Medicare, the covered Dependents whose medical coverage under the Plan would be reduced or terminated may continue coverage under the Plan for up to 36 months. Also, covered children may continue coverage for up to 36 months after they no longer meet the definition of Dependent under the terms of the Plan.

Certain events may extend the 18-month COBRA continuation period:

If a Subscriber’s Dependent(s) experience a second qualifying event within the original 18-month period, they (but not the Subscriber) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event);

If the Subscriber became entitled to Medicare while employed (even if it was not a qualifying event for his or her Dependents because their coverage was not lost or reduced) and then a second qualifying event (such as the Subscriber’s termination of employment) happens within 18 months, the Dependents may elect COBRA continuation for up to 36 months from the date the Subscriber became eligible for Medicare.

If a Subscriber or a Dependent is disabled (as determined by the Social Security Administration) on the date of the qualifying event or within the first 60 days of COBRA continuation coverage, each qualified beneficiary (whether or not disabled) may extend COBRA continuation coverage for up to an additional 11 months (for a total of up to 29 months). To qualify for this disability extension, the Employer must be notified of the person’s disability status within 60 days after the Social Security disability determination is issued and before the end of the original 18-month COBRA continuation period. Also, if the Social Security Administration determines that the qualified beneficiary is no longer disabled, the Employer must be notified within 30 days after this determination.

Important Note: If a second qualifying event occurs at any time during this 29-month disability continuation period, then each qualified beneficiary (whether or not disabled) may further extend COBRA coverage for seven more months, for a total of up to 36 months from the termination of employment or reduction in hours of employment.

Giving Notice That a COBRA Event Has Occurred

To qualify for COBRA continuation upon divorce or loss of a child's dependent eligibility under the Plan, the Employer must be notified within 60 days of the later of 1) the event, or 2) the date the individual would lose coverage under the Plan. The Employer will then provide instructions for continuing medical coverage under the Plan.

For other qualifying events (termination of employment, reduction in work hours, or entitlement to Medicare), the Employer will provide instructions for continuing medical coverage under the Plan. In the event of the Subscriber's death, the Employer will notify the Subscriber's covered Dependents how to continue coverage under the Plan.

The Employer must be notified if a divorce or loss of a child's dependent eligibility occurs that would extend the period of COBRA coverage.

Electing and Paying for COBRA Continuation Coverage

The Subscriber and his or her covered Dependents must choose to continue coverage within 60 days after the later of the following dates:

The date of the qualifying event; or

The date the Employer notifies the Subscriber and/or his or her covered Dependents of their right to choose to continue coverage as a result of the qualifying event.

If continuation coverage is elected, the initial premium (including all premiums due but not paid) must be paid within 45 days after the election. Thereafter COBRA premiums must be paid within 30 days of each due date. The cost of COBRA coverage is 102% of the full cost of Plan coverage. For the 19th through 29th months of coverage under the disability extension, the cost of coverage will remain 102% of the full cost.

If a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the individual is disabled. If a second qualifying event occurs during the otherwise applicable disability extension period (that is, the 19th through the 29th month), the 102% rate also applies to the 19th through 36th months of the COBRA continuation period.

Coverage During the Continuation Period

If coverage under the Plan is changed for active employees, the same changes will be provided to individuals on COBRA continuation. Qualified beneficiaries also may change their coverage elections during the annual enrollment periods or if a change in status occurs.

PRIVACY NOTIFICATON

This Plan is a “covered entity” for purposes of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) Privacy Rules.

HIPAA requires that “covered entities” protect the confidentiality of your private health information (“PHI”).

“PHI” means health information that:

- (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university or health care clearinghouse;
 - (2) relates to the past, present and future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and
1. either identifies the individual or reasonably could be used to identify the individual.

A complete description of your rights under HIPAA can be found in the Plan’s privacy notice, distributed to you upon enrollment and available upon request from the Employer.

The Plan will not use or further disclose information that is protected by HIPAA except as necessary for treatment, payment and health plan operations, or as required by law. The Plan requires all of its service providers to also observe HIPAA’s Privacy Rules.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

SECTION I

DEFINITIONS

This section defines the terms used in this document. These terms will be capitalized throughout this document when referred to in the context defined. There may be other terms defined in specific sections of this document.

- 1.1 **Allowed Charge** - the maximum dollar amount eligible for payment for a procedure or service as determined by the Plan. This includes billed charges, contracted amounts or Usual and Customary Rates, depending on the Healthcare Provider's relationship with the Plan and/or the Healthcare Services provided.
- 1.2 **Ambulance** - a specially designed or equipped vehicle used only for transporting the critically ill or injured to a healthcare facility, as authorized by Arizona Statute, title 36, chapter 21.1. Such transportation service must meet local requirements for providing transportation of the sick or injured, and must be operated by qualified personnel who are trained in the application of basic life support.
- 1.3 **Cancer Clinical Trial** - a course of treatment that satisfies the requirements of Arizona Revised Statute 20-1057.07.
- 1.4 **Claims Administrator** - a third party retained by the Employer to provide services including initial determination of the validity of claims and administration of benefit payments under the Plan. Complete responsibilities of the Claims Administrator are described in a contract with the Employer. The Claims Administrator is Mayo Clinic Health Solutions.
- 1.5 **COBRA** - Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time and as applied through the Public Health Services Act.
- 1.6 **Code** - the Internal Revenue Code of 1986, as amended from time to time.
- 1.7 **Confinement** - a continuous stay in the Hospital(s) or extended care facility(ies) or combination thereof, due to an illness or injury diagnosed by a Physician, which lasts at least one day and one night.
- 1.8 **Continued Care** - certain specified hours of service per day provided by a Registered Nurse, Licensed Practical Nurse, or Home Health Care aide, during a period of Skilled Care needed in order to maintain an ill Member at home.
- 1.9 **Cost Sharing Amounts** - the dollar amount a Member is responsible for paying when Covered Services are received from a Healthcare Provider. Cost Sharing Amounts include Coinsurance, Copayment, and Deductible amounts. Applicable Cost Sharing Amounts are identified in the *Schedule of Benefits* section. Healthcare Providers may bill a Member directly or request payment of Cost Sharing Amounts at the time Covered Services are provided.
 - (a) **Coinsurance** - The charge a Member must pay for certain Covered Services after any applicable Deductibles and Copayments have been paid and until the Annual Out-of-Pocket Maximum has been reached. Covered Services subject to Coinsurance and the amounts are listed in the Schedule of Benefits section. Coinsurance is a percentage of the Allowed Charge. In some instances, the Member will be responsible at the time and place of service to pay any Coinsurance directly to the Healthcare Provider. In other instances, the Member will be billed by the Healthcare Provider. These arrangements are between the Member and the Healthcare Provider.
 - (b) **Copayment** - the charge a Member must pay for certain Covered Services. Covered Services subject to a Copayment and the amounts are listed in the *Schedule of Benefits*

section. A Copayment is a flat dollar amount. In some instances, the Member will be responsible at the time and place of service to pay any Copayment directly to the Healthcare Provider. In other instances, the Member will be billed by the Healthcare Provider. These arrangements are between the Member and the Healthcare Provider.

- (c) **Deductible** – The aggregate amount for certain Covered Services that is a Member’s responsibility each Coverage Year before this Plan will begin to pay for Covered Services.
- (d) **Annual Out-of-Pocket Maximum** - The total Deductible, Coinsurance and Copayment amounts for certain Covered Services (including Prescription Drugs) that are a Member’s responsibility during a Coverage Year. The following amounts are not considered or taken into account: Charges that are not Covered Services under this Plan (e.g., charges which exceed Usual and Customary Rates and costs paid by the Member as a result of the Member’s failure to comply with Prior Authorization requirements) and charges in excess of Plan maximums. When the Annual Out-of-Pocket Maximum is met, this Plan will pay 100% of the Allowed Charge for certain Covered Services (including Prescription Drugs) incurred during the remainder of the Coverage Year. The Annual Out-of-Pocket Maximum renews on the Plan anniversary of each consecutive Coverage Year.

1.10 Coverage Year – July 1 to June 30.

1.11 Covered Service - Healthcare Services described in the *Schedule of Benefits* section for which benefits will be provided, based on date the Healthcare Service was received, unless limited or excluded in the *Exclusions* section.

1.12 Custodial Care - a type of care that is not Skilled Care and is designed to assist an individual to meet the activities of daily living. The care is of a nature that does not require the continuing attention of trained medical or paramedical personnel and can be provided by persons without professional skills or training, Including assistance in walking, getting in and out of bed, bathing, dressing, preparation of meals (Including special diets), supervision of medication that can be self-administered, rest cures and home care provided by family members.

1.13 Dependent - a dependent of the Subscriber who qualifies for membership under the Plan in accordance with the requirements specified below:

- (a) a Spouse.
- (b) the Subscriber’s child or children who meets the following requirements:
 - (1) is a resident of the United States; and
 - (2) is one of the following; and:
 - a) natural child,
 - b) stepchild,
 - c) legally adopted child,
 - d) child placed in the Subscriber’s physical custody whom the Subscriber intends to adopt, or
 - e) a child for whom the Subscriber and/or the Spouse has been named legal guardian
 - (3) is one of the following:
 - a) less than twenty-six (26) years of age, or

- b) mentally or physically disabled incapable of self-sustaining employment and dependent upon the Subscriber and Spouse (or former spouse), if applicable, for support and maintenance. The child must have been covered under the Plan immediately prior to reaching the age limitation (age 26). For the dependent child to qualify, the Plan must be notified within thirty (30) days after the date Dependent coverage would normally end. Proof of incapacity may thereafter be requested from time to time, but not more frequently than annually following the two (2) year period after the Dependent reached the age limitation (age 26).
- (c) Individuals specifically excluded from the definition of a Dependent are:
 - (1) any person on active military duty;
 - (2) the grandchild of a Subscriber and/or the Spouse except as specified in Section 1.14(b)2(d) or 1.14 (b)2(e)
 - (3) any person covered under the Plan as a Subscriber; and
 - (4) any person covered by another Subscriber on the Plan.
- 1.14 Disposable Supplies** - medical supplies that are Medically Necessary for a specific therapeutic purpose in treating an Illness or Injury and that are designed for one use only.
- 1.15 Durable Medical Equipment** - standard model medical equipment and/or supplies which are Medically Necessary, prescribed by a Healthcare Provider for a specific therapeutic purpose in treating an Illness or Injury, and designed to be used repeatedly, generally over extended periods of time.
- 1.16 Educational** - the primary purpose of a service or supply is to provide the Member with any of the following: training in the activities of daily living, instructions in scholastic skills such as reading and writing, preparation for an occupation or treatment for learning disabilities.
- 1.17 Eligible Employee** - an Employee who meets the eligibility criteria for the Plan as described in the *Eligibility and Participation* section and who has not ceased to meet the eligibility criteria.
- 1.18 Emergency** – the onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) serious jeopardy to the Member’s health; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.
- 1.19 Employee** - any person employed by the Employer. Employee does not include the following:
 - (a) a self-employed individual as described in Section 401 (c) of the Code, including, but not limited to, a sole proprietor if the Employer is a sole proprietorship, a person owning more than 2% of the Employer if it is a Subchapter S corporation, a partner of the Employer if it is a partnership, and a member of the Employer if it is a limited liability company and the members are treated as partners for income tax purposes;
 - (b) any individual included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the Employee under the Plan;
 - (c) any individual who is a nonresident alien and receives no earned income from the Employer from sources within the United States;
 - (d) any individual who is a leased employee as defined in Section 414(n)(2) of the Code;

- (e) any individual who performs services for the Employer through, and is paid by, a third-party (including but not limited to an employee leasing or staffing agency) even if such individual is subsequently determined to be a common law employee of the Employer; or
- (f) any individual who performs services for the Employer pursuant to a contract or agreement (whether verbal or written) which provides that such individual is an independent contractor or consultant, even if such individual is subsequently determined to be a common law employee of the Employer.

1.20 Employer – Town of Gilbert, which is an Arizona city, town, or county, and any subsidiary or affiliated entities recognized by Town of Gilbert as eligible to participate and that agree to participate in the Plan.

1.21 ERISA - Employee Retirement Income Security Act of 1974, as amended from time to time.

1.22 Experimental or Investigative - a drug, device, Healthcare Service or procedure that meets any one or more of the following criteria:

- (a) The drug, device, Healthcare Service or procedure cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished.
- (b) Reliable evidence shows that the drug, device, Healthcare Service or procedure is the subject of ongoing Phase I, II, or III clinical trials. (Phase I clinical trials determine the safe dosages of medication for Phase II trials and define acute effects on normal tissue. Phase II clinical trials determine clinical response in a defined patient population. If significant activity is observed in any disease during Phase II, further clinical trials usually study a comparison of the experimental treatment with the standard treatment in Phase III trials. Phase III trials are typically quite large and require many patients to determine if a treatment improves outcomes in a large population of patients.)
 1. Reliable evidence shows that the drug, device, Healthcare Service or procedure is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.
 2. Reliable evidence shows that the consensus among experts regarding the drug, device, Healthcare Service or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Notwithstanding the above, the Plan may determine that a drug, device, Healthcare Service or procedure is not Investigative if it shows sufficient promise. In order to show sufficient promise, the Plan must find, on a case-by-case basis, that the drug, device, Healthcare Service or procedure meets the following criteria:

1. Reliable evidence preliminarily suggests a high probability of improved outcomes compared to standard treatment (e.g., significantly increased life expectancy or significantly improved function); and
2. Reliable evidence suggests conclusively that beneficial effects outweigh any harmful effects; and
3. If applicable, the FDA has indicated that the approval of the drug, device, Healthcare Service or procedure for other proposed use is pending and likely to occur in the near future.

Reliable evidence will include only published reports and articles in the authorized medical and scientific literature that delineates the written protocol or protocols used by the treating facility or by another facility studying substantially the same drug, device, Healthcare Service, or procedure, and that describes among its objectives determinations of safety, efficacy, or efficacy in comparison to conventional alternatives, or toxicity.

1.23 Family – a Subscriber and his/her properly enrolled Dependents.

- 1.24 Formulary** - a list of Prescription Drugs approved by the Plan for use by Members, as amended from time to time.
- 1.25 FMLA** - the Family and Medical Leave Act of 1993, as amended from time to time.
- 1.26 Healthcare Provider** - Institutional Healthcare Providers or Professional Healthcare Providers providing Healthcare Services to Members. Each must be licensed, registered or certified by the appropriate state agency where the Healthcare Services are performed. Where there is no appropriate state agency, registration or certification by the appropriate professional body is required. Healthcare Provider Includes those listed below:
1. **Advanced Practice Registered Nurse** - Including a Clinical Nurse Specialist, Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife and Nurse Practitioner.
 2. **Ambulatory Surgical Facility** - a facility with an organized staff of Physicians that:
 1. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis; and
 2. provides treatment by or under the direct supervision of a Physician or other Healthcare Provider; and
 3. does not provide inpatient accommodations; and
 4. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or Dentist.
 5. **Chiropractor** - a Doctor of Chiropractic (D.C.).
 6. **Dentist** – a Doctor of Dental Surgery (D.D.S.), Oral Pathologist, Oral Surgeon or Doctor of Dental Medicine (D.M.D.).
 7. **Durable Medical Equipment Provider.**
 8. **Home Health Agency** - an agency that provides Home Health Care and that is Medicare certified and licensed or approved under state or local law.
 9. **Hospice** - an organization that provides medical, social and psychological services as palliative treatment for Members with a terminal illness and life expectancy of less than six months.
 10. **Hospital** - a licensed institution operated pursuant to law that is engaged in providing inpatient and outpatient diagnostic and therapeutic services for the diagnosis, treatment and care of sick and injured persons by or under the direct supervision of Physicians or other Healthcare Providers.
 11. **Licensed Practical Nurse (L.P.N.)** - A graduate of a school of practical nursing who has passed the practical nursing state board examination and is licensed to administer care, usually working under direction of a licensed physician or a registered nurse.
 12. **Licensed Registered Dietitian** – A specialist in dietetics who has met the requirements for certification stipulated by the American Dietetic Association.
 13. **Occupational Therapist** - An individual who has met the requirements to practice in states with licensure laws governing occupational therapy and typically certified by the National Board for Certification in Occupational therapy as a registered occupational therapist (OTR). Some state governments, as part of their licensure statutes, permit use of the OTR/L or LOTR designations.
 14. **Optometrist** – a Doctor of Optometry (O.D.).
 15. **Physical Therapist** - A licensed practitioner of physical therapy who has graduated from an accredited physical therapy education program.

16. **Physician** - a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).
 17. **Physician Assistant** - an individual licensed by the medical examining board to provide medical care with Physician supervision and direction.
 18. **Podiatrist** - a Doctor of Podiatry (D.P.), Doctor of Surgical Chiropody (D.S.C.), Doctor of Podiatric Medicine (D.P.M.) or Doctor of Surgical Podiatry (D.S.P.).
 19. **Psychologist** – one who is trained in methods of psychological analysis, therapy, and research.
 20. **Radiation Therapist** – radiation therapy technologist.
 21. **Registered Nurse (R.N.)** –a nurse who has graduated from a state-approved school of nursing, has passed the professional nursing state board examination, and has been granted a license to practice within a given state.
 22. **Rehabilitation Facility** - an institution, or a distinct part of an institution providing rehabilitation services and related services to persons on an inpatient basis.
 23. **Respiratory Therapist.**
 24. **Skilled Nursing Facility** - an institution, or a distinct part of an institution providing Skilled Care and related services to persons on an inpatient basis.
 25. **Social Worker** - an individual who is qualified through education, training and experience to provide services in relation to the treatment of emotional disorders, psychiatric conditions or substance abuse when employed by, or under the supervision of, an M.D., D.O., or Ph.D.
 26. **Speech Therapist.**
 27. **Urgent Care Facility** - a clinic, acute care facility or walk-in clinic with Urgent Care hours or walk-in clinic hours providing treatment for Urgent Care.
- 1.27 **Health Care Reform** - Patient Protection and Affordable Health Care Act (“PPACA”) as amended by the Health Care and Education Reconciliation Act (“Reconciliation Act”), collectively referred to herein as Health Care Reform.
- 1.28 **Healthcare Services** - the provision of all medical treatment, Disposable Supplies, Durable Medical Equipment, Orthotics or Prosthetics as defined in the Plan.
- 1.29 **HIPAA** - Health Insurance Portability and Accountability Act of 1996, as amended from time to time.
- 1.30 **Home Health Care** - Skilled Care for the treatment of a homebound Member’s Illness or Injury requiring only Intermittent Care.
- 1.31 **Illness** - a non-occupational sickness or disorder, Including pregnancy and related conditions. The term “Illness” does not include an illness with respect to which benefits are payable under any workers’ compensation, occupational disease, or similar law.
- 1.32 **Including or Includes** - including, but not limited to.
- 1.33 **Injectable Prescription Drug** – a product which meets the definition of a Prescription Drug but is administered by injection. For purposes of this Plan, insulin and sumatriptan (Imitrex) are considered to be Prescription Drugs and not Injectable Drugs.
- 1.34 **Inherited Metabolic Disorders** - an inherited disorder: (1) specified in the newborn screening program prescribed by Arizona law, Including phenylketonuria (PKU), maple sugar urine disease, homocystinuria, and galactosemia; (2) involving amino acid, carbohydrate, or fat metabolism; (3) having medically standard methods of diagnosis, treatment, and monitoring Including quantification of metabolites in blood, urine, or spinal fluid or enzyme or DNA confirmation in tissues; and (4) requiring specially processed or treated medical foods: (i) that are generally available only under the supervision and

direction of a Physician, (ii) that must be consumed throughout life, and (iii) without which the Member may suffer serious mental or physical impairment.

Any condition not included in the newborn screening program is not an Inherited Metabolic Disorder.

- 1.35 Injury** - a non-occupational accidental physical damage caused directly and exclusively by external, violent, and purely accidental means. The term “Injury” does not include an injury with respect to which benefits are payable under any workers’ compensation, occupational disease, or similar law.
- 1.36 In-Network** – the network of Healthcare Providers. For the Prescription Drug benefit, In-Network shall mean the pharmacy network (as indicated on the Membership Card). For medical, behavioral health, and chiropractic services, In-Network shall mean the Blue Cross Blue Shield Arizona network and Mayo Clinic providers in the state of Arizona. By election of the Subscriber during initial enrollment, open enrollment, or within 30 days of an eligible qualifying event as listed in Section II, the Subscriber and covered dependents (if applicable) may participate in a national network option available under the Plan. In-Network shall also mean the First Health Network for providers outside of the state of Arizona for members enrolled in the national network option under the Plan.
- Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross and Blue Shield Association, provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross and Blue Shield Plans outside of Arizona.
- 1.37 Institutional Healthcare Provider** - Healthcare Providers Including an Ambulatory Surgical Facility, Home Health Agency, Hospice, Hospital, Skilled Nursing Facility or Urgent Care Facility.
- 1.38 Intermittent Care** - a medically predictable need for Skilled Care at least once every sixty (60) days.
- 1.39 Medical Support Order (MSO)** – a medical support order as described in AZ Statute 20-1692.03.
- 1.40 Medically Necessary / Medical Necessity** - Healthcare Services appropriate, in terms of type, frequency, level, setting, and duration, to the Member’s diagnosis or condition, and diagnostic testing and preventive services that are not otherwise excluded under the Plan. Such care must:
1. be consistent with generally accepted parameters as determined by Healthcare Providers in the same or similar general specialty as typically manage the condition, procedure or treatment at issue; and
 2. help restore or maintain the Member’s health; or
 3. prevent deterioration of the Member’s condition; or
 4. prevent the reasonably likely onset of a health problem or detect an incipient problem.
- 1.41 Medicare** - Title XVIII of the Social Security Act, as amended from time to time.
- 1.42 Member** - a Subscriber or Dependent who is participating under the Plan in accordance with the *Eligibility and Participation* section and whose coverage has not terminated. Member also includes former Subscribers and former Dependents who are otherwise entitled to coverage and properly enrolled under the Plan.
- 1.43 Membership Card** - an identification card issued in the Subscriber’s name identifying the membership number of the Subscriber.
- 1.44 Orthotic** - a custom made brace or external device made for a weak, diseased or injured body part that can increase, decrease or eliminate motion or support the weak, diseased or injured body part.
- 1.45 Out-of-Network** - Healthcare Providers that are not In-Network. When Members seek Covered Services from Healthcare Providers who are not In-Network, they are not covered unless specifically listed in this Plan.

- 1.46 Part-Time Care** - care that is required less than eight (8) hours a day or forty (40) hours a week.
- 1.47 Plan** - the Town of Gilbert Medical Benefit Legacy Plan for the provision of healthcare benefits to Members, as amended from time to time.
- 1.48 Prescription Drug** - medications and drugs that bear the legend “Federal law prohibits dispensing without a prescription.” This term also includes medicines and drugs that contain a legend drug that requires compounding by a pharmacist to the order of a Physician or other authorized Healthcare Provider and are approved by the U.S. Food and Drug Administration (FDA). Insulin and diabetic supplies (e.g., syringes, lancets and testing strips) are generally covered under this definition. Medications and drugs included under this definition are categorized as:
- (a) **Brand Name Drug** –Typically, an original patent-protected medication or drug. Designation of Brand Name status is made by MediSpan, an independent third party provider, based on the number of manufacturers of a given product and price differential between the original product and subsequent manufacturers. While not typical, it is possible for a drug to have more than one manufacturer designated as “Brand Name”.
 - (b) **Generic Drug** – Typically, a medication or drug on which patent has expired and that is manufactured by multiple pharmaceutical companies. FDA A-rated generics (which are the only type covered under the Plan) contain the same active ingredient as the Brand Name Drug, are manufactured under the same FDA standards and are considered equivalent in all respects to the Brand Name Drug. Designation of Generic status is made by MediSpan, an independent, third party provider, based on the number of manufacturers of a given product and the price differential between the original product and subsequent manufacturers.
- 1. Formulary** - A list of Prescription Drugs approved by this Plan for use by Members, as amended from time to time.
- (d) **Specialty Drug** - a Prescription Drug used to treat a specific, sometimes rare, medical condition. Specialty Drugs are typically expensive, often including bioengineered products, and require special handling, administration, monitoring, and patient education.
- 1.49 Preventive Care** - Healthcare Services rendered solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.
- 1.50 Primary Care Provider (PCP)** – the In-Network Healthcare Provider chosen by each Member to provide and/or coordinate the Covered Services rendered to the Member.
- 1.51 Prior Authorization** - authorization from the Plan for specific Covered Services before they are rendered, in accordance with the *Utilization Management* section.
- 1.52 Professional Healthcare Provider** - Healthcare Providers Including an Advanced Practice Registered Nurse, Chiropractor, Dentist, Licensed Registered Dietitian, Nurse Practitioner, Occupational Therapist, Physician, Physician Assistant, Podiatrist, Radiation Therapist, Respiratory Therapist and Speech Therapist.
- 1.53 Prosthetic** - a fixed or removable device that replaces all or part of an extremity or body part, Including such devices as an artificial limb, intraocular lens or breast prosthesis.
- 1.54 Rescission or Rescind** - A cancellation of coverage or discontinuance of coverage under the Plan that has retroactive effect. Such action is prohibited under Health Care Reform unless attributable to (a) a failure to timely pay the cost of coverage, or (b) fraud or intentional misrepresentation of material fact, as those circumstances are described under Health Care Reform and regulatory guidance.
- 1.55 Respite Care** – care provided to a Member receiving Covered Services for Hospice care, for the purpose of giving the Member’s uncompensated primary caregivers relief when necessary in order to maintain the Member at home.

- 1.56 **Short-Term** – no longer than three (3) weeks.
- 1.57 **Skilled Care** - nursing or rehabilitative services requiring the skills of technical or professional medical personnel to develop, provide and evaluate the care and assess the Member’s changing condition.
- 1.58 **Spouse** – an individual who is in a current valid marriage with the Subscriber as recognized under federal tax laws, including the Code, and who is a resident of the same country in which the Subscriber resides. Such individual must have met all the requirements of a valid marriage contract of the state or country in which the marriage of such parties was performed. An individual who is legally separated or divorced from the Subscriber is specifically excluded from the definition of Spouse.
- 1.59 **Standard Medical Reference Compendia** – Includes the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, Drug Information for the Health Care Provider, and other medical literature meeting the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or is published in a journal specified by the United States Department of Health and Human Services as acceptable peer reviewed medical literature pursuant to section 186(t)(2)(B) of the Social Security Act.
- 1.60 **Subscriber** - an Eligible Employee, former Employee, or COBRA continuee who is entitled to coverage and properly enrolled under the Plan.
- 1.61 **Summary Benefit Description (SBD)** – This document, which provides a written summary of the benefits under the Plan. This document is the SBD for The Town of Gilbert Medical Benefit Legacy Plan.
- 1.63 **Urgent Care** - a condition requiring Medically Necessary care to treat an unforeseen Illness or Injury which is necessary to prevent serious deterioration of a Member’s health, and which cannot be reasonably delayed until the next available appointment.

SECTION II

ELIGIBILITY AND PARTICIPATION

2.1 Eligibility for Employee Coverage. Eligibility and participation are as follows:

- (a) **Eligible Employees.** An Employee is an Eligible Employee as long as he/she is regularly scheduled to work at least 60 hours per pay period for the Employer or serving as a Town Council member and properly enrolled as described below.
- (b) **FMLA Members.** FMLA leaves of absence will be administered according to applicable law and policies established by the Employer. Copies of FMLA policies are available from the Employer.
- (c) **Military Leave Members.** Military leaves of absence will be administered according to applicable law and policies established by the Employer. Copies of military leave policies are available from the Employer.
- (d) **Leave of Absence.** Employees who would normally be working as a regular Employee for the Employer for at least the required number of hours per pay period to qualify as an Eligible Employee, but who are on an Employer approved leave of absence, including FMLA absences, remain Eligible Employees.

1. Eligibility for Dependent Coverage.

- (a) **General Rule.** Dependents are eligible for coverage under the Plan at the same time Eligible Employees are eligible for coverage under the Plan or at the time the Eligible Employee first gains a Dependent, whichever occurs first, except in the case of a qualified medical support order under Arizona law.
- (b) **Medical Support Orders.** A Dependent whose coverage is required under a medical support order will be eligible to participate in the Plan as of the date specified in the order, provided the medical support order satisfies the requirements of Arizona law. The Employer will review a medical support order and determine whether it is qualified under Arizona law. Upon request to the Employer, Members may obtain a copy of the procedures governing medical support order determinations, which is available at no charge.
- (c) **Adoption or Placement for Adoption.** In general, Dependents who are adopted or placed for adoption are eligible for coverage under the Plan at the time the Eligible Employee first gains the Dependent. However, in certain situations, coverage may be available for the Healthcare Services provided in connection with the birth of such a Dependent. In order to receive such coverage, special requirements must be satisfied, including special notice requirements. Those requirements are described in the *Maternity* subsection of the *Schedule of Benefits* section.

2.3 Enrollment. The following paragraphs describe enrollment. Please note that in order for an Eligible Employee's Dependents to be enrolled, the Eligible Employee must be enrolled or enrolling.

- (a) **Initial Enrollment.**
 - (1) **Eligible Employees.** An Eligible Employee has thirty (30) days from the date he/she first satisfies the definition of Eligible Employee to enroll for coverage in the Plan. This is called the initial enrollment period. Enrollment materials are available from the designated person of the Employer. Enrollment materials must be completed and

returned to the Employer, or its designee, within the thirty (30) day period. If enrollment does not occur within this initial period, the Eligible Employee may enroll in the Plan only if a “special enrollment” situation occurs or during the annual open enrollment. Subscribers and Dependents covered by the subscriber may elect to participate in the national network option under the Plan, but must remain enrolled in that option until the end of the Coverage Year or until coverage termination.

- (2) **Dependents.** Except as otherwise provided under a medical support order qualified under Arizona law, a Dependent must be enrolled within thirty (30) days from the date he/she first satisfies the definition of Dependent under the Plan. If enrollment does not occur within this initial period, the Dependent may enroll in the Plan only if a “special enrollment” situation occurs or during the annual open enrollment.
- (b) **Open Enrollment.** Prior to the start of a Coverage Year, the Plan has an open enrollment period. “Open enrollment period” means the period of time occurring toward the end of the Coverage Year during which (1) Eligible Employees who are not covered under the Plan may elect to begin coverage effective the first day of the upcoming Coverage Year and (2) Subscribers will be given an opportunity to change their coverage effective the first day of the upcoming Coverage Year. The terms of the open enrollment period, including duration of the election period, shall be determined by the Employer and communicated prior to the start of an open enrollment period. Subscribers and Dependents covered by the Subscriber who elect to participate in the national network option under the Plan must remain enrolled in that option until the end of the Coverage Year or until coverage termination.
1. **Special Enrollment Due to Loss of Other Health Coverage.** Under certain circumstances, an Eligible Employee or his/her Dependent(s) who did not enroll during the initial enrollment period, during open enrollment, or when a change in status event occurred may enroll before the next open enrollment period. These circumstances warrant “special enrollment” and also provide an opportunity for the Eligible Employee to elect the national network option under the Plan, with a requirement to remain enrolled in that option until the end of the Coverage Year or until coverage termination. Special enrollment shall be allowed for either of the following:
1. The Eligible Employee or the Dependent satisfies all of the following criteria:
 1. Was covered under a group health plan or health insurance coverage (this prior coverage does not include continuation coverage required under federal law, but does include other coverage options that may be available from your Employer) at the time the Eligible Employee or Dependent was eligible to enroll under this Plan;
 2. Declined coverage in writing for that reason;
 3. Presents to the Employer, or its designee, evidence of a loss of the prior coverage due to a loss of eligibility for that coverage, or evidence of the termination of employer contributions toward that coverage. “Loss of eligibility” does not include a loss due to the failure of the Eligible Employee or eligible Dependent to pay premiums on a timely basis or termination of the prior coverage for cause, but may include:
 1. loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment;
 2. Cessation of Dependent status under the other plan’s eligibility criteria;

3. incurring a claim that causes the Eligible Employee or Dependent to meet or exceed the lifetime limit on all benefits;
4. Discontinuance of a benefit plan for a class of similarly situated individuals that includes the Eligible Employee or Dependent;
5. Eligible Employee or Dependent no longer resides, or is employed within the service area for prior coverage under a group HMO plan, provided no other coverage option is available.

Loss of eligibility occurs regardless of whether the Eligible Employee or Dependent is eligible for or elects continuation of coverage required under federal law;

and

4. Submits a written request for enrollment to Employer, or its designee, within thirty (30) days of the date of the loss of coverage, the date the employer's contribution toward that coverage terminated or the date on which the claim is denied due to the operation of a lifetime limit.
2. The Eligible Employee or Dependent satisfies all of the following criteria:
 1. Was covered under a group health plan or health insurance coverage under COBRA;
 2. Declined coverage in writing for that reason;
 3. Presents to the Employer, or its designee, evidence that the Eligible Employee has exhausted such COBRA coverage and has not lost such coverage due to the failure of the Eligible Employee or Dependent to pay premiums on a timely basis or termination of coverage for cause (the Eligible Employee or Dependent will be deemed to have exhausted COBRA coverage if such coverage ceases as a result of the Employer's failure to remit premiums on a timely basis or as a result of the Eligible Employee or Dependent incurring a claim that meets or exceeds the lifetime limit on all benefits and no other COBRA continuation is available); and
 - d) Submits a written request for enrollment to the Employer, or its designee, within thirty (30) days of the date of the loss of coverage.
 - (3) The Eligible Employee or Dependent satisfies all of the following criteria:
 - a) Effective April 1, 2009, an Eligible Employee or Dependent with coverage under a State Medicaid plan or Children's Health Insurance Program (SCHIP) loses such eligibility;
 - b) Loss of eligibility under such plan is not due to the Eligible Employee's or Dependent's failure to pay required premiums on a timely basis or termination for cause;
 - c) Submits a written request for enrollment to Employer, or its designee, within sixty (60) days of the date of the loss of coverage.
2. **Special Enrollment Due to Addition of Dependent.** An Eligible Employee's marriage or the birth, adoption, placement for adoption, or legal guardianship of an Eligible Employee's child triggers special enrollment rights and also provides an opportunity for the Eligible Employee to

elect participation under the national network option under the Plan, with a requirement to remain enrolled in that option until the end of the Coverage Year or until coverage termination.

1. **Non-Participating Employees May Also Enroll.** The addition of a new dependent triggers enrollment rights for an Eligible Employee even if he/she does not participate in this Plan at the time of the event. For example, upon the birth of an Eligible Employee's child, the Eligible Employee (assuming that he/she did not previously enroll), his/her Spouse, and his/her newborn child may all enroll because of the child's birth. The same rule applies to the Eligible Employee's marriage or adoption of a child if the Eligible Employee had not previously enrolled in this Plan.
 2. **Deadline for Special Enrollment Period.** The Eligible Employee must request special enrollment in this Plan within thirty (30) days of marriage or birth, adoption or placement for adoption of his/her child. If the Employer, or its designee, does not receive the Eligible Employee's completed request for enrollment within this deadline, the Eligible Employee and his/her Dependents lose special enrollment rights for that event. Notwithstanding the foregoing, with respect to a Subscriber who acquires a new Dependent via birth, adoption, or placement for adoption, coverage for the new Dependent shall begin immediately upon birth, adoption, or placement for adoption and shall not be conditioned upon the enrollment of the new Dependent. However, if an additional premium is charged for the new Dependent and if the new Dependent fails to enroll within the thirty (30) day time period referenced above, the coverage shall cease upon expiration of such time period. Even if no additional premium is charged, the Subscriber should notify the Employer of the birth, adoption, or placement for adoption.
 3. **Special Enrollment Due to Premium Assistance Under State Medicaid Plan or State Children's Health Insurance Program (SCHIP).** If an Eligible Employee or Dependent(s) did not enroll during the initial enrollment period, during open enrollment, or when a change in status event occurred, and becomes eligible for premium assistance under a State Medicaid or State Children's Health Program (SCHIP), then the Eligible Employee or Dependent(s) may enroll before the next open enrollment period as long as they notify the Employer in writing within sixty (60) days of the date they became eligible for the premium assistance.
 4. **Additional Events to allow election in the Plan's national network option:** Within 30 days of a Subscriber or eligible Dependent's relocation out of state, the Subscriber may elect to participate in the national network option. The effective date of In Network coverage under the Plan's national network option shall be the later of the date of relocation or the date the election is received by Town of Gilbert Human Resources. Documentation of relocation may be required, as determined by the Town of Gilbert. In no case shall the national network option be made retroactive. If the national network option is elected, coverage under the option shall continue until the end of the Coverage Year or coverage termination.
 5. **Opt Out.** An Eligible Employee may decline coverage ("opt out") under this Plan. Such an Eligible Employee shall be provided with the appropriate notice required under HIPAA regarding opting out of coverage.
- 2.4 **Effective Date of Coverage.** The date on which coverage becomes effective depends upon when enrollment occurs.
- (a) **Enrollment Within Initial Enrollment Period.**
 1. **Eligible Employees.** An Employee is an Eligible Employee on the first day of employment or on the first day of change to an eligible status with the Employer.

2. **Dependents.** The effective date of coverage for Dependents is at the time of the Eligible Employee's enrollment. Except as provided in Section 2.3(c)(2), if Dependent status is acquired after the Subscriber's initial eligibility, the effective date of coverage shall be the date on which the new Dependent becomes eligible for coverage under the Plan, provided the Subscriber completes a change form and submits it to the Employer within thirty (30) days after the attainment of Dependent status.
- (b) **Enrollment Not Within Initial Enrollment Period.** If an Eligible Employee or Dependent does not enroll within the initial enrollment period, he or she must wait until the next open enrollment period unless a "special enrollment" situation occurs. If a "special enrollment" situation occurs, the Eligible Employee or Dependent must enroll within thirty (30) days of the "special enrollment" situation's occurrence.
1. **Special Enrollment.** When enrollment occurs as the result of a special enrollment due to loss of other health coverage as described above, the effective date of coverage shall be no later than the first day of the month following the date on which the request for enrollment was received by the Employer or its designee. When enrollment occurs as the result of a special enrollment due to addition of a Dependent as described above, the effective date of coverage is the date of the event.

2.5 **Retiree Coverage.**

- (a) **Requirements.** Employees who retire from the Town of Gilbert through the Arizona State Retirement System or Arizona Public Safety Personnel Retirement System with 10 or more years of service with Gilbert are eligible to continue coverage under the Plan for the retiree and eligible Dependents. Eligibility under the Plan will end effective the last day of the month in which the earliest of the following events occurs:
1. The retiree reaches age 65
 2. The retiree opts out of such coverage
 3. The retiree fails to pay necessary premiums to the Employer within established payment schedule as communicated directly to the retiree
- During the retiree's continuation period, the retiree has the same rights to add dependents as outlined for active employees in 2.3 b, d, and e.
4. **Election.** The retiree must elect to continue health coverage under the Plan under the provisions of this section for him/herself and any Dependents within sixty (60) days after the end of the month of the retirement. If a retiree's election of retiree health coverage is not made within sixty (60) days after the month of the retirement, the retiree's coverage under the Plan and coverage for any Dependents will cease unless continuation coverage is timely elected under the provisions of COBRA. If coverage under this section is elected, the retiree is responsible for paying the full cost of coverage as determined by the Employer.

1. **USERRA.** Special rules apply to those Eligible Employees whose coverage is reinstated following a leave of absence governed by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Under USERRA, an Eligible Employee entitled to have coverage reinstated upon returning to work following a military leave of absence shall be treated as if no break in coverage occurred during the leave.

- 2.7 Membership Card.** The Membership Card issued by the Claims Administrator to a Member pursuant to the Plan is for identification purposes only. Possession of a Membership Card confers no right to services or benefits under the Plan, and misuse of such Membership Card may be grounds for termination of a Member's coverage under the Plan. To be eligible for services or benefits under the Plan, the holder of the Membership Card must be a Member. Any person receiving services or benefits which he/she is not entitled to receive pursuant to the provisions of the Plan will be charged for such services or benefits at prevailing rates. If any Member permits the use of his/her Membership Card by any other person, such card may be retained by the Plan, and all rights of such Member pursuant to the Plan may be terminated.
- 2.8 Subscriber Termination of Coverage.** Except as provided in the *Retiree Coverage* subsection above and the *Continuation of Healthcare Coverage* section, a Subscriber's participation under the Plan will terminate at midnight on the last day of the calendar month in which the earliest of the following events occurs:
1. The date the Subscriber terminates employment with the Employer.
 2. The date the Subscriber's employment position or status changes such that he/she is no longer an Eligible Employee.
 3. The date ending the period for which the last contribution is made if the Subscriber fails to make any required contributions when due.
 4. The date the Employer terminates the Plan or its participation in the Plan.
 5. The date of the Subscriber's death.
- 2.9 Dependent Termination of Coverage.** Except as provided in the *Retiree Coverage* subsection above and the *Continuation of Healthcare Coverage* section, a Dependent's participation under the Plan will terminate immediately upon termination of the Plan or will terminate at midnight on the last day of the calendar month in which the earliest of the following events occurs:
1. the dependent ceases to be an eligible Dependent as defined in the Plan.
 2. termination of the Subscriber's coverage under the Plan (see above).
 3. the dependent becomes covered under the Plan as a Subscriber.
 4. Dependent coverage is discontinued under the Plan.
 5. the Subscriber ceases to make the required contributions for the Dependent.
 6. Dependents whose coverage is required pursuant to a Medical Support Order, coverage is no longer required under the terms of the order or the Plan.
 7. Dependents whose coverage became effective upon their birth, adoption, or placement for adoption under Section 2.3(c), the date thirty-one (31) days from the effective date of coverage if an additional premium is charged for the new Dependent and the new Dependent fails to enroll with-in thirty-one (31) days following the birth, adoption, or placement for adoption.
- 2.10 Member Termination of Coverage.** Except as provided in the *Retiree Coverage* subsection above, the *Continuation of Healthcare Coverage* section, and the *Rescission* subsection below any Member's participation under the Plan will terminate immediately upon termination of the Plan or will terminate at midnight upon the occurrence of the earliest of:
1. The date on which a Member allows persons not covered under the Plan to obtain medical benefits for themselves. See *Membership Card* subsection above.
 2. The date on which a Member provides fraudulent information to obtain Plan benefits or coverage, including falsifying information on his/her applications for coverage and/or submitting

fraudulent, altered or duplicate billings for his/her personal gain. Claims paid under the Plan for expenses attributable to such fraudulent information will be treated as erroneously paid claims under Section 10.8.

- 2.11 Rescission.** Coverage under this Plan may be Rescinded under certain circumstances, including if you act fraudulently or make material misrepresentations of fact in connection with your or your Dependents' coverage under this Plan. It is your responsibility to provide accurate information and to make accurate and truthful statements including information and statements regarding familial status, age, relationships, etc. In addition, it is your responsibility to update previously provided information and statements and to notify the Plan of changes in status, such as a divorce or a child reaching the maximum age for coverage under the Plan. Failure to do so may result in your coverage, including the coverage of those provided coverage through you such as your spouse or children, being cancelled and such cancellation may be retroactive. A determination by the Plan that a Rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Member whose coverage is being Rescinded will be provided a 30 day notice period as described under Health Care Reform and regulatory guidance. Such notice shall be considered an Adverse Benefit Determination. At the conclusion of the 30 day notice period, coverage shall be terminated retroactive to the date identified in the notification. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under Section 10.8. Notwithstanding the foregoing, the 30 day notice period requirement shall not apply in the case of retroactive termination of coverage due to nonpayment.

SECTION III

CONTINUATION OF HEALTHCARE COVERAGE

1. **Continuation of Healthcare Coverage.** Continued coverage shall be provided only if and as required under COBRA. The Plan Administrator shall, within the parameters of the law, establish uniform policies for the purpose of providing such continuation of coverage. Please see the *COBRA Notice of Rights Section* for more information.

- 3.2 **Conversion.** There is no conversion coverage under the Plan offered by the Employer.

SECTION IV

UTILIZATION MANAGEMENT

- 4.1 Introduction.** This section describes utilization management programs under the Plan and the Member's responsibilities under these programs. Utilization management programs assist Members to ensure maximum benefit coverage while optimizing clinical outcomes across a continuum of care.
1. The utilization management programs are designed to assist the Plan in:
 1. evaluating Members' Healthcare Services for Medical Necessity and appropriateness
 2. evaluating alternate level of care opportunities
 3. coordinating care needs
 4. identifying benefit limitations
 5. Identifying high risk Members for proactive case management programs when applicable
 2. The Plan uses the methods described in this *Utilization Management* section to coordinate and review care, and to determine whether services are Covered Services under the Plan
- 4.2 Utilization Management Criteria.** Members will receive benefits under the Plan only for Covered Services that are determined to be Medically Necessary and not Experimental or Investigative. The fact that a Member's Healthcare Provider has prescribed, ordered, recommended, or approved a Healthcare Service, or has informed the Member of its availability does not in itself make it Medically Necessary. The Plan will make the final determination of whether any service (a) constitutes Medically Necessary care, or (b) is considered Experimental or Investigative.
- 4.3 Medical Care Decisions.** The Member's medical care is between the Member and the Member's Healthcare Provider. The ultimate decision on the Member's medical care must be made by the Member and the Member's Healthcare Provider. The Plan only has authority to determine whether provided services are Covered Services under the Plan.
- 4.4 Out-of-Network.** The member is entitled to coverage from Out-of-Network Healthcare Providers if such Medically Necessary Covered Services receive Prior Authorization by the Plan, except that Emergency Services and Urgent Care services do not require Prior Authorization. The Plan will grant Prior Authorization to Out-of-Network Healthcare Providers for services that would be Covered Services only when:
- (1) The Plan determines the Healthcare Services are not available from In-Network Healthcare Providers; and
 - (2) The Healthcare Services are recommended in writing by an In-Network Physician and receive Prior Authorization from the Plan.

Covered Services rendered by an Out-of-Network Healthcare Provider are not eligible for coverage (i.e. payment) under the Plan unless the Member obtains Prior Authorization from the Plan (except for Emergency services and Urgent Care services).

1. Coverage of such Healthcare Services is subject to all conditions and limits of this Plan Including any applicable Copayment(s).
1. A referral by an In-Network Healthcare Provider to an Out-of-Network Healthcare Provider does not satisfy the requirement for Prior Authorization from the Plan.
2. The Member or an In-Network Physician must contact the Plan by faxing a request including an explanation of the need for Out-of-Network services with supporting documentation to the Plan at:

1-800-632-9885

or by calling:

1-866-465-5148

TDD for the deaf is 1-800-407-2442

4.5 Prior Authorization. Prior Authorization is authorization from the Plan for specific Covered Services before they are rendered, in accordance with this *Prior Authorization* subsection. Requesting Prior Authorization is a Pre-Service Claim as described in the *Claim and Appeal Procedures* section.

(a) Limitations.

1. Prior Authorization does not guarantee that proposed Healthcare Services are covered under the Plan. Coverage for authorized services is subject to the definitions, conditions, limitations and exclusions of the Plan. Services provided after Prior Authorization is received may be subject to further review by the Plan to ensure the services are Medically Necessary. Benefits will be denied if the Member is not eligible for coverage under the Plan on the date services are incurred, if services received are not Medically Necessary, or if the Plan terminates.
2. Prior Authorization does not determine the level at which benefits will be available.

(b) Certain Covered Services Require Prior Authorization. Certain Covered Services require Prior Authorization under the Plan Including:

- (1) **Durable Medical Equipment, Orthotics or Prosthetics over \$750 or any rental to exceed four (4) months.**

Please note: Prior Authorization is not required for oxygen and oxygen supplies

- (2) **Apnea testing**
- (3) **Infant apnea monitors**
- (4) **Dental Services and Oral Services**
- (5) **Implantable Hearing Devices**
- (6) **Certain elective surgeries, Including:**

1. **Breast surgery**

Please note: Prior Authorization is not required for any surgery related to cancer treatment or reconstruction following a mastectomy for breast cancer treatment.

2. **Cosmetic or reconstructive procedures and surgery**

Please note: Prior Authorization is not required for reconstruction following a mastectomy for breast cancer treatment.

Including:

1. Reconstructive surgery for congenital deformities which do not impose a functional impairment, but result in absence of a body part, Including cleft lip, nasal deformities, breast reconstruction for Poland's Syndrome, and microtia repair
2. Treatment of keloid scars
3. Breast reconstruction after a mastectomy
4. Breast reduction surgery

3. **Oral surgery, maxillofacial surgery or uvulopalatopharyngoplasty (UPPP)**

Please note: Prior Authorization is not required for oral surgery for treatment of cancer.

1. **Varicose vein treatment**

1. **Weight reduction surgery**

(7) **Home Health Care**

(8) **Hospice care**

(9) **Infertility services**

(10) **Non-Emergency Ambulance**

(11) **Non-Emergency Hospital Admissions**, Including admissions for mental health, chemical dependency or medical procedures.

Please note: Prior Authorization is not required for emergency admissions to the Hospital; however, the Member should notify the Claims Administrator within 48 hours after the admission or as soon as reasonably possible.

1. **Out-of-Network services that are not available from an In-Network Healthcare Provider and the Member is requesting the In-Network level of benefits or an In-Network Healthcare Provider has recommended the Healthcare Services in writing.**
2. **Positron Emission Tomography (PET) Scan**
3. **Proton Beam Therapy**
4. **Respite Care**
5. **Skilled Nursing Facility and Rehabilitation Facility**
6. **Therapy (Physical Therapy, Speech Therapy, Occupational Therapy, and Respiratory Therapy) for services exceeding the 30 visit combination maximum per Coverage Year.**

7. **Specified Prescription Drugs** as listed in the *Outpatient Prescription Drugs* subsection of the *Schedule of Benefits* section, including self-administered Injectable Prescription Drugs, with the exception of insulin and sumatriptan (Imitrex)
- (19) **Temporomandibular joint disorder (TMJ/TMD) treatment**
 - (20) **Transplants and transplant related services**, including organ transplants, bone marrow transplants and stem cell transplants.
 - (21) **Excluded or restricted services as detailed in this SBD:** Where this SBD expressly excludes or restricts benefits for services, a member may request Prior Authorization for such services. If prior authorization is denied, the member may initiate a Pre-Service Appeal.
- 1. **How to Obtain Prior Authorization.** See the *Claim and Appeal Procedures* section for information on how to file a Pre-Service Claim.
 - 2. **Review.** In cases where Prior Authorization is required but not obtained, such services will be subject to review to determine whether the services are Covered Services under the Plan.
- 4.6 **Utilization Review.** Utilization review is the process of reviewing certain services that have been requested or provided to evaluate:
- (a) Medical Necessity.
 - (b) Verification that services are Covered Services under the Plan.
 - (c) Verification the Member obtained Prior Authorization if required.
 - (d) Identification of case management or coordination of care needs.
- 4.7 **Discharge Planning.** Utilization Management may act as a resource in assisting Members with the transition to an appropriate level of care following acute inpatient and/or outpatient Healthcare Services. If the Member is not able to return home, the Plan may coordinate or assist in the coordination of the Member's care to identify the most appropriate alternative setting and services.
- 4.8 **Case Management.** Case management is collaborative, systematic, and ongoing management of Members with complex diagnoses, catastrophic Injuries or Illnesses, chronic health problems, and/or poor histories of self-management or compliance. Case management involves coordination of the Member's healthcare needs and a treatment plan across the healthcare continuum.
- 4.9 **Questions Regarding Utilization Management Procedures.** If the Member has any questions regarding these procedures, the Member or the Member's Healthcare Provider should contact the Claims Administrator's Customer Service Department at the number listed in the *Introduction* section.

SECTION V

SELECTING A HEALTHCARE PROVIDER

Under the Plan, benefits are only payable for Covered Services received from In-Network Healthcare Providers, except for Emergency and Urgent Care services. Non-Emergency Medically Necessary services from Out-of-Network Healthcare Providers are payable under the Plan only when certain conditions are met and Prior Authorization is obtained.

- 5.1 Provider Directories.** Members may receive a list of In-Network Healthcare Providers online, which also allows individual Members to print their own copy if desired. The Provider Directory is continually updated – for information regarding specific Healthcare Providers, go to www.mayoclinichealthsolutions.com or call the Claims Administrator’s Customer Service Department at the number listed in the *Introduction* section.
- 5.2 Healthcare Provider Status.** Enrolling in this Plan does not guarantee that a particular Healthcare Provider will remain an In-Network Healthcare Provider or that a particular Healthcare Provider will provide Members with Healthcare Services. Members should verify a Healthcare Provider’s status as an In-Network Healthcare Provider each time Healthcare Services are received from the Healthcare Provider.
- 5.3 Choice of Healthcare Provider.** The Member will have free choice of any legally qualified Healthcare Provider, and the Healthcare Provider-patient relationship will be maintained. If the Member chooses to receive services from an Out-of-Network Healthcare Provider, he or she may not receive benefits under the Plan.
- 5.4 Continuity of Care.** Notwithstanding anything in this Plan to the contrary, in the event a Member joins the Plan or a Healthcare Provider ceases to be an In-Network Healthcare Provider, a Member shall have the opportunity to continue receiving treatment from his/her Healthcare Provider even though that Healthcare Provider is not an In-Network Healthcare Provider as provided herein.
- (a) A new Member may continue an active course of treatment for a life threatening disease or condition with a Healthcare Provider who is not an In-Network Healthcare Provider for a transitional period of thirty (30) days from the effective date of the new Member’s coverage under the Plan.
 - (b) In the event a new Member has entered the third trimester of pregnancy, such new Member may continue to receive care from a Healthcare Provider who is not an In-Network Healthcare Provider for a transitional period beginning on the effective date of the new Member’s coverage under the Plan and ending upon the earlier of: (i) the cessation of care related to the delivery of the child, or (ii) six (6) weeks after the delivery.
 - (c) A Member may continue an active course of treatment for a life threatening disease or condition with a Healthcare Provider who was terminated from the provider network for a transitional period of thirty (30) days from the date the Healthcare Provider ceases to be an In-Network Healthcare Provider. In the event the Healthcare Provider was terminated for reasons of medical incompetence or unprofessional conduct, this provision shall not apply.

In order for this continuity of care provision to apply, the Healthcare Provider must agree in writing to accept, as payment in full, reimbursement at the rates established by the Plan, comply with the Plan’s quality assurance and utilization review requirements, and comply with the Plan’s policies and procedures relating to obtaining Prior Authorization. For a Healthcare Provider who was terminated from the provider network, the rates shall be the rates applicable before the termination. For all other Healthcare

Providers, the rates shall not exceed the level of reimbursement applicable to similar services of Healthcare Providers within the provider network. The Plan will not provide coverage for benefits not otherwise covered under this Plan.

SECTION VI

SCHEDULE OF BENEFITS

6.1 Cost Sharing and Benefits.

This *Schedule of Benefits* section details the Covered Services, and related costs to the Member under the Plan. The Member will generally pay a Cost Sharing Amount for Covered Services.

This *Schedule of Benefits* section is limited by the express exclusions and limitations set out in the *Exclusions* section.

Some Covered Services under the Plan are subject to Prior Authorization requirements, as indicated in the *Utilization Management* section. Please refer to the *Utilization Management* section for information regarding Prior Authorization.

1. Level of Benefits.

1. A Member may receive coverage for non-Emergency Medically Necessary services from Out-of-Network Healthcare Providers only when certain conditions are met. Please see the *Utilization Management* section.
2. Covered Services under the Plan not available In-Network will be paid at the In-Network benefit level if Prior Authorization is obtained.
3. Covered Services under the Plan provided by an Out-of-Network Professional Healthcare Provider at an In-Network Institutional Healthcare Provider will be paid at the In-Network level of benefits.
4. Diagnostic tests sent to an Out-of-Network Healthcare Provider by an In-Network Healthcare Provider and anesthesiology services performed by an Out-of-Network Healthcare Provider at an In-Network facility will be paid at the In-Network level of benefits.

2. Maximum Annual Benefits Paid by the Plan for Certain Covered Services. The Plan has established limits on the amount of benefits it will pay for certain Covered Services. These specific services and their applicable limits are identified in this *Schedule of Benefits* section.

3. Annual Out-of-Pocket Maximums.

	In-Network
Annual Out-of-Pocket Maximum	\$2,000 per Member \$4,000 per Family

- The Annual Out-of-Pocket Maximum for Prescription Drugs does not include: Cost Sharing Amounts for non-Formulary Prescription Drugs, charges that are not Covered Services under this Plan (e.g., the difference in price between the Generic Drug and the Brand Name Drug if a Brand Name Drug is dispensed when a Generic Drug is available) and charges for medical expenses other than outpatient Prescription Drugs.

Maximum Annual Benefit	In-Network
Chiropractic Services	20 visits Per
<p><u>Durable Medical Equipment</u></p> <ul style="list-style-type: none"> - Jobst sleeves, stockings and gloves - Contact lenses for keratoconus (fitting and purchase) <p>Prosthetics</p> <ul style="list-style-type: none"> - Medically Necessary Bras for breast prosthesis (incidental to a covered mastectomy) - Breast prosthesis (incidental to a covered mastectomy) - Removable dental splints for the treatment TMJ <p>Orthotics</p> <p>Disposable Supplies</p> <p><u>Skilled Nursing Facility - Skilled Nursing Facility</u></p> <ul style="list-style-type: none"> - 	<p>1 item per affected body part*</p> <p>1 set</p> <p>2 bras</p> <p>2 breast prosthesis</p> <p>1 splint</p> <p>1 pair</p> <p>1 oral splint (interocclusal appliance)</p> <p>90 days</p> <p>* Unless the item has outlived its useful life or must be replaced to accommodate bodily growth.</p>

Maximum Lifetime Benefit	In-Network
<p>Durable Medical Equipment</p> <p>1. Contact Lenses following surgery for aphakia (fitting and purchase)</p> <p>- Respite Care</p>	<p>1 set</p> <p>5 days**</p> <p>* 30-day limit is conditional upon the Member being enrolled in a Plan approved home Hospice program.</p> <p>** 5-day limit during which twelve (12) or more hours of respite services are provided in an In-Network Institutional Healthcare Provider.</p>

1. **Covered Services.** This section describes the Covered Services for which benefits are available under the Plan. This Section is subject to the definitions, exclusions, conditions and limitations of the Plan. This section is also subject to Cost Sharing Amounts and Maximum Annual Benefits of the Plan.

(a) AMBULANCE

Service	In-Network cost to Member
Ambulance	\$0 Copayment

Non-Emergency Ambulance services are covered subject to Prior Authorization. Prior Authorization is required for coverage of certain Covered Services under this Plan. See the *Utilization Management* section for a list of these services. See the *Pre-Service Claims* subsection of the *Claim and Appeal Procedures* section for details on how to obtain Prior Authorization.

Benefits may not be available for some services. See the *Exclusions* section for a list of these services not covered by this Plan.

Covered Services under the Plan include:

1. licensed Ambulance transportation for an Emergency to the nearest Healthcare Provider qualified to provide care
2. air Ambulance charges when it is the only Medically Necessary means of transporting the Member as determined by the Plan
3. Ambulance services for an Emergency even if the Member is not transported

(b) CHIROPRACTIC SERVICES

Service	In-Network cost to Member
Chiropractic Services	\$20 Copayment per Visit

Benefits may not be available for some services. See the *Exclusions* section for a list of these services not covered by this Plan.

Covered Services under the Plan Include:

1. chiropractic treatment (Including nonsurgical and noninvasive treatment of neck and back pain through physical therapy, musculoskeletal manipulation and other physical corrections of musculoskeletal conditions within the scope of the chiropractic practice, such as modalities, diathermy, heat or cold therapy and electrical stimulation for spinal skeletal system and/or surrounding tissue)

For chiropractic services, In-Network shall mean the Blue Cross Blue Shield Arizona Network.

The maximum annual benefit for chiropractic services is 20 visits per Member per Coverage Year.

(c) DENTAL SERVICES

Service	In-Network cost to Member
Dental Services Office Visits	\$20 Copayment per visit if service provided by Primary Care Physician
	\$35 Copayment per visit if service provided by specialist

Prior Authorization is required for coverage of all dental services, TMJ treatment, and oral services. See the *Utilization Management* section for a list of these services. See the *Pre-Service Claims* subsection of the *Claim and Appeal Procedures* section for details on how to obtain Prior Authorization.

This is not a comprehensive dental plan. Covered Services under the Plan include only the following dental services or oral maxillofacial services that relate to a Member’s medical condition:

1. Immediate (within one year of the Injury or within one year of first becoming covered under the Plan, unless there is a medical reason for delay) treatment of acute, accidental, traumatic Injuries to sound, natural teeth (including replacement of avulsed teeth due to traumatic complications) or jaws. Coverage is for an Injury that results from external trauma to face and mouth only, not for cracked or broken teeth which result from biting or chewing.

The following are Covered Services under the Plan only if they are a direct result of the Injury:

1. dental implants
 2. orthodontia
 3. fixed or removable dental prosthetic devices, including crowns, bridges, and dentures
 4. corrections of malocclusions
5. Coverage for oral surgery is limited and includes the following Covered Services under the Plan:
 - a. Oral surgical treatment of the management of cleft lip or cleft palate for Dependents up to age eighteen (18). Dental services which are not required for the treatment of cleft lip or cleft palate are not covered.
 - b. Oral surgery for tumors or cysts of the jawbone or mouth (excluding restorative or orthodontic treatment that may or may not relate to the tumor or cyst).
 - c. Oral surgery for partial or complete bony impaction of teeth, but not repair, restoration, or extraction of erupted teeth or teeth impacted under soft tissue only.
 6. Hospital and general anesthesiology services only for:
 1. Dependents under the age of five (5) years; or
 2. a Member who has a medical condition and requires hospitalization or general anesthesia for dental services; or
 3. Medically Necessary hospitalization for dental care.
 4. Medically Necessary treatment of temporomandibular disorder (TMJ/TMD), including:
 1. Non-surgical treatment:

1. interocclusal appliance (oral splint) therapy; however, payment is covered under the Durable Medical Equipment and is limited to one (1) splint per Coverage Year.

1. Surgical treatment to correct functional problems of the jaw:

The following are not Covered Services under the Plan:

1. removal of teeth (except as specifically listed above as a Covered Service)
2. dental implants (except as specifically listed above as a Covered Service)
1. prosthetic rehabilitation (temporary or permanent crowns, bridges, implants or dentures) (except as specifically listed above as a Covered Service)
2. orthodontic therapy (braces) (except as specifically listed above as a Covered Service)
3. restorative or periodontal dental procedures
4. "trigger point" injections (except as specifically listed above as a Covered Service)
1. physical therapy for mouth and jaw (Including myofunctional and iontophoresis therapy) (except as specifically listed above as a Covered Service)
2. diagnostic use of electromyography and other electrical instrumentation
3. oral maxillofacial surgical intervention, Including occlusal equilibration, Le Forte procedures and orthognathic surgery (except as specifically listed above as a Covered Service)
4. treatment for injury from biting or chewing, Including oral splints
5. replacement of teeth missing prior to the occurrence of an Injury or Illness
6. defective fillings
7. correction of malocclusions (except as specifically listed above as a Covered Service)
8. services provided for cosmetic or dental reasons, Including orthodontic treatment, dental restorations, or fixed or removable prostheses (except as specifically listed above as a Covered Service)
9. routine dental services

(d) DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, DISPOSABLE AND CONSUMABLE SUPPLIES

Service	In-Network cost to Member
Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies	\$0 Copayment
Medical foods	50% Coinsurance
Amino acid-based formula	25% Coinsurance

Prior Authorization is required for coverage of certain Covered Services under the Plan, including Durable Medical Equipment, Orthotics, or Prosthetics over \$750 or any rental to exceed four (4) months, infant apnea monitors, and implantable hearing devices. See the *Utilization Management* section for a list of these services. See the *Pre-Service Claims* subsection of the *Claim and Appeal Procedures* section for details on how to obtain Prior Authorization.

Covered Services under the Plan include the following types of Medically Necessary Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies, but only if prescribed by a Healthcare Provider for use outside of a Hospital or Skilled Nursing Facility.

Durable Medical Equipment:

1. home renal dialysis equipment and supplies
2. equipment necessary to treat respiratory failure
 3. for insulin-treated diabetic Members
4. drawing up devices for the visually impaired
5. injection aids
6. podiatric appliances for prevention of complications associated with diabetes, if coverage is required under Medicare
7. any other device, equipment, or supply for which coverage is required under Medicare after January 1, 1999 (effective six months after the coverage is required under Medicare)
8. inhalation devices
9. apnea monitoring devices for infants
10. oxygen and equipment for a supplemental oxygen delivery system
11. a wheelchair or a hospital-type bed with no features over and above that which best meets the Medical Necessity of the Member
12. Jobst sleeves, stockings and gloves are covered only for post-phlebotic conditions or post-surgical edema, and coverage is limited to one item per affected body part per Coverage Year unless the item has outlived its useful life or must be replaced to accommodate bodily growth
13. bronchial drainage systems that employ a chest percussion vest and vest compressor
14. the fitting and purchase of one (1) set of contact lenses following surgery for aphakia, one (1) per Member lifetime
15. the fitting and purchase of one (1) set of contact lenses for keratoconus per Coverage Year
16. TENS units
17. Holter monitoring devices
18. Implantable hearing devices if Prior Authorized and approved by the Plan

Prosthetics:

19. removable, non-dental Prosthetic devices that are durable and custom made for the Member, but do not require surgical connection to nerves, muscles or other tissue
20. trusses or orthopedic appliances that are durable and custom made for the Member
21. incidental to a covered mastectomy, up to two (2) Medically Necessary bras for breast prosthesis and up to two (2) breast prosthesis per Coverage Year.
1. a semi-rigid penile prosthesis or external pump is covered for the correction of sexual dysfunction resulting from organic (i.e., not psychogenic) factors. When considered a Covered Service, coverage is limited to the least expensive option.

Orthotics:

2. Orthotics that are durable and custom-made for the Member, are limited to one (1) pair per Coverage Year
3. Orthopedic footwear and orthopedic shoes associated with diabetes

Disposable Supplies:

4. dressings
5. silicone sheeting for treatment of recurring Keloid scars
6. splints (limited per one (1) splint per Coverage Year)
7. oral splint for obstructive sleep apnea
8. braces
9. ostomy and colostomy supplies
10. slings

Consumable Supplies

Enteral Tube Feedings

The Plan covers tube feeding when the Member has a permanent* impairment involving the gastrointestinal tract that prevents adequate oral nutritional intake to maintain weight and strength.

*NOTE: If the judgment of the attending Physician, substantiated in the medical record, is that the impairment can reasonably be expected to exceed three (3) months (ninety (90) days), the test of permanence is considered met.

If the claim involves a pump, it must be supported by sufficient medical documentation, i.e., gravity feeding is not satisfactory due to aspiration, diarrhea, and dumping syndrome.

Infant Formula

Standard infant formulas are covered if administered via the tube-feeding route and the criteria for coverage of tube feedings are met.

Calorically dense formulas are also covered for tube feedings if they are indicated.

To be eligible for coverage for medical foods, ALL of the following criteria must be met:

1. the Member must be diagnosed with one of the inherited metabolic disorders as defined above;
2. the inherited metabolic disorder must involve amino acid, carbohydrate or fat metabolism and have medically standard methods of diagnosis, treatment and monitoring, including qualification of metabolites in blood, urine, or spinal fluid, or enzyme or DNA confirmation in tissues;
3. the Member must require specially processed or treated medical foods generally available only under the supervision of an In-Network Physician;
4. the medical foods must be prescribed or ordered under the supervision of an In-Network Physician for the therapeutic treatment of one of the inherited metabolic disorders identified above; and
5. the prescribed/ordered specially processed or treated medical foods must be consumed throughout life, without which, the Member may suffer serious mental or physical impairment.

It may be necessary for the Plan to obtain medical record documentation to determine the above criteria are met.

For this section only the following terms are defined as:

“Medical foods” - modified low protein foods and metabolic formulas. Each of these terms are defined as follows:

“Modified low protein foods” - foods that are ALL of the following:

- formulated to be consumed or administered through the gastrointestinal tract under the supervision of a Physician;
- processed or formulated to contain less than one (1) gram of protein per unit of serving;
- administered for the medical and nutritional management of a Member with limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and
- essential to the Member’s optimal growth, health and metabolic homeostasis.

“Metabolic formula” - foods that are ALL of the following:

- formulated to be consumed or administered through the gastrointestinal tract under the supervision of an In-Network Physician;
- processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs;
- administered for the medical and nutritional management of a Member with limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and
- essential to the Member’s optimal growth, health and metabolic homeostasis.

To receive coverage the Member must purchase medical foods (as defined above) from an In-Network Healthcare Provider.

Rental of Durable Medical Equipment will be the general practice. However, if there is evidence the Durable Medical Equipment will be required long enough to justify purchase, reimbursement will be limited to the purchase price. The Plan reserves the right to determine if an item will be approved for rental versus purchase.

Replacement or repair of Durable Medical Equipment, Prosthetics or Orthotics is covered due to normal wear and tear, if they have outlived their useful life, or to accommodate bodily growth.

The following are not Covered Services under the Plan:

1. adult apnea monitors
 1. charges incurred for the rental or purchase of any type of air conditioner, humidifiers, dehumidifiers, air purifier, therapeutic mattress or any such similar device or appliance

2. ordinary over-the-counter items such as cotton balls/swabs, alcohol wipes, bandages and ace wraps
3. batteries
4. breast pumps

(e) EMERGENCY SERVICES AND URGENT CARE SERVICES

Service	In-Network cost to Member	Out-of-Network cost to Member
Emergency Room (Physician services and facility charges)	\$150 Copayment (Waived if Admitted)	\$150 Copayment (Waived if Admitted)
Inpatient Emergency Hospital and Physician Services	\$150 Copayment	\$150 Copayment
MRI/CT/PET Scans	\$100 Copayment	\$100 Copayment
Urgent Care Services	\$50 Copayment	\$50 Copayment

In the case of an Emergency, the Member should go to the nearest Emergency care Healthcare Provider.

Emergency and Urgent Care Covered Services under the Plan include:

1. Institutional Healthcare Provider charges
2. Professional Healthcare Provider charges
1. MRI, CT and PET scans
2. other diagnostic tests (excluding MRI, CT and PET scans)

Notification of Emergency hospitalization is required within 48 hours or as soon as reasonably possible. The responsibility for notification belongs to the Healthcare Provider when care is received In-Network. When care is received Out-of-Network, notification is the responsibility of the Member and is accomplished by contacting the Claims Administrator's Customer Service Department at the number listed in the *Introduction* section.

If the Member is admitted directly to inpatient status from the Emergency room, the Copayment for the Emergency room services will be waived, and the Hospital inpatient Copayment applies. Follow-up services in the Emergency room are not Covered Services unless Medically Necessary.

Coverage is provided at In-Network Healthcare Providers, without Prior Authorization or utilization review, for the following Covered Services:

3. an initial medical screening examination upon the Member's presentation to an Emergency In-Network Healthcare Provider and
4. any immediately necessary stabilization treatment

If the Member is in an Out-of-Network Hospital, the Member must cooperate in being transferred to an In-Network Hospital upon the request of an In-Network Physician or the Plan as soon as medically appropriate. Such determination will include consideration of the opinion of the Member's Out-of-Network attending Physician.

(f) HOME HEALTH CARE

Service	In-Network cost to Member
Home Health Care	\$0 Copayment

Prior Authorization is required for coverage of home health care. See the *Utilization Management* section for a list of these services. See the *Pre-Service Claims* subsection of the *Claim and Appeal Procedures* section for details on how to obtain Prior Authorization.

All services, except therapy as described in (o) of this section, that are provided in the member's home are considered home health care. Only certain services as described in this section are covered under the Home Health Care benefit.

Covered Services under the Plan Include the following Part-Time Care or Intermittent Care and therapeutic services, for conditions that would otherwise require Confinement in a Hospital or Skilled Nursing Facility, when rendered in the Member's home:

1. Skilled Care by a Registered Nurse or Licensed Practical Nurse
2. Home Health Care aide services
3. Laboratory services
4. Physical, occupational, and speech therapy are covered under (o) of this section and are subject to limits on therapy services
5. Inhalation therapy
6. Home intravenous (IV) antibiotic therapy; parenteral and enteral nutrition, chemotherapy and anticoagulant therapy
7. Necessary training for the primary caregiver(s) in the home

Home Health Care is covered only when rendered as rehabilitative, and not as maintenance, Custodial Care, or Respite Care. Home Health Care is not provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home.

The Plan will not provide benefits for services listed above, performed by a person who ordinarily resides in the Member's household or is related (by blood or law) to the Member. Benefits also are not available for the above services provided at a school or any site other than the Member's home

For purposes of Home Health Care under the Plan, a service shall not be considered Skilled Care merely because it is performed by, or under the direct supervision of, a licensed nurse. Where a service such as tracheotomy suctioning or ventilator monitoring, or like services, can be safely and effectively performed by a non-medical person or self-administered, without the direct supervision of a licensed nurse, the service shall not be regarded as Skilled Care, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a skilled nurse provides it. Only the Skilled Care component of so-called "blended" services (i.e., services which include skilled and non-skilled components) are covered under the Plan.

The following are not Covered Services under the Plan:

1. nursing services to administer home infusion therapy the Member or another caregiver can be successfully trained to administer
2. home infusion services that do not involve direct Member contact, such as delivery charges and record-keeping

(g) HOSPICE CARE

Service	In-Network cost to Member
Hospice Care	\$0 Copayment

Prior Authorization is required for coverage of hospice and respite care. See the *Utilization Management* section for a list of these services. See the *Pre-Service Claims* subsection of the *Claim and Appeal Procedures* section for details on how to obtain Prior Authorization.

Covered Services under the Plan are described below for Members who are terminally ill and accepted as Hospice program participants. Members must meet the eligibility requirements of the program, and elect to receive services through the Hospice program. Services will be provided in the Member's home, with inpatient care available when Medically Necessary. Members who elect to receive Hospice services do so in lieu of curative treatment for their terminal illness for the period they are enrolled in the Hospice program.

Covered Services under the Plan Include:

1. Part-Time Care provided in the Member's home by an interdisciplinary Hospice team, which may include a Physician, Registered Nurse, Social Worker, home health aide, and spiritual counselor.
2. Continued Care in the Member's home or in a setting which provides day care for pain or symptom management. The period or periods of Continued Care and respite Care combined are limited to thirty (30) days per Member lifetime and conditional upon the Member being enrolled in a Plan approved home Hospice program
3. Inpatient care when Medically Necessary
4. Limited Respite Care. Benefits for Respite Care are limited to five (5) days during which twelve or more hours of respite services are provided.

The following are not Covered Services under the Plan:

1. financial or legal counseling services
2. housekeeping or meal services in the Member's home
3. maintenance or Custodial Care related to Hospice services, whether provided in the home or in a nursing home
4. any services provided by a person who ordinarily resides in the Member's household or is related (by blood, marriage or applicable law) to the Member

(h) INFERTILITY SERVICES

Service	In-Network cost to Member
Infertility Services	\$20 Copayment per visit if service provided by Primary Care Physician \$35 Copayment per visit if services provided by specialist

Prior Authorization is required for coverage of infertility services. See the *Utilization Management* section for a list of these services. See the *Pre-Service Claims* subsection of the *Claim and Appeal Procedures* section for details on how to obtain Prior Authorization.

Infertility Covered Services under the Plan Include:

1. an infertility diagnostic evaluation and diagnostic services limited to consultation by an In-Network Physician, laboratory tests, and certain procedures limited to sperm count, hysterosalpingography, and endometrial biopsy.

The following are not Covered Services under the Plan:

1. services related to the treatment of infertility
2. charges related to or in connection with the reversal of a sterilization procedure
3. charges for donor ova or sperm, and sperm storage charges
4. charges for assisted reproduction including but not limited to:
 1. in vitro and in vivo fertilization
 2. gamete intrafallopian transfer (GIFT)
 3. zygote intrafallopian transfer (ZIFT)
 4. intracytoplasmic sperm injection (ICSI),
 5. use of donor egg, and experimental procedures
6. charges related to or in connection with adoption
7. charges incurred by or for a non-Member surrogate's pregnancy (other than in the case of an adoption where all the requirements of A.R.S. § 20-1057.K. and L. are met); and any related charges incurred for these excluded procedures.
8. Therapeutic infertility services
9. Diagnostic services related to infertility treatment once treatment for infertility has been initiated

(i) INPATIENT AND OUTPATIENT HOSPITAL AND PHYSICIAN SERVICES

Service	In-Network cost to Member
Physician Visit and Related Services (except Preventive Care)	\$20 Copayment per visit – Primary Care Physician \$35 Copayment per visit - Specialist
Inpatient Hospital Services (Non-Emergency)	\$300 Copayment
Outpatient Hospital, Ambulatory Care or Surgical Facility Services	\$150 Copayment if operating room facility is required or \$0 Copayment if no operating room
Allergy Shots or other treatment injections with no associated office visit	\$0 Copayment

Prior Authorization is required for coverage of certain Covered Services under the Plan, Including apnea testing, non-emergency hospital admissions, and certain elective surgeries such as breast surgery, cosmetic or reconstructive procedures, oral surgery, maxillofacial surgery or uvulopalatopharyngoplasty, varicose vein treatment, and weight reduction surgery. See the *Utilization Management* section for a list of these services. See the *Pre-Service Claims* subsection of the *Claim and Appeal Procedures* section for details on how to obtain Prior Authorization.

Physician And Related Services (Except Preventive Care)

Covered Services under the Plan Include the following when provided, requested, or directed by In-Network Healthcare Providers:

1. diagnosis, surgery and office treatment
2. professional administration of medications
3. diagnostic tests
4. initial examination and tests required to diagnose infertility
5. medication management
6. Disposable Supplies
7. services of In-Network Professional Healthcare Providers at an Institutional Healthcare Provider Including surgery, anesthesiology, radiology, pathology, and consultation with and treatment by consulting Professional Healthcare Providers

Inpatient Hospital Services (Non-Emergency)

Covered Services for inpatient Hospital services Include room, board, and general nursing service in semi-private accommodations. Charges for private room are covered only when Medically Necessary. Covered Services under the Plan also include Hospital ancillary services Including: operating room and related facilities; intensive care; cardiac care (Including Phase I cardiac rehabilitation while the Member is an inpatient); diagnostic imaging; laboratory and other diagnostic tests; physical therapy; inhalation therapy; speech therapy; chemotherapy; occupational therapy; anesthesia; oxygen; inpatient medications; Prescription Drugs dispensed at the time of dismissal for outpatient use (unless the Hospital uses an In-Network pharmacy, then such Prescription Drugs are subject to the *Outpatient Prescription Drugs* subsection of this *Schedule of Benefits* section); biological and Disposable Supplies for in-Hospital use; in-Hospital use of medical equipment; renal dialysis; electro-convulsive therapy; and patient education.

The following are not Covered Services under the Plan:

1. extended Hospital stays for reasons other than Medical Necessity

2. a continued Hospital stay if the attending Physician has documented that care could be provided in a less acute care setting
3. any admission for diagnostic tests that can be performed on an outpatient basis
4. All Physician services provided in the home are described under the Home Health section of this *Schedule of Benefits*

Emergency inpatient services, inpatient maternity services, transplant services, and dental services are described elsewhere in this *Schedule of Benefits* section.

Outpatient Hospital, Ambulatory Care or Surgical Facility Services

Covered Services under the Plan for outpatient Hospital, ambulatory care or surgical facility services Include: inhalation therapy, radiation therapy, chemotherapy, use of special medical equipment, renal dialysis, and pathology.

If a Member is admitted directly to inpatient status from outpatient surgery at an In-Network Institutional Healthcare Provider, the outpatient surgery Copayment will be waived and the Hospital Inpatient Copayment applies.

The Following Are Covered Services under the Plan, Whether Performed In or Out of the Hospital:

1. charges for mastectomy-related services Including all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of mastectomy (Including lymphedemas)
2. elective sterilization
3. charges for the processing and administration of blood or blood components
4. blood transfusion services, Including the cost of blood, blood plasma and other blood products not donated or replaced by a blood bank or otherwise
5. charges for oxygen and other gases and their administration
6. charges for the cost and administration of local or general anesthetic in conjunction with a covered surgical or medical procedure
7. charges for dialysis as an inpatient or at an outpatient dialysis center
8. inhalation therapy
9. radiation therapy and chemotherapy
10. charges in relation to corneal grafts, and, for aphakic patients, sclera shells intended for use as corneal bandages
11. charges for blepharoplasty and other procedures to correct Lid Ptosis unless taped visual field testing demonstrates at least a twenty degree improvement in vision compared to untapped visual field testing
12. charges for apnea testing if Prior Authorized
13. charges for surgical correction of sleep apnea if the Member has failed the use of CPAP or BiPAP therapy
14. charges for fitting and purchase of one (1) set of contact lenses following surgery for aphakia, one (1) per Member lifetime
15. charges for fitting and purchase of one (1) set of contact lenses for keratoconus per Coverage Year
16. charges for treatment for the following foot conditions:
17. Metatarsalgia or bunions when an open cutting operation is performed

18. Corns and calluses or toenails when at least part of the nail root is removed or due to peripheralvascular disease
19. Reconstructive surgery (other than reconstructive breast surgery, mastectomy and other breast procedures) is limited to surgery to improve or repair a body part only if it impairs function *and* (1) is the result of, or incidental to, an initial surgery/Injury/Illness on that body part or (2) if that initial surgery/Injury/Illness was for the diagnosis or treatment of an Injury or disease which would have qualified for Covered Services under this Plan had the Member been enrolled at the time of the initial surgery/Injury/Illness.
20. Reconstructive surgery for the treatment of a medically diagnosed congenital disease or anomaly which requires Medically Necessary treatment (other than an oral or dental defect).
21. Reconstructive surgery for the treatment of a congenital disease or anomaly that does not impose a functional impairment, but results in the absence of a body part is a Covered Service. A functional defect is one that interferes with a Member's ability to perform activities of daily living, as determined by the Plan. Examples Include coverage for cleft lip, nasal deformities, breast reconstruction for Poland's Syndrome (congenital absence of the breast), and microtia repair (congenital absence of the ear).
22. Surgical correction of scars causing a functional deformity is covered. Examples Include ectropion, joint contracture, and reconstruction of severe burn scars of the face and hands. Treatment of keloid scars is covered. The Plan does not cover otoplasty (correction for prominent ears), removal of non-malignant birth marks (port wine stains, café-au-lait) or other non-malignant skin lesions (except when on the face, neck, or upper extremities of children), scar revisions, bifid ear lobes from pierced ears, or treatment of acne scarring.
23. Breast reconstructive surgery is limited to the following: 1) for Poland's Syndrome (congenital absence of the breast and chest wall muscle), (2) in conjunction with surgical correction of the chest deformity, or (3) in repair of breast asymmetry due to a mastectomy.
24. Coverage for reduction mammoplasty surgery (breast reduction) is limited. Breast reduction surgery is not covered to correct macromastia unless both signs and symptoms of macromastia are present. Conditions that may contribute to symptomatic macromastia should be corrected prior to surgery, including a body mass index in excess of thirty-five (35).

Additional criteria:

1. Proposed surgery must remove a minimum of 500 gms of actual breast tissue per breast (does not include tumescent fluid).
2. Those Members proposed for breast reduction surgery age forty (40) and over must have had a negative mammogram within six (6) months of the surgical procedure
3. A Member receiving coverage for a mastectomy who elects breast reconstruction after the mastectomy, will receive coverage for:
 1. Reconstruction of the breast on which the mastectomy has been performed;
 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 3. Breast prostheses; and,
 4. Treatment of physical complications of all stages of the mastectomy, including lymphedemas.

Coverage will be provided in consultation with the attending Physician and the Member, and will be subject to the same Cost-Sharing Amounts requirements that apply for the mastectomy.

5. Medical treatment or surgery, for excess weight or obesity that results in the dysfunction of a body organ and causes life threatening health problems as defined below which cannot be treated effectively by another modality.

6. An initial consultation to determine a medical care program for weight reduction.
7. In order to be considered for weight reduction surgery, a Member must be twenty-one (21) years old, have a Body Mass Index (BMI) of at least thirty-five (35), and have stabilized their weight within ten (10) pounds during the six (6) months prior to the procedure. In addition, the Member must have at least one of the following:
 1. Diabetes mellitus type one or two
 2. Documented uncontrolled hypertension with medication
 3. Documented uncontrolled hyperlipidemia with medication
 4. Steatohepatitis
 5. Documented coronary heart disease
 6. Sleep apnea

OR

The Member must be twenty-one (21) years old, have a Body Mass Index (BMI) of at least forty (40), and have stabilized their weight within ten (10) pounds during the twelve (12) months prior to the procedure. In addition, the Member must be at high risk for obesity-associated morbidity and mortality.

7. Resection of redundant tissue of skin (abdomen and thighs) following massive weight loss is considered reconstructive when performed to relieve specific clinical signs and symptoms. These services are covered when ALL of the following criteria are met:
 1. Member has a minimum Body Mass Index (BMI) of twenty-seven (27) after massive weight loss (BMI greater than [40]) and has maintained a steady weight for one (1) year, AND
 2. Documentation by the Member's surgeon demonstrating the following signs or symptoms listed for each procedure:

Abdominal Panniculectomy:

Severe skin ulcers, stage III -IV
 Symptoms and signs present of a minimum of one year
 Documentation of failure to respond to conservative therapy
 (Belt lipectomy or total body lift is non-covered)

Mastopexy

Non-covered (see Section VII)

Braichioplasty

Non-covered (see Section VII)

Medial thigh lift (lateral thigh lift is non-covered)

Severe skin ulceration, stage III-IV
 Symptoms and signs present for one (1) year
 Documentation of failure to respond to conservative therapy

AND

1. Documentation and photographs must be provided to substantiate the resection of skin and fat redundancy following massive weight loss.

2. Documentation provided by the surgeon from the history or physical exam confirms the probability of significant relief of the clinical signs and symptoms. Photographs to document pre-operative conditions.
1. charges for the treatment of autism to the extent required by applicable law within the State of Arizona

Genetic Testing.

The Plan covers genetic testing to establish a molecular diagnosis of an inheritable disease when all of the following are met:

1. The Member displays clinical features, or is at direct risk of inheriting the mutation in question (presymptomatic)*; AND
2. The result of the test will directly impact the treatment being delivered to the Member; AND
3. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain, and one of the following diagnoses is suspected (this list is not all-inclusive):*

Fragile X Syndrome, Huntington's Disease, Cystic Fibrosis, Friedreich's ataxia, Familial Adenomatous Polyposis Coli, Spinal Muscular Atrophy, Duchenne Muscular Dystrophy, Myotonic Dystrophy, Prader-Willi Syndrome, Angelman Syndrome, Neurofibromatosis Type 1, Canavan disease, Hemochromatosis, Hemoglobin S and/or C **, Kennedy disease (SBMA), Charcot-Marie-Tooth, Medullary Thyroid Carcinoma, Classical Lissencephaly, Dentatorubral-pallidoluysian atrophy, Gaucher Disease, Neimann-Pick disease, Tay-Sachs, Von Hippel-Lindau syndrome, Retinoblastoma, Hemoglobin E thalassemia, Beta thalassemia**, Alpha thalassemia,** Albinism, Factor V Leiden mutation, Prothrombin 20210A mutation, Hereditary Neuropathy with Liability to Pressure Palsies (HNPP)

*When genetic tests are used to screen patients without signs or symptoms of disease, genetic tests are considered high-risk screening tests and are covered only for Members with preventive services benefits. By contrast, when genetic tests are used to diagnose patients displaying signs or symptoms of disease, they are considered diagnostic tests and are covered.

** Electrophoresis is the appropriate initial laboratory test for individuals judged to be at-risk for a hemoglobin disorder.

In the absence of specific information regarding advances in the knowledge of mutation characteristics for a particular disorder, the current literature indicates that genetic tests for inherited disease need only be conducted once per lifetime of the Member.

Note: Genetic testing Members is excluded from coverage if the testing performed is primarily for the medical management of other family members who are not covered under the Plan. In these circumstances, the insurance carrier for the family members who are not covered under this Plan should be contacted regarding coverage of genetic testing. Occasionally, genetic testing of tissue samples from other family members who are not covered may be required to provide the medical information necessary for the proper medical care of a Plan Member. The Plan covers genetic testing for heritable disorders in non-Members when ALL of the following conditions are met:

1. The information is needed to adequately assess risk in the Member; and
2. The information will be used in the immediate care plan of the Member; and
3. The non-Member's benefit plan, if any, will not cover the test (a copy of the denial letter* from the non-Member's benefit plan must be provided). *The Plan may also request a copy of the certificate of coverage from the non-Member's health insurance plan if:
4. the denial letter from the non-Member's insurance carrier fails to specify the basis for noncoverage or

5. the denial is based on a specific plan exclusion; or
6. the genetic test is denied by the non-Member's insurance carrier as not Medically Necessary and the medical information provided to the Plan does not make clear why testing would not be of significant medical benefit to the non-Member.

Cancer Clinical Trials

The "patient costs" directly associated with a Cancer Clinical Trial that is offered within the State of Arizona and in which the Member voluntarily participates are Covered Services under the Plan, whether performed in or out of the hospital. Benefits will be provided only at the same level as would have paid if the Covered Services received during the Cancer Clinical Trial were provided by an In-Network Healthcare Provider. Covered Services include only "patient costs" that are otherwise considered Covered Services and shall not include any portion of the Cancer Clinical Trial, the cost of which is customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources. "Patient cost" means any fee or expense that is a Covered Service and that is for a service or treatment that would be required if the Member were receiving usual and customary care.

"Patient cost" does not include:

7. the cost of any drug or device provided in a phase I Cancer Clinical Trial;
8. the cost of any Investigative drug or device;
9. the cost of non-health related services that might be required for a person to receive treatment or intervention;
10. the cost of managing the research of the clinical trial;
11. the cost of services or supplies that are not Covered Services; and
12. the cost of treatment or services provided outside the State of Arizona.

Botulinum Toxin

Botulinum toxin type A (Botox®) is covered and Prior Authorization is not required for treatment of Members with any of the following conditions:

1. Strabismus, Including neuromyelitis optic and Schilder's disease. Strabismus repair is not covered in adult patients with uncorrected congenital strabismus and no binocular fusion, as this is considered cosmetic.
2. Blepharoplasty and brow lift surgery
3. Hemifacial spasm/post-facial nerve palsy synkinesis
4. Laryngeal spasm
5. Focal dystonias, Including cervical dystonia (spasmodic torticollis), lingual dystonia, laryngeal dystonia, jaw-closing oromandibular dystonia, hand dystonia (organic writers cramp), symptomatic torsion dystonia
6. Limb spasticity, Including spastic paraplegia, limb spasticity due to multiple sclerosis, spastic hemiplegia, and infantile cerebral palsy
7. Esophageal achalasia, for patients who have at least one of the following:
 1. Have failed conventional therapy;
 1. Are at high risk of complications of pneumatic dilation or surgical myotomy;
 2. Have failed a prior myotomy or dilatation;
 3. Have had a previous dilation-induced perforation; OR
 4. Have a epiphrenic diverticulum or hiatal hernia, both of which increase the risk of dilation-induced perforation.
5. Chronic anal fissure unresponsive to conservative therapeutic measures
6. Focal hyperhidrosis, when all of the following criteria are met:

1. Topical aluminum chloride or other extra-strength antiperspirants are ineffective or result in a severe rash; AND
2. Member is unresponsive or unable to tolerate pharmacotherapy prescribed for excessive sweating; AND
3. Significant disruption of professional and/or social life has occurred because of excessive sweating.
4. Ptyalism (excessive secretion of saliva) that is refractory to pharmacotherapy
5. Facial myokymia and trismus associated with postradiation myokymia
6. Non-relaxing pubococygeal syndrome (inability to defecate) unresponsive to biofeedback

Botulinum toxin type B (Myobloc®) is covered and Prior Authorization is not required for symptomatic treatment of Members with cervical dystonia (spasmodic torticollis).

Prior Authorization is required for coverage of botulinum toxin (type A or B) for any condition not listed above.

Limitations:

7. Treatment for reconstructive or cosmetic surgery to restore bodily function or correct deformity resulting from Illness or Injury must be performed within a reasonable period of time, but no later than three (3) years after the Injury or Illness or within three (3) years of becoming covered under the Plan, whichever is later, unless there is a medical reason for delay of repair.

(j) MATERNITY

Service	In-Network cost to Member
Prenatal Care Services	\$0 Copayment (Except for initial office visit when pregnancy is determined – then \$20 Copayment)
Maternity	\$300 Copayment per admission (inpatient hospitalization)

Maternity Covered Services under the Plan Include:

1. routine prenatal and postnatal visits
1. inpatient maternity services Including delivery
2. services provided in connection with the birth of a child who is legally adopted by a Member if all of the following are true:
 1. the Dependent was adopted within one year of his/her birth
 2. the Member is legally obligated to pay the costs of the adopted Dependent's birth
 3. the Member has notified the Employer of the Member's acceptability to adopt children under Arizona law within sixty (60) days of the later of: (i) receipt of approval from the State, or (ii) becoming covered under the Plan

See the *Coordination of Benefits* section for additional information regarding the coordination of coverage of services provided in connection with the birth of a child who is legally adopted by a Member.

Federal law requires the following notice be included in the SBD, verbatim:

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or midwife, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on pre-certification, contact your Employer.

Notification for inpatient Hospital maternity services that exceed the minimum coverage stated above is required within 48 hours. The responsibility for notification belongs to the Healthcare Provider when care is received In-Network. Except in the case of an Emergency, inpatient maternity services are only covered if provided in an In-Network Hospital and authorized or arranged by the Member's Primary Care Physician or Plan obstetrician before or during Confinement. When care is received Out-of-Network, notification is the responsibility of the Member and is accomplished by contacting the Claims Administrator's Customer Service Department at the number listed in the *Introduction* section .

(k) MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

Service	In-Network cost to Member
Mental Health – Outpatient	\$20 Copayment
Mental Health – Inpatient	\$300 Copayment
Chemical Dependency – Outpatient	\$20 Copayment
Chemical Dependency - Inpatient	\$300 Copayment

Prior Authorization is required for coverage of certain Covered Services under the Plan. See the *Utilization Management* section for a list of these services. See the *Pre-Service Claims* subsection of the *Claim and Appeal Procedures* section for details on how to obtain Prior Authorization.

Covered Services under the Plan Include:

1. **Outpatient Treatment Coverage:** individual or group visits to a mental health or chemical dependency Healthcare Provider's office.
2. **Non-residential Structured Treatment Coverage:** day or evening treatment programs that provide a planned therapeutic program for Members who do not require hospitalization, but who need broader programs that are not possible from single outpatient visits.
3. **Residential Structured Treatment Coverage:** a licensed sub-acute program in a facility or distinct part of a facility for children and adult psychiatric and chemical dependency care that provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
4. **Inpatient Treatment Coverage:** Acute inpatient treatment services for mental health and chemical dependency provide psychiatric diagnosis and treatment of mental illness requiring medical management and Skilled Care.
5. All services and treatment for attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD), including the initial evaluation, must be done by the Member's Primary Care Physician or mental health provider.

Inpatient services covered under this Section include semi-private care in an In-Network Institutional Healthcare Provider. Any cost difference between a semi-private and a private room is covered by the Plan only if a private room is Medically Necessary.

The following are not Covered Services under the Plan:

1. anonymous support groups.
2. developmental and neuroeducational testing or treatment
3. halfway houses
4. wilderness programs
5. group homes
6. summer camps
7. mental health and chemical dependency Educational programs and social skills training
8. therapy for learning disability, communication delay, perceptual disorders or sensory deficit
1. biofeedback
2. family counseling, unless Medically Necessary or the family counseling is part of Medically Necessary treatment for a minor child Member that has been recommended by a Healthcare Provider treating the minor child
3. Certain Mental Health Services and Supplies. Mental health services, supplies, and Prescription Drugs are not covered for a mental illness not listed in the Diagnostic and Statistical Manual IV of the American Psychiatric Association.

(I) OUTPATIENT DIAGNOSTIC TESTS

Service	In-Network cost to Member
MRI, CT & PET Scans	\$100 Copayment
Other Diagnostic X-ray	\$0 Copayment

Prior Authorization is required for coverage of certain Covered Services under the Plan. See the *Utilization Management* section for a list of these services. See the *Pre-Service Claims* subsection of the *Claim and Appeal Procedures* section for details on how to obtain Prior Authorization.

Covered Services under the Plan Include the following tests provided, requested, or directed by Physicians or other Healthcare Providers in their offices, clinics, mobile units, at Urgent Care facilities or Hospital outpatient settings (Including an emergency room):

1. diagnostic lab services
2. diagnostic imaging (MRIs, CT & PET scans, and x-rays)

Outpatient diagnostic tests performed in conjunction with a routine periodic preventive exam, an office visit, Emergency room visit or Urgent Care visit are covered in the other subsections of this *Schedule of Benefits* section.

The following are not Covered Services under the Plan:

3. admissions for the purpose of performing diagnostic tests that can be performed on an outpatient basis
4. dental x-rays

(m) OUTPATIENT PRESCRIPTION DRUGS

Service	In-Network cost to Member
<u>Prescription Drugs, insulin and diabetic supplies*</u>	
Retail pharmacy (up to 34 day supply)**	
Preferred Generic	\$10 Copayment per prescription or refill
Generic Drugs	\$20 Copayment per prescription or refill
Brand Name Drugs (no generic equivalent)	\$50 Copayment per prescription or refill
Non-Formulary Prescription Drugs	\$75 Copayment per prescription or refill
Specialty Drugs	\$100 Copayment per prescription or refill
<u>Prescription Drugs, insulin and diabetic supplies*</u>	
Optum Mail Pharmacy (up to 102 day supply)	
Preferred Generic	\$30 Copayment
Generic Drugs	\$60 Copayment
Brand Name Drugs (no generic equivalent)	\$150 Copayment
Non-Formulary Prescription Drugs Brand Name	\$225 Copayment
Specialty Drugs	\$300 Copayment

*If diabetic supplies are filled on the same day as an insulin prescription, there is no Copayment for the diabetic supplies. With no insulin fill, the applicable Copayment is charged.

**Up to a 34-day supply for one Copayment; up to a 68-day supply for two Copayments; up to a 102-day supply for three Copayments.

The Membership Card also functions as a Prescription Drug card. The Membership Card and associated benefits will only be recognized at In-Network pharmacies.

When a Member has a prescription from a Healthcare Provider for a Prescription Drug, the Member should take the prescription to an In-Network pharmacy and present the prescription and his/her Membership Card to the pharmacy. Generally, the In-Network pharmacy will fill the prescription and collect a Cost Sharing Amount from the Claimant. Prescription Drugs dispensed by Out-of-Network pharmacies are not covered, except in an Emergency. In-Network benefits will apply in an Emergency situation. If a Claimant needs a Prescription Drug in an Emergency and an In-Network pharmacy is not available, the Claimant should take the prescription to an Out-of-Network pharmacy and pay the amount requested by the Out-of-Network pharmacy. In addition to Cost Sharing Amounts, the Member will also be responsible for any charges above the In-Network rate when receiving Prescription Drugs Out-of-Network in an Emergency. *This is not considered a claim for benefits under the Plan.* See the *Claim and Appeal Procedures* section for information regarding how to file a Prescription Drug claim under the Plan.

The *Coordination of Benefits* section does not apply to Prescription Drugs.

Prescription Drugs are covered according to Formulary. Prescription Drugs listed in the Formulary will be covered at a higher level of benefits as shown above. A Member may obtain a covered non-Formulary Prescription Drug and pay a higher cost sharing amount. A Member may call the Claims Administrator's Customer Service Department at the number listed in the *Introduction* section with questions regarding a particular Prescription Drug, or may request a Prescription Drugs Formulary which is available at no charge. Formulary Generic Drugs, when available, will be dispensed in place of the more costly Formulary Brand Name Drug by an In-Network pharmacy. *If a Brand Name Drug is dispensed when a Generic Drug is available, the Member pays the Generic Drug Copayment plus the difference in price between the Generic Drug and Brand Name Drug.*

Prescription Drugs covered by the Plan Include:

1. FDA approved contraceptive drugs and devices, Including oral, and injectable contraceptive drugs, and prescription barrier methods
2. a Prescription Drug prescribed for the treatment of cancer that has not been approved by the FDA for the treatment of the specific type of cancer for which the Prescription Drug has been prescribed, provided: (1) the Prescription Drug has been recognized as safe and effective for treatment of that specific type of cancer in one or more of the Standard Medical Reference Compendia, (2) the United States Food and Drug Administration has not determined that the Prescription Drug is contraindicated for that type of cancer, , and (3) if the Prescription Drug has been recognized as safe and effective in a Standard Medical Reference Compendia other than one of the specifically named publications listed in *Definitions* section, at least two articles from major peer reviewed professional medical journals have recognized, based on scientific or medical criteria, the Prescription Drug's safety and effectiveness for treatment of the indication for which the Prescription Drug has been prescribed; and (ii) no article from a major peer reviewed professional medical journal has concluded, based on scientific or medical criteria, that the Prescription Drug is unsafe or ineffective or that the Prescription Drug's safety and effectiveness cannot be determined for the treatment of the indication for which the Prescription Drug has been prescribed
3. prescribed oral agents for controlling blood sugar that are included in the Formulary to the extent coverage is required under Medicare
4. any other diabetes medication for which coverage is required under Medicare (Coverage for such medications shall be effective six months after the coverage is required under Medicare)
5. human growth hormone may be approved only for the treatment of short stature in growth hormone deficient children. The Member must to obtain Prior Authorization through the Plan non-Formulary exception process

Prior Authorization under the Plan is required for the following Prescription Drugs:

1. acne medications for Members over age twenty-five (25)
2. Antimicrobials (e.g., Cayston, Difucid, Monurol, Zyvox)
3. Anti-obesity drugs (e.g., Xenical, Phentermine)
4. Antispasmodics (e.g., Oxytrol, Sanctura XR, Vesicare)
5. biological anti-psoriatic/anti-rheumatic medications (e.g., Cimzia®, Enbrel®, Humira®, Kineret®)
6. Cardiovascular medications (e.g., Advicor, Effient)
7. certain cardiac medications (e.g., Adcirca®, Crestor®)
8. COX-2 inhibitors (e.g., Celebrex®)
9. erectile dysfunction medications prescribed for Pulmonary Artery Hypertension or post-surgical rehabilitation
10. growth hormones (e.g., Genotropin®, Humatrope®)
11. linezolid (Zyvox®)
12. memantine (Namenda®)
13. omalizumab (Xolair®)
14. Tretinoin (e.g., Retin-A, Avita) for Members over age twenty-six (26)

At any time, the Plan may implement electronic approval criteria or Prior Authorization on additional Prescription Drugs. A Member may call the Claims Administrator's Customer Service Department at the number listed in the *Introduction* section with questions regarding whether a particular Prescription Drug requires Prior Authorization, or may request a listing of the Prescription Drugs that require Prior Authorization which is available at no charge.

The Plan may impose dispensing limitations on the quantity covered per Copayment for specific drug products because of the manufacturer's packaging systems or as dictated by medically appropriate clinical use.

See the *Pre-Service Claims* subsection of the *Claim and Appeal Procedures* section for details on how to obtain Prior Authorization.

The following are not Covered Services under the Plan:

1. anabolic steroids
2. anti-obesity medications
3. appetite suppressants
4. cosmetic medications, including the following
 5. anti-wrinkle agents (e.g., Renova®)
 6. minoxidil (e.g., Rogaine®) for alopecia
 7. tretinoin (e.g., Retin-A®) for Members over age 25 for cosmetic purposes
 8. hair removal products (e.g., Vaniqa®)
9. drug efficacy study indicator (DESI) drugs (Prescription Drugs determined by the FDA as lacking substantial evidence of effectiveness)
10. duplicate, lost, stolen, or damaged Prescription Drugs
11. infertility medications
12. mineral and nutrient supplements
13. needles and syringes (except as diabetic supplies)
14. nutritional supplements
15. outpatient non-legend (over-the-counter) drugs or any Prescription Drug with an over-the-counter equivalent -- regardless of whether there is a prescription, except insulin and non-sedating antihistamines
16. over-the-counter vitamins, singly or in combination, except prescribed prenatal vitamins and those required by applicable law or regulation.
17. pigmenting/depigmenting agents (e.g., Solaquin Forte®, Hydroquinone®)
18. Prescription Drugs dispensed by a Healthcare Provider at his/her office or clinic facility for use outside the office or clinic facility unless the Healthcare Provider is part of the pharmacy network
19. Prescription Drugs labeled "investigational" or "experimental"
20. vitamins singly or in combination except prescription vitamins including pediatric and prenatal vitamins

(n) PREVENTIVE AND ROUTINE CARE

Service	In-Network cost to Member
Preventive Care	0% Coinsurance after Deductible
	\$0 Copayment

Prior Authorization is required for coverage of certain Covered Services. See the Utilization Management section for a list of these services. See the Pre-Service Claims subsection of the Claim and Appeal Procedures section for details on how to obtain Prior Authorization.

Covered Preventive Services are:

- (1) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;
- (2) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved;
- (3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- (4) With respect to women, to the extent not described in 1 above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

Any changes to the recommendations or guidelines referred to above will not be deemed Preventive Services until the first day of the Plan Year beginning on or after the date that is one year after the new recommendation or guideline went into effect.

Covered Services are provided for Preventive Care, Including:

- (a) Well-baby/child exams and routine periodic preventive exams, Including routine gynecological exams
- (b) Required school and school athletic physicals and camp physicals
- (c) Preventive care services in conjunction with a routine periodic preventive exam as outlined below
- (d) Routine immunizations (Including immunizations for foreign travel)
- (e) Routine hearing exams (limit of one exam per Member per Coverage Year)
- (f) Routine vision exams (limit of one exam per Member per Coverage Year)

Preventive Care Services	AGES
<i>Covered preventive care services are limited to once per member per coverage year unless otherwise indicated.</i>	

All Members		> 5	≥ 11	≥ 12	≥ 18	≥ 19	≥ 20	≥ 45	≥ 50	≥ 55	≥ 60	≥ 75	> 80	
Hepatitis C (HCV) screening for people at high risk for infection and one-time screening for people born between 1945 and 1965		X	X	X	X	X	X	X	X	X	X	X	X	
Hepatitis B (HBV) screening for people at high risk for infection		X	X	X	X	X	X	X	X	X	X	X	X	
Obesity screening and counseling		X	X	X	X	X	X	X	X	X	X	X	X	
Chlamydia, gonorrhea and syphilis screening			X	X	X	X	X	X	X	X	X	X	X	
High intensity behavioral counseling to prevent sexually transmitted diseases			X	X	X	X	X	X	X	X	X	X	X	
Human immunodeficiency virus (HIV) screening			X	X	X	X	X	X	X	X	X	X	X	
Depression screening				X	X	X	X	X	X	X	X	X	X	
Diabetes screening					X	X	X	X	X	X	X	X	X	
High blood pressure screening					X	X	X	X	X	X	X	X	X	
Alcohol misuse screening and counseling						X	X	X	X	X	X	X	X	
Healthy diet for hyperlipidemia/risk for diet related chronic disease counseling						X	X	X	X	X	X	X	X	
Tobacco use behavioral interventions and FDA approved pharmacotherapy for adults who use tobacco						X	X	X	X	X	X	X	X	
Lipid panel once every 5 years							X	X	X	X	X	X	X	
Colorectal cancer screening options (one of the following): 1. Fecal occult blood test (series of three) with flexible sigmoidoscopy every 5 years 2. Barium enema and flexible sigmoidoscopy every 5 years 3. CT Colonography every 5 years 4. Colonoscopy once every 10 years										X	X	X	X	
Lung cancer screening with history of smoking										X	X	X		
Herpes zoster/shingles vaccine one time only											X	X	X	
Intensive behavioral counseling interventions to promote a healthful diet and physical activity for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors					X	X	X	X	X	X	X	X	X	
Children's Health	Birth	2	3	5	6	7	9	10	11	12	18	19	20	21
Expanded newborn screen (blood)	X													
Phenylketonuria (PKU) once at birth	X													
Evoked otoacoustic emissions (EOAE) once at birth	X													
Prophylactic eye medication for gonorrhea once at birth	X													
Congenital hypothyroidism screening – one time only between birth and 1 year	X													
Sickle cell disease screening – one time only between birth and 1 year	X													
Iron supplements – between 6-12 months*	X													
Autism screening	X	X												
Developmental screening – up to four screenings between birth and 36 months	X	X	X											
Psychosocial/Behavioral assessment – up to	X	X	X											

<i>Committee on Immunization Practices</i>			
Diphtheria, Tetanus, Pertussis (Tdap)*	X	X	X
Hepatitis A*	X	X	X
Hepatitis B*	X	X	X
Influenza*	X	X	X
Measles, Mumps, Rubella (MMR)*	X	X	X
Meningococcal*	X	X	X
Pneumococcal*	X	X	X
Inactivated Poliovirus (IPV)*	X	X	
Rotavirus*	X		
Haemophilus Influenzae Type B*	X		
Human papillomavirus (HPV)*		X	X
Varicella*		X	X

* Items noted with an asterisk may be covered under the outpatient prescription drug benefit.

If a diagnosis is indicated after a routine Preventive Care exam, the exam will be payable under the routine Preventive Care benefit; however, all Healthcare Services related to the diagnosis will be payable as any other Illness. Coverage for Members exhibiting an Illness or symptoms is included in the *Inpatient and Outpatient Hospital and Physician Services* subsection of this *Schedule of Benefits* section.

The following are not Covered Services under the Plan:

1. Physicals for purposes of research, licensure, employment, or insurance
2. The fitting, purchase, adjustment or repair of hearing aids
3. Certain allergy testing: skin titration (Rinkle method), Cytotoxicity testing (Bryan's test), RAST testing, urine auto-injections, Provocative and Neutralization testing.
4. Purchase or fitting of eyeglasses or other fabricated optical devices and purchase of contact lenses are not covered, except as specified in this section
5. Radial keratotomy (RK)
6. LASIK
7. Photo refractive keratotomy (PRK)
8. Other vision correction surgical procedures
9. Orthoptics
10. Orthoptic training
11. Eye exercises, eye training and vision training
12. Preventive Care services provided Out-of-Network
13. Required school, athletic, and camp physicals
14. Preventive Care services provided Out-of-Network, except well-baby/child exams as listed above

(o) THERAPY SERVICES

Service	In-Network cost to Member
Therapy Services	\$10 Copayment

Prior Authorization is required for coverage of certain Covered Services under the Plan. See the *Utilization Management* section for a list of these services. See the *Pre-Service Claims* subsection of the *Claim and Appeal Procedures* section for details on how to obtain Prior Authorization.

Covered Services under the Plan Include physical, occupational, speech, respiratory therapy provided the services can be expected to bring significant improvement in the Member's condition within a reasonable period of time. Physical and occupational therapy on an inpatient basis is covered. See the *Utilization Management* section of this document.

The following limitations will apply:

1. There is no coverage for Physical therapy once a maintenance level is achieved or for therapy that is primarily Educational in nature.
2. Cardiac rehabilitation is limited to Phase I and Phase II. Phase I cardiac rehabilitation is a medically supervised multidisciplinary program covered under the inpatient Hospital benefit. Phase II cardiac rehabilitation usually begins upon dismissal from the Hospital. It is Physician directed and closely supervised by paramedical personnel. The program components include carefully prescribed exercise, education, counseling and risk-factor modification. Phase II cardiac rehabilitation is covered only for those Members who have the following conditions:
3. A documented arrhythmia of clinical significance during Phase I cardiac rehabilitation or during an exercise treadmill after Phase I cardiac rehabilitation; or
4. Evidence of ongoing significant ischemia as documented during Phase I cardiac rehabilitation or during an exercise treadmill after Phase I cardiac rehabilitation.

Those Members ineligible for Phase II cardiac rehabilitation are covered for up to five (5) rehabilitation visits per Member by referral for the development of a home exercise program and follow-up.

The following are not Covered Services under the Plan:

1. treatment for tongue thrust
2. vocational rehabilitation, testing or training (Including work hardening)
3. recreational therapy

(p) SKILLED NURSING FACILITY AND REHABILITATION FACILITY

Service	In-Network cost to Member
Rehabilitation Facility	\$0 Copayment
Skilled Nursing Facility	\$0 Copayment

Prior Authorization is required for coverage of skilled nursing facility and rehabilitation facility services. See the *Utilization Management* section for a list of these services. See the *Pre-Service Claims* subsection of the *Claim and Appeal Procedures* section for details on how to obtain Prior Authorization.

There is a 90 day maximum per Member per Coverage Year for Skilled Nursing Facility.

There is a 90 day maximum per Member per Coverage Year for Rehabilitation Facility.

Confinement in a Skilled Nursing Facility in semi-private accommodations is a Covered Service. Coverage Includes skilled nursing and therapeutic services, but only as Medically Necessary for short-term convalescence. Physical, occupational, and speech therapy are covered subject to the limits for Rehabilitation Services in the *Schedule of Benefits* section. Any difference between semi-private and private room costs will not be covered unless a private room is Medically Necessary.

Rehabilitation Facility coverage Includes rehabilitation, Skilled Care and therapeutic services; but only for Short-Term convalescence. Physical, occupational, respiratory and speech therapy are covered subject to certain limitations, see the *Rehabilitation Services* subsection of this *Schedule of Benefits* section.

(q) TRANSPLANTS

Service	In-Network cost to Member
Transplants - hospitalization	\$300 Copayment
Transplants – associated office visits	\$0 Copayment

Prior Authorization is required for coverage of transplants under the Plan. See the *Utilization Management* section for a list of these services. See the *Pre-Service Claims* subsection of the *Claim and Appeal Procedures* section for details on how to obtain Prior Authorization.

Definitions

1. **Autologous.** When the source of cells is from an individual's own marrow or stem cells.
2. **Allogeneic.** When the source of cells is from a related or unrelated donor's marrow or stem cells.
3. **Autologous Bone Marrow Transplant.** When bone marrow is harvested from the individual and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is then re-infused (transplanted).
4. **Allogeneic Bone Marrow Transplant.** When bone marrow is harvested from a donor and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is re-infused (transplanted).
5. **Autologous/Allogeneic Stem Cell Support.** A treatment process that includes stem cell harvest from either bone marrow or peripheral blood, tumor ablation with high-dose chemotherapy and/or radiation, stem cell re-infusion, and related care. Autologous/allogeneic bone marrow transplantation and high dose chemotherapy with peripheral stem cell rescue/support are considered to be autologous/allogeneic stem cell support.
6. **Transplant Services.** This is transplantation including re-transplants of the human organs or tissue listed below including all related post-surgical treatment and drugs and multiple transplants for a related cause. Transplant services do not include other organ or tissue transplants or surgical implantation of mechanical devices that function as a human organ, except surgical implantation of FDA approved Ventricular Assist Devices (VAD), functioning as a temporary bridge to heart transplantation.

Covered Services include services, supplies, inpatient medications, and related aftercare (Including procedures to determine rejection or success of transplant) for only the following human organ and bone marrow transplants and stem cell support procedures expressly listed below:

1. Autologous Bone Marrow Transplant.
2. Allogeneic Bone Marrow Transplant.
3. Autologous/Allogeneic Stem Cell Support.
4. heart, heart-lung, liver, lung (single or double), for end-stage kidney disease, and cornea transplants for end stage disease;
5. partial organ transplants, including partial liver or partial pancreas;
6. pancreas transplant for a diabetic with end-stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative sessions or a medically uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired.

When the donor is a Member, eligible medical charges incurred by the donor will be considered Covered Services under the Plan.

When the recipient is a Member, eligible medical charges incurred by the recipient will be considered Covered Services under the Plan.

If both the donor and the recipient are Members, eligible medical charges incurred by each person will be treated separately for each person.

1. the Usual and Customary Rate of securing an organ from a cadaver or tissue bank, Including the surgeon's fee for removal of the organ and the Hospital's fee for the storage and transportation of the organ
2. Organ or tissue procurement and acquisition fees, Including surgery, storage, and organ or tissue transport costs directly related to a living or non-living donor
3. testing to determine transplant feasibility and donor compatibility
4. anti-rejection drugs
5. FDA approved drugs
6. medically necessary equipment and supplies
7. two round trip "coach" air transportation charges for the Member and one (1) family member or companion, to and from the approved transplant facility for each required visit approved by the Plan. The Plan benefit payable for air transportation, lodging and meals combined is \$10,000 per transplant;
8. lodging and meals, outside the Service Area, for two (2) people as Prior Authorized by the Plan. Maximum reimbursement for lodging is \$150 per day for one (1) room. Maximum reimbursement for meals is \$25 per person per day for up to two (2) people. Receipts are required when submitting meals, lodging and transportation expenses for payment consideration. The Plan benefit payable for air transportation, lodging and meals combined is \$10,000 per transplant;
9. reasonable and necessary healthcare expenses incurred by a donor who is covered by the Plan, without any Copayments applicable to those expenses; or
10. reasonable and necessary healthcare expenses incurred by a donor who is not covered by the Plan, without any Copayments applicable to those expenses, but only to the extent the expenses of the donor are not covered by the donor's own insurance or healthcare plan.

The following are not Covered Services under the Plan:

11. services, supplies, drugs and aftercare for or related to organ and bone marrow transplant and stem cell support procedures not specifically listed above as Covered Services
12. charges associated with the purchase of any organ
13. artificial organs, devices, or systems, whose purpose is to assist or replace a natural body organ, and any charges for the implantation, attachment or use of such organ, device or system, including follow-up care. This exclusion does not apply to kidney dialysis or pacemakers or cochlear implants. This exclusion does not apply to Healthcare Services or surgery for immediate life-threatening health problems as determined by the Plan or to charges in relation to artificial organs that may be necessary on a temporary short-term basis until a suitable donor organ is available.
14. high dose chemotherapy with Autologous bone marrow transplantation to treat breast cancer
15. charges in connection with non-human organ or tissue transplants
16. services or supplies furnished in connection with the transportation of a living donor

SECTION VII
EXCLUSIONS

7.1 Exclusions. Notwithstanding any provision in the Plan to the contrary, the Plan will not provide benefits for the following services, medical procedures or supplies, regardless of Medical Necessity or recommendation by a Healthcare Provider. The Member is responsible for 100% of the charges associated with the listed exclusions. These charges are not Covered Services under the Plan and, therefore, will not count toward the Annual Out-of-Pocket Maximum. In addition to those exclusions listed below, the *Schedule of Benefits* section contains additional exclusions.

The Plan will not provide benefits for the following services or expenses:

- (1) Services or supplies provided before the Member's coverage is effective, or services or supplies provided after the Member's coverage terminates, even though the Member's Illness or Injury started while coverage was in force.
- (2) Charges in excess of the Maximum Annual Benefit, Maximum Lifetime Benefit and maximum allowances as detailed in the *Schedule of Benefits* section.
- (3) Out-of-Network services, unless due to an Emergency or Urgent Care or non-Emergency Medically Necessary services when certain conditions are met. See the *Utilization Management* section for details.
- (4) Services or supplies that are not Medically Necessary, except if specifically listed in the *Schedule of Benefits* section as Covered Services.
- (5) Experimental or Investigative Healthcare Services, procedures, drugs, devices, services or supplies.
- (6) Services or supplies that do not meet generally accepted standards of practice in the medical community.
- (7) Services that are prohibited by law or regulation.
- (8) Services provided by non-licensed, non-registered, or non-certified providers.
- (9) Services performed for a Member by the Member or by a person who ordinarily resides in the Member's household or is related (by blood or law) to the Member.
- (10) Services or supplies for which the Member has no legal obligation to pay, which are free or which would not be provided except for the availability of benefits under the Plan, unless payment is required by applicable law.
- (11) Services of the clergy.
- (12) Services or supplies that are paid or payable under workers' compensation, occupational disease law or similar law.
- (13) Services or supplies furnished by any level of government, unless payment is required by applicable law.
- (14) Services or supplies (Including hospitalization) ordered by a court or other third party, unless otherwise covered under the Plan.
- (15) Charges actually incurred by other persons.

- (16) Charges for preparing medical reports, bills or claim forms, mailing/shipping/handling charges, broken appointments, telephone calls (including treatment or consultations provided via telephone), late fees, credit card interest, or photocopying fees.
- (17) Illness, Injury or charges due to declared or undeclared war (including resistance to armed aggression), riot, insurrection, rebellion, invasion or military aggression or caused during service in the armed forces of any country, if benefits are available for such Illness, Injury or charges under the laws of the United States or any political subdivision thereof, unless payment is required by applicable law.
- (18) Charges incurred due to an Illness or Injury resulting from the Member's voluntary participation in a criminal act (Including burglary, robbery, assault, criminal trespass, participation in a riot or civil disturbance), or while the Member is engaged in an illegal occupation, unless it results from an act of domestic violence or a medical condition (including both physical and mental health conditions).
 1. Any services needed from intentionally self-inflicted injuries or self-induced illnesses unless they result from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- (19) Charges for a private room, unless Medically Necessary.
- (20) Extended Hospital stays for reasons other than Medical Necessity.
- (21) A continued Hospital stay if, as determined by the Plan, care could be provided in a less acute care setting.
- (22) Any admission for the purpose of performing diagnostic tests that can be performed on an outpatient basis.
- (23) Hospitalization when such Confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care or any routine physical examinations or tests not connected with an actual Illness or Injury.
- (24) Educational materials and supplies.
- (25) Physical examinations for research or obtaining licensure, employment or insurance.
- (26) Charges for professional certification, licensure or the like.
- (27) Religious counseling or training services.
- (28) Halfway houses, wilderness programs, group homes, summer camps.
- (29) Biofeedback, unless it is the standard of care for treatment of an Illness or Injury and is provided by a qualified Healthcare Provider.
- (30) Family counseling, unless Medically Necessary or the family counseling is part of Medically Necessary treatment for a minor child Member that has been recommended by a Healthcare Provider treating the minor child.
- (31) Developmental and neuroeducational testing or treatment, except as permitted under Preventive Care in the *Schedule of Benefits* section.
- (32) Services, treatment, or supplies associated with smoking cessation, except Prescription Drugs for smoking cessation except as permitted under Preventive Care in the *Schedule of Benefits* section.

- (33) Treatment of compulsive gambling.
- (34) Anonymous support groups.
- (35) Infirmary and other healthcare charges from a school or other educational facility.
- (36) Personal comfort and convenience items for the Member or the Member's caregiver.
- (37) Health club memberships and all services provided by a health club facility, air conditioners, room humidifiers, room dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic or therapeutic mattresses, home or automobile modification, environmental change, pools, whirlpools, and similar items, even if recommended, ordered or prescribed by a Healthcare Provider.
- (38) Charges for personal growth/development, holistic medicine or other programs with an objective to provide complete personal fulfillment.
- (39) Vocational rehabilitation, testing or training (Including work hardening).
- (40) Self-care and self-help training (non-medical).
- (41) Services or supplies related to academic or vocational education, Including computers and computer software programs.
- (42) Recreational therapy.
- 2. Chelation therapy, except in the treatment of heavy metal poisoning.
- 3. Homeopathy or herbal therapy.
- (43) Massage therapy, rolfing and related services, except as allowable under the chiropractic care benefit.
- (44) Physical/occupational/speech therapy when it cannot reasonably be expected to significantly improve functionality, or after maintenance level is achieved.
- (45) Phase III and Phase IV outpatient cardiac rehabilitation programs. Phase III cardiac rehabilitation begins at the completion of Phase II and may continue for six months or more. The program consists of group education at a community exercise facility, Hospital or clinic, or may be a home exercise program. Phase IV cardiac rehabilitation is a non-medically supervised maintenance program.
- (46) Coma stimulation programs.
- (47) Penile prosthesis/implants except as specifically listed in the *Schedule of Benefits* section.
- (48) Genetic testing/procedures or genetic counseling except as specifically listed in the *Schedule of Benefits* section.
- (49) Acquisition or storage of cord blood for stem cell or other uses.
- (50) Reversal of a sterilization procedure.
- (51) Abortion, unless an abortion is necessary to either save the life of the woman having the abortion or to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion. If complications arise after the performance of any

- abortion, charges incurred to treat those complications will be eligible, whether the abortion was eligible or not.
- (52) Natural foods that are naturally low in protein and/or galactose.
 - (53) Spices and flavorings.
 - (54) Foods and formulas available to any person, even a person with an Inherited Metabolic Disorder as defined in the Outpatient Prescription Drugs subsection in the Schedule of Benefits, that may be purchased without an In-Network Physician prescription/order and/or do not require supervision by an In-Network Physician.
 - (55) Charges related to correction of gynecomastia (mastectomy or liposuction), either unilateral or bilateral except as specifically listed as Covered Services in the *Schedule of Benefits* section.
 - (56) Services, drugs, or supplies for the purpose of, or related to, the diagnosis and testing of infertility, including drugs and procedures for the promotion of conception (e.g., assisted reproductive technology (ART) procedures, sperm banking, artificial insemination, in vitro fertilization (IVGF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (AIFT) with or without cryopreservation, frozen embryo transfer, and charges for donor ova or sperm).
 - (57) Charges related to or in connection with adoption, except to the extent coverage is specifically provided in the *Maternity* subsection in the *Schedule of Benefits* section.
 - (58) Lamaze or other childbirth classes.
 - (59) Services of a doula.
 - (60) Delivery services of a Certified Nurse Midwife when performed at an unlicensed, unaccredited facility.
 - (61) Charges related to services to change lifestyle or alter sexual characteristics, including transsexual (sex change) procedures, preparation for such procedures, including counseling, any related services or complications thereof.
4. Charges for sex transformation surgery and any related charges.
- (62) Routine treatment of obesity, or weight control counseling (including fees, vitamins, nutrients, supplements, or exercise therapy) and any related diagnostic testing unless necessitated as the result of a specifically identifiable condition of disease etiology. Preventive screening and counseling are Covered Services as listed under Preventive Care in the *Schedule of Benefits* section.
 - (63) All services and medication for the purpose of weight reduction including the surgical treatment of obesity (e.g., gastric restrictive, intestinal bypass and repeat and reversal procedures), except as specifically listed in the Schedule of Benefits section.
 - (64) Reconstructive or cosmetic surgery/services/drugs that restore or improve bodily appearance without affecting body function necessary for life except as specifically listed as Covered Services in the *Schedule of Benefits* section.
 - (65) Breast reduction, unless Medically Necessary or following a Medically Necessary mastectomy. Reconstruction of the other breast to produce symmetrical appearance will be covered in the case of a unilateral mastectomy.

- (66) Breast augmentation, except following a Medically Necessary mastectomy. Reconstruction of the other breast to produce symmetrical appearance will be covered in the case of a unilateral mastectomy.
- (67) Charges related to surgical removal or other treatment of axillary fat or axillary fat roll, which is not part of the breast.
- (68) Charges related to removal, replacement, revision or treatment of complications of silicone or saline breast implants placed for cosmetic reasons. This Includes treatment of capsule formation, capsulectomy (removal of the firm scar tissue surrounding the breast implant), capsulotomy (incision of firm scar tissue surrounding the breast implant), capulorrhaphy (correction or improvement of implant position), mastopexy (breast lift), and treatment/removal of ruptured breast implants.
- (69) Breast reconstruction to correct breast asymmetry except as specified under the *Inpatient and Outpatient Hospital and Physician Services* subsection of the *Schedule of Benefits* section.
- (70) Cosmetic surgeries and associated services or supplies to improve or change appearance except as specifically listed as Covered Services in the Schedule of Benefits section.
- (71) Surgical treatment of disfigurement from rosacea (e.g., telangiectasias, rhinophyma, and scarring).
- (72) Surgical treatment of disfigurement from HIV and related treatment, including facial wasting and fat deposits on the back of the neck (cervical hump).
- (73) All dental care, except services specifically listed as Covered Services in the *Dental Services* subsection of the *Schedule of Benefits* section.
- (74) Routine vision care, except routine vision exams are Covered Services as specified under the *Preventive Care* subsection of the *Schedule of Benefits* section.
- (75) Blepharoplasty and other procedures to correct Lid Ptosis except as specifically listed in the Schedule of Benefits.
- (76) Vision therapy or eye exercises.
- (77) Sunglasses (including any colored or tinted lenses) or safety glasses.
- (78) Repair of lenses or frames.
- (79) Drugs or medications of any kind related to routine vision services.
- (80) Eyeglasses, lenses or contact lenses, except as specifically listed in the *Schedule of Benefits* section.
- (81) Surgical correction of refractive error and refractive keratoplasty including radial keratotomy (RK), automated lamella keratoplasty (ALK), Lasik surgery or any similar procedure.
- 5. Routine hearing care, except routine hearing exams are Covered Services as specified under the *Preventive Care* subsection of the *Schedule of Benefits* section.
- (82) The purchase or fitting of external hearing aids. This exclusion does not apply to implantable hearing devices.
- (83) Routine foot care for hygienic reasons or for paring/removing corns, calluses, or toenails (except removing nail roots and/or the treatment of metabolic or peripheral vascular disease).

- (84) Treatment of weak, strained, flat, unstable or unbalanced feet.
- (85) Orthopedic shoes, orthotics, arch supports or any such similar device which is not custom made.
- (86) Splints, braces, or mouth guards used for non-medical purposes (i.e., support worn primarily during participation in sports or similar physical activities).
- (87) Breast pumps.
- (88) Adult apnea monitoring devices.
- (89) Charges for laser assisted uvuloplasty (LAUP) and similar procedures for the treatment of snoring and/or sleep apnea.
- (90) Surgical correction of sleep apnea except as specifically listed in the Schedule of Benefits.
- (91) Blood pressure monitoring devices.
- 6. Wigs and artificial hair pieces.
- (92) Replacement or repair of Durable Medical Equipment, Prosthetics or Orthotics which are stolen; lost; or damaged or destroyed by Member misuse, abuse, or carelessness.
- (93) Charges for equipment, models, or devices having features over and above that which best meets the Medical Necessity of the Member.
- (94) Motor vehicles, lifts for wheelchairs, or scooters.
- (95) Batteries.
- (96) Duplicate services or supplies.
- (97) Private duty nursing services, except to the extent coverage is specifically provided in the *Home Health Care* subsection of the *Schedule of Benefits* section.
- (98) Outpatient nutritional supplements Including home meals, food, food supplements, diets, vitamins, minerals, naturopathic or homeopathic services/substances, other nutritional supplies and over the counter electrolyte supplements, except (a) as required for treatment of phenylketonuria (PKU) and enteral and parenteral nutrition, or (b) to the extent coverage for such items is specifically provided in the *Outpatient Prescription Drugs* subsection of the *Schedule of Benefits* section.
- (99) Custodial and domiciliary care. Services which are primarily custodial or domiciliary are not covered. This Includes homemaker, home health aide, routine nursing home services, rest cures, and days in a Skilled Nursing Facility which are not covered under the *Skilled Nursing Facility and Rehabilitation Facility* and *Rehabilitation Services* subsection of the *Schedule of Benefits* section.
- (100) Respite Care, except as specifically listed in the *Hospice Care* subsection of the *Schedule of Benefit* section.
- (101) Nursing services to administer home infusion therapy that the Member or another care giver can be successfully trained to administer; and home infusion services that do not involve direct Member contact, Including delivery charges and record-keeping.
- (102) Financial or legal counseling services.
- (103) Housekeeping or meal services in the Member's home.

- (104) Charges for services, supplies, drugs and aftercare for or related to transplants not specifically listed in the *Transplant* subsection of the *Schedule of Benefits* section.
- (105) Artificial organs, devices, or systems, whose purpose is to assist or replace a natural body organ, and any charges for the implantation, attachment or use of such organ, device or system, including follow-up care. This exclusion does not apply to kidney dialysis, pacemakers or cochlear implants. This exclusion does not apply to Healthcare Services or surgery for immediate life-threatening health problems as determined by the Plan or to charges in relation to artificial organs that may be necessary on a temporary short-term basis until a suitable donor organ is available.
- (106) High dose chemotherapy with autologous bone marrow transplantation to treat breast cancer.
- (107) Charges in connection with non-human organ or tissue transplants.
- (108) Charges associated with the purchase of any organ.
- (109) Services or supplies furnished in connection with the transportation of a living donor.
- (110) Processing, storage and administration charges related to self-donated blood for potential transfusion to the Member unless incurred after the Member is scheduled for surgery.
- (111) Services of a blood donor.
- (112) Those Prescription Drugs and other items specifically excluded in the *Outpatient Prescription Drugs* subsection of the *Schedule of Benefits* section.
- (113) The cost of administering Prescription Drugs that are designed for self-administration.
- (114) Over the counter home testing and monitoring supplies and devices unless used in connection with the treatment of diabetes.
- (115) Charges for or related to travel, except immunizations for foreign travel as specifically listed in the *Schedule of Benefits* section and travel charges related to transplants as specifically listed in the *Schedule of Benefits* section.
- (116) Charges related to transportation to or between healthcare facilities, except as specifically provided under the *Ambulance* subsection of the *Schedule of Benefits* section.
- (117) Non-Emergency Ambulance services.
- (118) If a Member receives Healthcare Services outside of the United States, its territories or Canada, benefits shall be provided for those charges to the extent the services rendered are included as Covered Services in the Plan, and provided the Member did not travel to such a location for the sole purpose of obtaining Healthcare Services.
- (119) Physician fees for any treatment or service which is not rendered by and in the physical presence of a Physician.
- (120) Mayo Clinic Scottsdale Executive Health Exam Services. The Mayo Clinic Scottsdale Executive health exam and all other executive health programs/exams are not covered under the physical exam benefit. Any charges for services related to the Mayo Clinic Scottsdale Executive health exam and all other executive health programs/exams will be the responsibility of the Member.
- (121) Autopsies and related charges.
- (122) Car seats.

(123) Charges incurred if a Member fails to honor an appointment with a Healthcare Provider.

SECTION VIII

CLAIM AND APPEAL PROCEDURES

8.1 Introduction. All claims must be submitted to this Plan and all claims review will comply with the rules and procedures set forth in this *Claim and Appeal Procedures* section.

8.2 Definitions.

- (a) Adverse Benefit Determination - a denial, reduction, or termination of a benefit, or a Rescission, or a failure to provide or make payment (in whole or in part) for a benefit or a Rescission.
- (b) Authorized Representative - a person designated by a Claimant or this Plan to act on behalf of a Claimant.
- (c) Claimant - a person who believes he/she is entitled to benefits under this Plan. In this *Claim and Appeal Procedures* section, the term Claimant shall also include a Claimant's Authorized Representative, if applicable.
- (d) Concurrent Care Claim - a claim that requires Prior Authorization under this Plan that is reconsidered after a course of treatment has been initially approved. There are two types of Concurrent Care Claim, (1) where reconsideration by this Plan results in a reduction or termination of coverage for a previously approved benefit, and (2) where an extension is requested by the Claimant for coverage beyond the initially approved benefit.
- (e) External Review – An independent review of an Adverse Benefit Determination (following final appeal under the Plan) regarding medical judgment or a rescission under applicable state or federal external review procedures pursuant to the Health Care Reform.
- (f) Independent Review Organization (IRO) – An independent, accredited organization, contracted by the Plan, but separate and apart from the Plan, responsible for conducting External Review of an Adverse Benefit Determination.
- (g) Post-Service Claim - any claim for a benefit under this Plan that is submitted for payment or reimbursement after the services have been rendered.
- (h) Pre-Service Claim - any claim for a benefit under this Plan where receipt of the benefit is specifically conditioned, in whole or in part, on receiving approval in advance of obtaining the medical care. Benefits under this Plan that are Pre-Service Claims (i.e., subject to approval in advance) are listed in the *Utilization Management* section as services that require Prior Authorization.
- (i) Urgent Pre-Service Claim - an Urgent Pre-Service Claim is a type of Pre-Service Claim. An Urgent Pre-Service Claim is any claim for medical care or treatment with respect to which the application of the timeframes for making non-urgent determinations could seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or – in the opinion of a Physician with knowledge of the Claimant's medical condition – would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If a Physician with knowledge of the Claimant's medical condition determines that a claim is an Urgent Pre-Service Claim, the claim will be treated as an Urgent Pre-Service Claim. A Physician may be required to complete an "Urgent Pre-Service Claim Determination by Physician" form, if

requested, in such cases.

8.3 Types of Claims.

- (a) This Plan has four categories of claims as defined above.
- (1) Concurrent Care Claim
 - (2) Post-Service Claim
 - (3) Pre-Service Claim
 - (4) Urgent Pre-Service Claim
1. Each category of claim has its own set of claim and appeal requirements. The primary difference between the categories of claims is the timeframes within which claims will be determined.
 2. For the purpose of determining which claim and appeal procedures to follow, the claim type is determined initially. However, if the nature of the claim changes as it proceeds through the claim and appeal process, the claim can be re-characterized. For example, a claim may initially be an Urgent Pre-Service Claim. If the urgency subsides, it may be re-characterized as a Pre-Service Claim. Once the services are rendered and submitted to this Plan for payment, it becomes a Post-Service Claim.

8.4 Authorized Representative. For the purpose of this Plan's claims and appeal procedures, an Authorized Representative may act on a Claimant's behalf with respect to any aspect of a claim or appeal.

For Post-Service Claims in the Mayo Clinic Health Solutions Appeals process, an "Authorized Representative" form must be received by this Plan in order for a person to be recognized as a Claimant's Authorized Representative for both claims and appeals. Such forms are available by calling or writing the Claims Administrator's customer service department:

Mayo Clinic Health Solutions
 PO Box 211698
 Eagan, MN 55121
 1-866-465-5148
 TDD (for hearing impaired) 1-800-407-2442

Once an Authorized Representative is recognized, this Plan will direct all information, notification, etc. regarding the claim to the Authorized Representative, unless the Claimant provides specific written direction otherwise.

8.5 Information Regarding Prescription Drug Claims

- (a) In-Network Pharmacies. If the In-Network pharmacy determines the Prescription Drug requested is not a Covered Service under the Plan, or if the Claimant disputes the Cost Sharing Amount determined by the pharmacy, the Claimant may pay the amount determined by the pharmacy and request reimbursement from the Plan or dispute the Cost Sharing Amount, both of which may be accomplished by following the procedure described below for filing a Post-Service Claim. The Plan will then determine whether the Prescription Drug is a Covered Service and/or the appropriate Cost Sharing Amount. When a Member has a prescription from a Healthcare Provider for a Prescription Drug, the Member should take the prescription to an In-Network pharmacy and present the prescription and his/her Membership Card to the pharmacy. Generally, the In-Network pharmacy will fill the prescription and collect a Cost Sharing Amount from the Member. *This is not considered a claim for benefits under the Plan.*

- (1) If the In-Network pharmacy determines the Prescription Drug requested is not a Covered Service under the Plan, or if the Member disputes the Cost Sharing Amount determined by the pharmacy, the Member may do one of the following:
1. Pay the amount determined by the pharmacy and request reimbursement from the Plan or dispute the Cost Sharing Amount by following the procedure described below for filing a Post-Service Claim. The Plan will then determine whether the Prescription Drug is a Covered Service and/or the appropriate Cost Sharing Amount; or
 2. Contact the Claims Administrator's Pharmacy Department to request a Pre-Determination. The Plan requires additional information for certain Prescription Drugs to determine whether they are Covered Services under the Plan. The Prescription Drugs that require this additional information are listed in the *Outpatient Prescription Drugs* subsection of the *Schedule of Benefits* section. If a Member would prefer to submit the information before filling the prescription, he/she may do so by having his/her Healthcare Provider contact the Claims Administrator's Pharmacy Department to provide the information requested. The Claims Administrator's Pharmacy Department will notify the Member and the Member's Healthcare Provider in writing whether or not the Prescription Drug requested is a Covered Service. If the Prescription Drug requested is a Covered Service, the Member will pay the appropriate Cost Sharing Amount at the pharmacy when picking up the Prescription Drug.

A Pre-Determination must be in writing and submitted to the Claims Administrator's Pharmacy Department at:

Town of Gilbert Medical Plan
c/o Mayo Clinic Health Solutions
 PO Box 211698
 Eagan, MN 55121

Attn: Pharmacy Dept.

Fax: 1-800-632-9885

Please note: A Pre-Determination is not required in order to obtain coverage for any Prescription Drug. The additional information required for certain Prescription Drugs may also be submitted after the prescription is filled by following the procedures described below for filing a Post-Service Claim. The Member will be reimbursed if the Prescription Drug is a Covered Service.

- (b) Out-of-Network Pharmacies. The Plan does not provide coverage for Prescription Drugs obtained at Out-of-Network pharmacies except in the case of an Emergency. To request reimbursement from the Plan, the Claimant must follow the procedure described below for filing a Post-Service Claim.

8.6 How to File a Claim.

- (a) Post-Service Claims. Healthcare Providers may submit Post-Service Claims on a Claimant's behalf. *If a Healthcare Provider submits a Post-Service Claim on a Claimant's behalf, the Healthcare Provider will not be considered an Authorized Representative and will not receive the notification described below in the case of an Adverse Benefit Determination.*

- (1) A Post-Service Claim must be submitted electronically or be in writing and submitted to:
- | | |
|---|---|
| <p><u>Medical Services Claims</u></p> <p>Mayo Clinic Health Solutions
PO Box 211698
Eagan, MN 55121</p> | <p><u>Prescription Drug Claims</u></p> <p>Mayo Clinic Health Solutions
PO Box 211698
Eagan, MN 55121
Attn: Pharmacy Dept.</p> |
|---|---|
- (2) A Post-Service Claim for medical services or supplies should be filed on a universal billing form and must include the following information:
1. the name of this Plan
 2. the identity of the Claimant, Including name, address, and date of birth
 3. the date(s) of service
 4. the name, credentials and tax identification number of the Healthcare Provider
 5. the place of service
 6. a specific diagnosis code [current International Classification of Disease, Clinical Modification (ICD, CM) format]
 7. a specific service code for which payment is requested [current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format]
 8. the amount of billed charges
 9. if a Claimant has already paid for the medical service or supply and is requesting reimbursement, he/she must also submit proof of payment
1. A Post-Service Claim for Prescription Drugs must be filed on a Prescription Drug claim form (which is available from the Claims Administrator) and must include the following information:
10. the name of this Plan, the carrier number and the group number
 11. the identity of the Claimant, Including name, address, date of birth and Member identification number
 12. the date(s) of service
 13. the name and credentials of the Healthcare Provider
 14. the place of service [e.g., National Association of Boards of Pharmacy (NABP) number]
 15. a specific product code for which payment is requested [current National Drug Code (NDC) format], the dose and the number of days supply
 16. the amount of billed charges
 17. if the item required Prior Authorization, clinical information for this Plan to make a coverage determination
 18. if a Claimant has already paid for the Prescription Drug and is requesting reimbursement, he/she must also submit proof of payment
1. A Post-Service Claim must be filed within one (1) year following the date of service.

- (b) Pre-Service Claims (Including Urgent Pre-Service Claims). Typically, a Pre-Service Claim is made on the Claimant's behalf by the treating Physician as an Authorized Representative. However, it is the Claimant's responsibility to ensure that a Pre-Service claim has been filed. The Claimant can accomplish this by having his/her Healthcare Provider contact the Claims Administrator to file a Pre-Service Claim on behalf of the Claimant.

- (1) A Pre-Service Claim must be submitted to:

Medical Services Claims

Mayo Clinic Health Solutions
PO Box 211698
Eagan, MN 55121

Attn: Health Services Dept.

Fax: 1-888-889-7822

Prescription Drug Claims

Mayo Clinic Health Solutions
PO Box 211698
Eagan, MN 55121

Attn: Pharmacy Dept.

Fax: 1-507-284-2011

Urgent Pre-Service Claims and inpatient admissions where the underlying services do not require Prior Authorization may be submitted orally at the following phone numbers:

Providers: 1-800-645-6296

Members: 1-866 - 465-5148

- (2) A Pre-Service Claim must include the following information:

19. the name of this Plan
20. the identity of the Claimant, Including name, address, and date of birth
21. the proposed date(s) of service
22. the name and credentials of the Healthcare Provider
23. an order or request from the Healthcare Provider for the requested service
24. the proposed place of service
25. a specific diagnosis
26. a specific proposed service code for which approval or payment is requested [current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format]
27. clinical information for this Plan to make a Medical Necessity determination

- (3) A Pre-Service Claim for Prescription Drugs must include the following information:

28. the name of this Plan
29. the identity of the Claimant, Including name, address, and date of birth
30. the name of the Prescription Drug requested
31. the name and credentials of the Healthcare Provider prescribing the requested Prescription Drug
32. a specific diagnosis

33. clinical information for the Plan to make a Medical Necessity determination

(4) Incorrectly Filed Claim. Failure to submit a claim to the proper place and/or in writing, if required, may result in the claim being treated as an incorrectly filed claim. If a Pre-Service Claim has been filed incorrectly, this Plan will notify the Claimant as soon as possible but no later than the timeframes stated below:

1. Pre-Service Claims (not including Urgent Pre-Service Claims). No later than 5 days following receipt of the incorrectly filed claim.
2. Urgent Pre-Service Claims. No later than 24 hours following receipt of the incorrectly filed claim.

(c) Concurrent Care Claims. Where an extension is requested for benefits beyond the initially approved benefit, a Claimant should follow the instructions for how to file a Pre-Service Claim.

8.7 Timeframes for Claim Decisions Under the Plan. A Claimant may voluntarily agree to extend the timeframes specified below for this Plan to make a decision.

(a) Timeframes. The following timeframes apply unless the claim is incomplete, as described below.

(1) Post-Service Claims. This Plan will determine the claim within 30 days of receipt of the claim.

If the Plan is not able to determine the claim within this time period due to matters beyond its control, this Plan may take an additional period of up to 15 days to determine the claim. If this additional time will be needed, this Plan will notify the Claimant in writing prior to the expiration of the initial 30 day time period for determining the claim.

(2) Pre-Service Claims. The Plan will determine the claim within 15 days of receipt of the claim.

If the Plan is not able to determine the claim within this time period due to matters beyond its control, the Plan may take an additional period of up to 15 days to determine the claim. If this additional time will be needed, the Plan will notify the Claimant in writing prior to the expiration of the initial 15 day time period for determining the claim.

1. Urgent Pre-Service Claims. The Plan will determine the claim as soon as possible but no later than 72 hours after receipt of the claim.

2. Concurrent Care Claims.

1. For a reduction or termination of coverage for a previously approved benefit, this Plan will determine the claim sufficiently in advance to allow the Claimant to appeal and obtain a determination on review before coverage for the previously approved benefit is reduced or terminated.

2. Where an extension is requested by the Claimant for coverage beyond the initially approved benefit,

1. If the request meets the definition of an Urgent Pre-Service Claim this Plan will determine the claim within the Urgent Pre-Service Claim timeframe.

2. If the request does not meet the definition of an Urgent Pre-Service Claim, the Plan will determine the claim within 15 days.

1. If this Plan is not able to determine the claim within this time period due to matters beyond its control, this Plan may take an additional period of up to 15 days to determine the claim. If this additional time will be needed, this Plan will notify the Claimant in writing prior to the expiration of the initial time period for determining the claim.

(b) Incomplete Claims.

- (1) Post-Service Claims and Pre-Service Claims (not including Urgent Pre-Service Claims). Incomplete claims can be addressed through the extension of time described above. If the reason for the extension is the failure to provide necessary information and the Claimant is appropriately notified, this Plan's period of time to make a decision is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the Claimant responds or should have responded.

The notification will include a timeframe of at least 45 days in which the necessary information must be provided. Once the necessary information has been provided, this Plan will decide the claim within the extension described above. If the requested information is not provided within the time specified, the claim may be denied.

- (2) Urgent Pre-Service Claims. This Plan will notify the Claimant of an incomplete claim as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notification will describe the information necessary to complete the claim and specify the timeframe of at least 48 hours within which the claim must be complete.

Notification may be made orally to the Claimant or the Healthcare Provider, unless the Claimant requests written notice.

This Plan will make a claim determination as soon as possible but not later than the earlier of (1) 48 hours after receipt of the specified information, or (2) the end of the period of time provided to submit the specified information.

8.8 Notification of Claim and Pre-Determination Decisions Under the Plan.

(a) When this Plan Will Provide Notification of a Claim Determination.

- (1) Post-Service Claims and Concurrent Care Claims. Notification will be provided only if the decision is an Adverse Benefit Determination.
- (2) Pre-Service Claims (Including Urgent Pre-Service Claims) and Pre-Determination Requests. Notification will be provided whether the claim or request is approved or denied.

(b) Content of Notification.

- (1) Adverse Benefit Determination. Notice of an Adverse Benefit Determination will be provided in written or electronic form in a culturally and linguistically appropriate manner. For Urgent Pre-Service Claims, notification will be provided orally to the Claimant within the timeframe described above and written or electronic notification will be furnished not later than 3 days after the oral notification. A Plan decision to Rescind coverage shall be considered and treated as an Adverse Benefit Determination.

The notification will include the following:

1. the specific reason(s) for the determination;
2. reference to the specific Plan provision(s) on which the determination is based;
3. a description of any additional material or information necessary to complete the

claim and an explanation of why such information is necessary;

4. a description of this Plan procedures and time limits for appeal of the Adverse Benefit Determination and the right to sue in federal court;
 5. disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Benefit Determination or a statement that such information was relied upon in making the Adverse Benefit Determination and will be provided free of charge upon request;
 6. if the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of this Plan to the Claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request; and
 7. Disclosure of the availability of, and contact information for, any applicable office of health coverage consumer assistance or ombudsman to assist Members with the internal claims process and appeals and External Review process.
- (2) Not Adverse Decision. For Pre-Service Claim and Urgent Pre-Service Claim determinations that are not adverse, notice that the request for Prior Authorization has been approved will be provided.
 - (3) Denial of Pre-Determination. The notification will include the specific reason(s) for the denial.
 - (4) Approval of a Pre-Determination. Notice that the Pre-Determination request has been approved will be provided.

8.9 Complaints. If a Claimant has a complaint or dispute with this Plan, the Claimant may contact the Claims Administrator's customer service department by calling the number listed below in an attempt to resolve the complaint in an informal manner, rather than following the appeal procedures described below. If a complaint is submitted, the Claims Administrator will try to resolve the complaint through informal discussions within ten (10) days. If the complaint cannot be resolved to the Claimant's satisfaction, the Claimant may submit a written appeal by following the appeal procedures described below. Please note that a Claimant has 180 days after receiving an Adverse Benefit Determination to file a formal appeal. This time limit continues to run while the Claimant's complaint is being considered.

1-866-465-5148

TDD (for hearing impaired) 1-800-407-2442

8.10 Appeals Process. Health Care Reform requires appeal procedures for Adverse Benefit Determinations under which Claimants receive full and fair review of the claim and Adverse Benefit Determination. The following will apply to all types and levels of appeals of Adverse Benefit Determinations:

- (a) Right to Review Claim File. The Claimant will have the right to review his or her claim file.
- (b) Submission and Consideration of Comments. The Claimant will have the right to present "evidence and testimony" as that phrase is clarified through regulatory guidance. The Claimant will have the opportunity to submit documents, written comments, or other information in support of the appeal. The review of the Adverse Benefit Determination will take into account all information, whether or not presented or available for the initial determination. No deference will be given to the prior determination.
- (c) Disclosure of New or Additional Evidence. Claimant will be provided, as soon as possible, any new or additional evidence considered, relied upon, or generated by or at the direction of the Plan free of charge and pursuant to the regulatory guidance.

- (d) Disclosure of New or Additional Rationale. Claimant will be provided, as soon as possible, any new or additional rationale for the Adverse Benefit Determination free of charge and pursuant to regulatory guidance.
- (e) Decision. The review will be made by a person different from the person who made the prior determination and such person will not be a subordinate of the prior decision maker.
- (c) Consultation with Independent Medical Expert. In the case of a claim denied on the grounds of a medical judgment, a Healthcare Provider with appropriate training and experience will be consulted. The Healthcare Provider who is consulted on appeal will not be the individual who was consulted, if any, during the prior determination or a subordinate of that individual.

8.11 Filing a First Level Appeal. If there is an Adverse Benefit Determination or a denial of a Pre-Determination request, the Claimant may request a review by the Claims Administrator by filing a first level appeal.

- (a) A first level appeal request must be in writing and submitted to:

Mayo Clinic Health Solutions
4001 41st Street NW
Rochester, MN 55901-8901
Attn: Member Appeals

Special rule for expedited review of Urgent Pre-Service Claims under. A Claimant may request an expedited review orally or in writing and all necessary information (Including this Plan's benefit determination on review) will be transmitted by telephone, facsimile, or other available expeditious method.

- (b) A first level appeal must include the following information:
 - 8. the name of this Plan
 - 9. the identity of the Claimant, Including name, address, and date of birth
 - 10. information regarding the claim or Pre-Determination request being appealed, such as:
 - 1. for Post-Service Claims, a copy of the Explanation of Benefits or the claim number listed on the Explanation of Benefits
 - 2. for other types of claims, a copy of the Adverse Benefit Determination notice the Claimant received or other information to identify the claim
 - 3. for Pre-Determination requests, a copy of the denial letter
 - 4. a statement that the Claimant is requesting an appeal
 - 5. an explanation of why an appeal is being requested, Including the particular aspect of the Adverse Benefit Determination or denial of a Pre-Determination request the Claimant is disputing
 - 6. supporting documentation
- (c) A first level appeal of an Adverse Benefit Determination must be submitted to this Plan within 180 days following receipt of a notification of an Adverse Benefit Determination of a claim. *If a first level appeal is not requested within this 180 days, the Claimant loses the right to appeal.*
- (d) A first level appeal of a denial of a Pre-Determination request must be submitted to the Plan within 60 days following receipt of a denial of a Pre-Determination request. *If a first level appeal is not requested within this 60 days, the Claimant loses the right to appeal.*

8.12 Timeframes for First Level Appeals. A Claimant may voluntarily agree to extend the timeframes specified below to make a decision.

- (a) Post-Service Claims. This Plan will make a determination no later than 30 days from the date the first level appeal was received.
- (b) Pre-Service Claims. This Plan will make a determination no later than 15 days from the date the first level appeal was received.
- (c) Urgent Pre-Service Claims. This Plan will make a determination no later than 72 hours from the date the first level appeal was received.
- (d) Concurrent Care Claims.
 - (1) For a reduction or termination of coverage for a previously approved benefit, this Plan will make a determination sufficiently in advance to allow the Claimant to file a second level appeal and obtain a determination before the benefit is reduced or terminated.
 - (2) Where an extension is requested by the Claimant for coverage beyond the initially approved benefit:
 - 1. If the request meets the definition of an Urgent Pre-Service Claim, this Plan will make a determination within the Urgent Pre-Service Claim timeframe.
 - 2. If the request does not meet the definition of an Urgent Pre-Service Claim, the Plan will make a determination no later than 15 days from the date the first level appeal was received.
- (e) Pre-Determination Requests. The Plan will make a determination no later than 60 days from the date the first level appeal was received.

If this Plan is not able to determine the appeal within this time period, this Plan may take an additional period of up to 30 days to determine the appeal. If this additional time will be needed, this Plan will notify the Claimant prior to the expiration of the initial 60 day time period for determining the appeal.

8.13 Notification of Appeal Decisions.

- (a) When Notice Will Be Provided. Written or electronic notification of this Plan's determination will be provided in a culturally and linguistically appropriate manner to the Claimant for all appeals.
- (b) Content of Notification.
 - (1) Adverse Benefit Determination. The notification will include the following:
 - 1. the specific reason(s) for the Adverse Benefit Determination;
 - 2. reference to the specific Plan provision(s) on which the determination is based;
 - 3. a statement indicating entitlement to receive, upon request, and free of charge, reasonable access to or copies of all documents, records and other information relevant to the Claimant's claim for benefits;
 - 4. a statement regarding additional levels of appeal (if any) and the right to sue in federal court;
 - 5. disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Benefit Determination (or a statement that such information will be provided free of charge upon request);
 - 6. if the decision involves scientific or clinical judgment, an explanation of the scientific

or clinical judgment applying the terms of this Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

7. Disclosure of the availability of, and contact information for, any applicable office of health coverage consumer assistance or ombudsman to assist Members with the internal claims process and appeals and External Review process.

- (2) Not Adverse Decision. Notice will be provided that informs the Claimant the decision has been reversed, and the claim has been approved or under the Plan a Pre-Determination request has been approved.
- (3) Denial of Pre-Determination. The notification under the Plan will include the specific reason(s) for the denial.
- (4) Approval of a Pre-Determination. Notice will be provided that informs the Claimant the decision has been reversed, and the Pre-Determination request has been approved under the Plan.

8.14 Filing a Second Level Appeal. If there is an Adverse Benefit Determination or under the Plan a denial of a Pre-Determination appeal by the Claims Administrator on the first level of appeal, the Claimant may request a review by the Employer.

- (a) A second level appeal request must be in writing and submitted to:

Mayo Clinic Health Solutions
4001 41st Street NW
Rochester, MN 55901-8901
Attn: Member Appeals

Special rule for expedited review of Urgent Pre-Service Claims. A Claimant may request an expedited review orally or in writing and all necessary information (Including this Plan's benefit determination on review) will be transmitted by telephone, facsimile, or other available expeditious method.

- (b) A second level appeal must include the following information:
 8. the name of this Plan
 9. the identity of the Claimant, including name, address, and date of birth
 10. information regarding the appeal being appealed, such as a copy of the appeal denial letter
 11. a statement that the Claimant is requesting a second appeal
 12. an explanation of why a second appeal is being requested, including the particular aspect of the Adverse Benefit Determination or under the Plan denial of a Pre-Determination appeal being disputed; and
 13. supporting documentation
- (c) A second level appeal of an Adverse Benefit Determination must be submitted to this Plan within 180 days following receipt of a notification of an Adverse Benefit Determination at the first level of appeal. *If a second level appeal is not requested within these 180 days, the Claimant loses the right to appeal.*

- (d) A second level appeal of a denial of a Pre-Determination request must be submitted to the Plan within 60 days following receipt of a denial of a Pre-Determination at the first level of appeal. *If a second level appeal is not requested within this 60 days, the Claimant loses the right to appeal.*

8.15 Timeframes for Second Level Appeals. A Claimant may voluntarily agree to extend the timeframes specified below for this Plan to make a decision.

- (a) Post-Service Claims. This Plan will make a decision no later than 30 days from the date the second level appeal was received.
- (b) Pre-Service Claims. This Plan will make a decision no later than 15 days from the date the second level appeal was received.
- (c) Urgent Pre-Service Claims. This Plan will make a decision no later than 72 hours from the date the second level appeal was received.
- (d) Concurrent Care Claims.
- (1) For a reduction or termination of coverage for a previously approved benefit, this Plan will make a determination before the benefit is reduced or terminated.
 - (2) Where an extension is requested by the Claimant for coverage beyond the initially approved benefit,
 - a) If the request meets the definition of an Urgent Pre-Service Claim, this Plan will make a determination no later than 72 hours from the date the second level appeal was received.
 - b) If the request does not meet the definition of an Urgent Pre-Service Claim, the Plan will make a determination no later than 15 days from the date the second level appeal was received.
- (e) Pre-Determination Requests. The Plan will make a determination no later than 60 days from the date the second level appeal was received.
- (1) If the Plan is not able to determine the appeal within this time period, the Plan may take an additional period of up to 30 days to determine the appeal. If this additional time will be needed, the Plan will notify the Claimant prior to the expiration of the initial time period for determining the appeal.

8.16 Notification of Second Level Appeal Decisions. The Employer will provide notification of second level appeal decisions in accordance with the *Notification of Appeal Decisions* subsection above.

8.17 Filing a Request for Standard External Review. If there is an Adverse Benefit Determination by the Plan regarding medical judgment or a rescission, after the second level of appeal, the Claimant may request an External Review.

- (a) A Standard External Review request must be in writing and submitted to:

Mayo Clinic Health Solutions
 Attn: Member Appeals
 4001 41st Street NW
 Rochester, MN 55901-8901

- (b) An External Review must include the following information:

1. \$25 filing fee (check or money order made payable to the Plan). This filing fee will be refunded in the event the Adverse Benefit Determination is overturned upon External Review. (The maximum aggregate filing fee is capped at \$75 per Member per Coverage Year.)

2. The name of this Plan
3. The identity of the Claimant, Including name, address, and date of birth
4. Information regarding the appeal being requested for an External Review, such as a copy of the second level appeal denial letter
5. A statement that the Claimant is requesting an External Review
6. An explanation of why an External Review is being requested, Including the particular aspect of the Adverse Benefit Determination being disputed
7. Supporting documentation
 1. Generally, an External Review of an Adverse Benefit Determination must be submitted to this Plan within four (4) months following the date of receipt of a notice of a final internal Adverse Benefit Determination. There are a very limited number of circumstances where an External Review can be requested prior to a final internal Adverse Benefit Determination. Please contact the Claims Administrator for more information.

Claimants may not request an external review after the expiration of the four (4) month period.

8.18 Timeframes for Preliminary Review of Request for Standard External Review.

- (a) Within five (5) business days following the date of receipt of the External Review request, the Claims Administrator will complete a preliminary review of the request to determine whether:
 - (1) Claimant is (or was) covered under the Plan at the time the health care item or service was requested or provided;
 - (2) the Adverse Benefit Determination or the final internal Adverse Benefit Determination is not based on the fact that Claimant was not eligible for coverage under the Plan;
 - (3) Claimant has exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required); and
 - (4) Claimant has provided all the information required to process an External Review.
- (b) Within one (1) business day of the completion of its preliminary review, Claimant will be notified by the Claims Administrator of the results of the preliminary review.
 1. If Claimant's request is eligible for External Review, a notice will be sent informing Claimant of eligibility for External Review. Claimant's request is assigned by the Claims Administrator to an Independent Review Organization (IRO) to conduct the External Review. The Plan will contract with at least three (3) IRO's, and the Claims Administrator will rotate the External Reviews among the IRO's.
 2. If Claimant's request is complete but not eligible for External Review, a notice will be sent informing Claimant of non-eligibility for External Review. The notice will state the reasons for the request not being eligible for External Review and will provide contact information for the Employee Benefit Security Administration, toll free number 1-866- 444-EBSA (3272).

3. If Claimant's request is incomplete, a notice will be sent to the Claimant. The notice will describe the information, materials, etc. needed to complete the request. The Claimant will then be provided time to complete the request during the greater of:

1. The initial four month period within which to request an External Review; or
2. 48 hours (or as identified in the notice) after the receipt of the notice.

8.19 External Review Process Conducted by Independent Review Organization (IRO)

- (a) Upon assignment by the Claims Administrator, the IRO conducts the External Review of the Adverse Benefit Determination.
- (b) As part of their review, the IRO will utilize experts when appropriate to make determinations regarding the services being disputed. In addition, the IRO, when making their decision, may request additional information such as reports from appropriate health care professionals, evidence-based guidelines, and any applicable clinical review criteria developed and used by the Claims Administrator.

8.20 Timeframes for Independent Review Organization Determination.

Within 45 days after the IRO receives the request for External Review, the IRO will provide written notice of the final External Review decision.

8.21 Filing a Request for an Expedited External Review.

Under certain circumstances, an expedited External Review may be requested.

- (a) Claimant may request an expedited External Review when:
 - (1) An Adverse Benefit Determination involves a medical condition where the timeframe for completing an expedited internal appeal of an Urgent Pre-Service Claim would seriously jeopardize the Claimant's life, health, or ability to regain maximum function, and a request for an expedited internal appeal of an Urgent Pre-Service Claim has been filed; or
 - (2) A final internal Adverse Benefit Determination involves (i) a medical condition where the timeframe for completing a standard internal review would seriously jeopardize Claimant's life, health, or ability to regain maximum function, or (ii) an admission, availability of care, continued stay, or health care item or service for which Claimant received emergency services, but has not been discharged from a facility.

- (b) An expedited External Review request must be in writing and submitted to:

Mayo Clinic Health Solutions
 Attn: Member Appeals – Expedited External Appeal Request
 4001 41st Street NW
 Rochester, MN 55901-8901

3. An expedited External Review request must Include the following information:
 1. \$25 filing fee (check or money order made payable to the Plan.). This filing fee will be refunded in the event the Adverse Benefit Determination is overturned upon External Review. (The maximum aggregate filing fee is capped at \$75 per Member per Coverage Year.)
 2. The name of this Plan
 3. The identity of the Claimant, Including name, address, and date of birth
 4. Information regarding the appeal being requested for an External Review, such as a copy of the second level appeal denial letter
 5. A statement that the Claimant is requesting an expedited External Review

6. An explanation of why an expedited External Review is being requested, including the particular aspect of the Adverse Benefit Determination being disputed
7. Supporting documentation

8.22 Timeframe for Preliminary Review of Request for Expedited External Review.

- (a) Immediately upon receipt of the request for an expedited External Review, the Claims Administrator will determine whether the request meets the eligibility requirements (described above under the “Timeframes for Preliminary Review of Request for Standard External Review” section) for a standard External Review. The Claims Administrator will immediately notify Claimant of External Review eligibility.
- (b) Claimant will be notified by the Claims Administrator of the results of the preliminary review.
 - (1) If Claimant’s request is eligible for expedited External Review, a notice will be sent informing Claimant of eligibility for expedited External Review. Claimant’s request is assigned by the Claims Administrator to an Independent Review Organization (IRO) to conduct the expedited External Review. The Plan will contract with at least three (3) IRO’s, and the Claims Administrator will rotate the expedited External Reviews among the IRO’s.
 - (2) If Claimant’s request is complete but **not** eligible for External Review, a notice will be sent informing Claimant of non-eligibility for External Review. The notice will state the reasons for the request not being eligible for External Review and will immediately provide contact information for the Employee Benefit Security Administration, toll free number 1-866-444-EBSA (3272).
 - (3) If Claimant’s request is **incomplete**, a notice will be sent to the Claimant. The notice will describe the information, materials, etc. needed to complete the request. The Claimant will then be provided time to complete the request.

8.23 Expedited External Review Process Conducted by Independent Review Organization (IRO).

- (a) Upon assignment by the Claims Administrator, the IRO conducts the expedited External Review of the Adverse Benefit Determination.
- (b) As part of their review, the IRO will utilize experts when appropriate to make determinations regarding the services being disputed. In addition, the IRO, when making their decision, may request additional information such as reports from appropriate health care professionals, evidence-based guidelines, and any applicable clinical review criteria developed and used by the Claims Administrator.

8.24 Timeframes for Independent Review Organization Expedited Determination.

- (a) As expeditiously as the Claimant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for expedited External Review, the IRO will provide written notice to Claimant and the Plan of the final expedited External Review decision.
- (b) If the IRO’s notice of final expedited External Review decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to Claimant and the Plan.

8.25 Plan Interpretation. This Plan will be administered in accordance with its terms. The Employer, Claims Administrator and/or any other fiduciary acting as a fiduciary with respect to this Plan, to the extent that such individual or entity is acting in its fiduciary capacity, shall have the complete and final authority, responsibility, and control, in its sole discretion, to manage, administer and operate this Plan, to make factual findings, to construe the terms of this Plan, and to determine all questions arising in connection with the administration, interpretation, and application of this Plan, including the eligibility and coverage

of individuals and the authorization or denial of payment or reimbursement of benefits. All determinations and decisions will be binding on this Plan, Members, claimants, and all interested parties.

- 8.26 A Member's Right to Take Legal Action.** To the fullest extent permitted under applicable law, unless there are special circumstances, including circumstances described in Health Care Reform and regulatory guidance, the appeals process outlined above must be completed prior to initiating legal action regarding a claim for benefits. If a Claimant intends to initiate legal action, he or she must do so within two (2) years after receipt of a notification of an Adverse Benefit Determination at the second level of appeal. If, due to special circumstances, the Claimant was not required to complete the appeals process outlined above, legal action must be brought within two (2) years of the date the Claimant's claim for benefits was submitted to this Plan. *Claimants may not bring legal action after the expiration of the two-year period.*
- 8.27 Questions Regarding Claims and Appeals Procedures.** If a Claimant has any questions regarding these procedures, the Claimant should contact the Claims Administrator's Customer Service Department at the number listed in the *Introduction* section.

SECTION IX**COORDINATION OF BENEFITS****9.1 Coordination of Group Coverage.**

This COB provision does not apply to the outpatient Prescription Drug benefit.

If any Member is covered by another individual, group or government sponsored medical plan or by no fault automobile insurance that provides medical coverage, Members may get payment from those plans and this Plan.

The benefits paid from this Plan will be coordinated to pay up to 100 percent of the eligible charges. A plan without a coordinating provision similar to this Plan the person is enrolled in always pays first. Provided both plans have a coordination of benefits feature, payment will be made as follows:

- (a) The plan covering the person as an employee or retiree (if not eligible for Medicare) pays benefits first; the plan covering the person as an eligible dependent pays second.
- (b) If a child is covered under both parents' plans, the plan directly covering the parent whose birthday comes first during the calendar year is the primary plan. If both parents have the same birthday, the plan covering the parent longer pays benefits first. However, if the parents are divorced, the plan pays in this order:
 - (1) If the terms of a court decree have established one parent as financially responsible for the child's healthcare expenses, the plan of the parent with that responsibility is primary.
 - (2) The plan of the parent with custody of the child pays next.
 - (3) The plan of the stepparent married to the parent with custody of the child pays next.
 - (4) The plan of the parent without custody of the child pays last.
 - (5) If an adult child is covered as a Dependent under this Plan and as a Subscriber's Spouse by any other eligible employer-sponsored health plan other than this Plan, the plan covering the adult child as a Dependent who is a Subscriber's Spouse will pay first.

When a determination cannot be made, the plan that has covered the individual longer is primary. Coverage under any Workers' Compensation Act or similar law is primary.¹ Coverage under any No-Fault Act for auto insurance or medical payments or similar law is primary.

Special Rule for Coverage of Adopted Children: Coverage provided with respect to the birth of a child who is legally adopted by a Member as provided in the *Maternity* subsection of the *Schedule of Benefits* section shall be coordinated with any coverage of the birth mother, to pay up to 100 percent of the eligible charges. Notwithstanding the foregoing rules regarding which plan pays first, this Plan shall be secondary to the birth-mother's coverage, unless that coverage was made available pursuant to Arizona Statutes title 36, chapter 29, but not including coverage made available to persons defined as eligible for such coverage under section 36-2901, paragraph 6, subdivisions (b), (c), (d), and (e) of such law.

9.2 Medicare Order of Payment Rules for the Plan.

1. **Definitions.** For purposes of this section, the following terms will have the meanings given them below:
 1. Age 65 - the age attained at 12:01 a.m. on the first day of the month in which the Member or his/her Dependent reaches age 65.
 2. ESRD - end-stage renal disease.
 3. MSP - the Medicare Secondary Payer requirements under 42 U.S.C. § 1395y(b).
2. **The Plan Pays First; Medicare Pays Second.** The Plan is primary and pays first in the circumstances listed below. This means that the Allowed Charge will be paid by the Plan, and any remaining expenses not reimbursed by the Plan should be submitted to Medicare for supplemental reimbursement.
 1. Subscribers who continue working at and past age 65. This provision also applies with respect to Dependents who are covered by Medicare and the Plan when the Subscriber is still an Employee, regardless of whether the Subscriber is covered by Medicare.
 2. Members who have Medicare coverage due to a disability and the Subscriber is still an Employee.
 3. Members who have ESRD, provided the Plan shall be primary only for the first thirty (30) months of the Member's eligibility for or entitlement to Medicare due to ESRD.
3. **Medicare Pays First; The Plan Pays Second.** The Plan is secondary and pays second in the circumstances listed below. This means that any charges for medical care should be submitted to Medicare first, and any remaining expenses not reimbursed by Medicare should be submitted to the Plan for supplemental reimbursement.
 1. Subscribers who are no longer Employees (i.e., Subscribers who have retiree coverage or COBRA coverage) and are covered by Medicare. This provision also applies with respect to Dependents who are covered by Medicare who are receiving coverage through a Subscriber who is no longer an Employee.

Please note: If a Member Age 65 or older is covered as a retiree or Dependent of a retiree and is eligible for or entitled to Medicare but not actually covered under Medicare, Plan benefits may be reduced by the amount Medicare would have paid if Medicare coverage had been in effect.

 1. Members who have ESRD and who have been eligible or entitled to Medicare due to ESRD for thirty (30) months.
1. **Applicable Law.** This section is intended to comply with, but not provide coverage in excess of, MSP.

9.3 Medicaid Eligible Members.

- (a) In enrolling a Member or in determining or making any payments for benefits of a Member, the fact that the individual is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.
- (b) Benefit payments under the Plan will be made in accordance with any assignment of rights made by or on behalf of a Member as required by a state plan for medical assistance approved under

Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on August 10, 1993).

- (c) To the extent that a payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act for a Member's medical treatment for which the Plan would have had a legal liability to pay, benefits under the Plan will be paid in accordance with any applicable state law which provides that the state has acquired the right to payment for such medical treatment.

9.4 Subrogation and Reimbursement Under the Plan. There may be situations in which a Member has a legal right to recover the costs of his/her healthcare or medical expenses as a result of an Injury or Illness caused by or the responsibility of a third party. For example, if a Member is injured in a store, the owner may be responsible for the healthcare or other expenses for that Injury; if a Member is in a motor vehicle accident, another driver may be responsible; if a Member becomes sick or injured in the course and scope of employment, the employer or a workers' compensation insurer may be responsible for healthcare or other expenses from the Illness or Injury. If someone else is legally responsible or agrees to compensate any Member for Injuries or an Illness suffered by a Member, the Plan has the right to recover any and all benefits it has paid in connection with the Injury or Illness pursuant to A.R.S. 12-962. The Plan may enforce its right of recovery as allowed by A.R.S. 12-962 including the right to recover the cost of care if the Member, including dependent, or anyone acting on their behalf, actually receives payment from any source in the form of an award, damages, or settlement as a result of an Injury or Illness caused by, attributable to, or otherwise the responsibility of a third party or entity.

By enrolling and accepting coverage in the Plan, all covered Members agree to the following:

1. The entire amount collected by a Member from any source will be considered to be a first recovery of benefits paid under either the Plan regardless of the terms of any award, agreement, regulation, statute, etc., to the contrary. The fact that only a part of the payment or even none of the payment is allocated to medical, dental, or disability expenses does not affect the Plan's rights to recover all the benefits paid in connection with the Member's Injury or Illness. The Plan shall have a lien and a security in all such claims.
2. The Plan is entitled to reimbursement of all past, present and future medical expenses as a result of an Injury or Illness caused by, attributable to, or otherwise the responsibility of a third party or entity.
3. The Plan will be reimbursed 100 percent from any and all recovery before payment of any other existing claims including any claim made by a Member for general damages.
4. The Plan may collect the proceeds of any settlement or judgment recovered by a Member or the Member's legal representative regardless of whether the Member has been fully compensated or "made whole."
5. Every Member has an obligation to cooperate completely with the Plan. The Member must sign all documents that may be required and take any other action necessary to secure these rights under the Plan. In the event that the Member does not receive or accept any type of recovery, compensation, settlement or award and does not pursue legal action, the Member agrees that he or she will cooperate completely with the Plan's efforts to enforce its subrogation rights through legal action against a third party. Each Member also has an obligation to notify the Plan in writing immediately any time the Plan may have rights against another person or entity.
6. If a Member fails to immediately repay amounts owed to the Plan under this rule, the Plan may withhold any future payments from the Plan to satisfy the Member's obligation.
7. If a Member voluntarily accepts a lump sum or other settlement from any source without the Plan's consent, which may or may not cause either plan to lose its subrogation rights, the Plan

will have no obligation to pay any past, present, or future benefits or expenses relating to the Injury or Illness caused by, attributable to, or otherwise the responsibility of the other party. Past payments may be recovered from the medical provider.

The Plan's subrogation also applies to a Member's coverage under workers' compensation plans, disability, and lost time coverage, other substitute coverage, any other right of recovery, or any claim payment received from any motor vehicle insurance Including no-fault or medical payments insurance and uninsured or underinsured motorist coverage. In addition, it applies in the event a Member fails to obtain any mandated insurance coverage. The Plan reserves the right to recover expenses incurred on a Member's behalf even if the recovery is made by a family member if that recovery is based on a Member's Injuries or Illness. The Plan will represent itself in subrogation, reimbursement and intervention interests. Therefore, no reduction for attorney fees, costs, or expenses will be paid by the Plan or withheld from the Plan recovery.

- 9.5 Workers' Compensation.** Coverage under either the Plan is not in lieu of workers' compensation and does not affect any aspect of coverage under workers' compensation.

SECTION X**GENERAL PROVISIONS**

- 10.1 Applicable Law.** The Plan is intended to be construed, and all rights and duties hereunder are to be governed, in accordance with the laws of the State of Arizona, except to the extent such laws are preempted by the laws of the United States of America.
- 10.2 Conformity with Governing Law.** If any provision of the Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.
- 10.3 Section Titles.** Section titles are for convenience only and are not to be considered in interpreting the Plan.
- 10.4 No Guarantee of Employment.** Participation in the Plan will not be construed as giving a Member any right to continue in the employ of the Employer. Any Employee will remain subject to discharge by the Employer to the same extent had the Plan not been adopted.
- 10.5 Plan Provisions Binding.** The provisions of the Plan will be binding upon all Members and their respective heirs and legal representatives, upon the Employer, its successors and assigns, and upon the Claims Administrator and any other provider of services to either the Plan.
- 10.6 Construction of Terms.** Words of gender will include persons and entities of any gender. The plural will include the singular, and the singular will include the plural.
- 10.7 Non Discrimination Policy.**
- (a) The Plan will not discriminate against any Member based on race, color, religion, national origin, disability, gender, or age. The Plan will not establish rules for eligibility based on health status, medical condition, claims experience, receipt of healthcare, medical history, evidence of insurability, genetic information, or disability.
 - (b) The Plan is intended to be nondiscriminatory and to meet the requirements under applicable sections of the Code. If the Employer determines before or during any Plan year, that the Plan may fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated individuals, the Employer shall take such action as the Employer deems appropriate, under rules uniformly applicable to similarly situated Subscribers, to assure compliance with such requirements or limitation.
- 10.8 Erroneous Payments.** If the Plan makes a payment for benefits in excess of the benefits required by the Plan or makes a payment to or on behalf of an individual who is not covered by the Plan, the Plan shall be entitled to recover such erroneous payment from the recipient of such erroneous payment and/or the beneficiary of such erroneous payment.

SECTION XI**PLAN ADMINISTRATION**

- 11.1 Powers and Duties of Employer.** The Employer will have the powers and duties of the general administration of the Plan including the following:
- (a) The discretion to determine all questions relating to the eligibility of individuals to participate or remain a Member in the Plan and to receive benefits under such plans.
 - (b) To require any person to furnish such reasonable information as the Employer may request for the proper administration of the Plan as a condition of eligibility to participate as a Member under the Plan and to receive any benefits under such plan.
 - (c) To delegate to other persons authority to carry out any duty or power which would otherwise be a responsibility of the Employer under the terms of the Plan or applicable law.
 - (d) To maintain, or to delegate to others the duty of maintaining, all necessary records for the administration of the Plan.
 - (e) To interpret the provisions of the Plan and to make and publish such rules and procedures for regulation of the Plan and to prescribe such forms as the Employer deems necessary.
- 11.2. Records.** The Employer, the Claims Administrator and others to whom the Employer has delegated duties and responsibilities under the Plan shall keep accurate and detailed records of any matters pertaining to administration of the Plan in compliance with applicable law.
- 11.3 Release of Medical Information.** The Employer and Claims Administrator are entitled to receive information reasonably necessary to administer the Plan, subject to all applicable confidentiality requirements as defined in the Plan and as required by law, from any Healthcare Provider of services to a Member. By accepting coverage under the Plan, Members agree to sign the necessary authorization directing any Healthcare Provider that has attended or treated them, to release to the Employer and Claims Administrator upon request, any and all information, records or copies of records relating to attendance, examination or treatment rendered to Member. If the Member fails to sign the necessary authorization or otherwise inhibits the Employer and/or Claims Administrator from getting necessary information to pay claims, the Plan has no obligation to pay claims.
- 11.4 Assignment of Benefits.** The right to receive benefits hereunder is personal to that Member and may not be assigned, or be subject to anticipation, garnishment, attachment, execution, or levy of any kind, or be liable for the debts or obligations of a Member, except for assignment of the right to receive benefits to a Healthcare Provider of Healthcare Services. With respect to any assignment to a Healthcare Provider, that Healthcare Provider is subject to the same terms and conditions under the Plan as the Member.

SECTION XII**PLAN CONTRIBUTIONS**

- 12.1 Allocation of Plan Cost.** Prior to the start of each Coverage Year, the Employer will determine the aggregate cost necessary to provide the benefits under the Plan
- 12.2 Subscriber Contributions.** For each Coverage Year, the Employer will determine the amount of Subscriber contributions, if any, that Subscribers or any subgroup of Subscribers will be required to pay for coverage under the Plan. The portion of the cost of coverage for which the Subscriber is responsible may be paid on a pre-tax basis through a cafeteria plan of the Employer if such a plan is made available by the Employer and the Subscriber meets the eligibility requirements of the cafeteria plan.
- 12.3 Subscriber Contributions for Mid-month Enrollments and Changes.** Subscriber contributions are determined by the Employer based on the effective date of an enrollment or change. For mid-month effective dates, a pro-rated premium shall apply based on the number of days in the month in which the effective date occurs.
- 12.4 The Operating Expenses for the Plan.** Operating expenses may be paid either (1) out of Plan assets, if any, or (2) by Employer.
- 12.5 Plan Assets.** To the extent the Plan has assets, such assets shall be used for the sole and exclusive purpose of providing benefits under the Plan and defraying reasonable administrative costs of the Plan (Including disposition of Plan assets upon termination of the Plan).

SECTION XIII

AMENDMENT AND TERMINATION

- 13.1 Amendment.** The Employer reserves the right to amend or modify all or any portion of the coverage under the Plan at any time on a prospective basis; any such action being within its complete and sole discretion. The Employer must have valid and appropriate action taken by its managing body (e.g., Town Council) to amend the Plan.
- 13.2 Termination.** The Employer reserves the right to terminate all or any portion of the Plan at any time; any such action being within its complete and sole discretion. The Employer must have valid and appropriate action taken by its managing body (e.g., Town Council) to terminate the Plan.
- 13.3 Payment of Benefits After Plan Termination.** In the event of a termination of the Plan, benefits will be paid only for Covered Services incurred prior to the termination date.

SECTION XIV

HIPAA PRIVACY AND SECURITY

RESPONSIBILITIES OF MAYO CLINIC HEALTH SOLUTIONS AND THE PLAN

Effective April 14, 2004, the Privacy Rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") apply to certain portions of the Plan that constitute "covered entities" within the meaning of HIPAA (e.g., employer sponsored group health plans). For purposes of this Section, "Plan Sponsor" refers to the Employer as Plan Sponsor and as the entity capable of acting on behalf of the covered entity, the Plan.

14.1 Use and Disclosure of PHI. The Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

- (a) *Payment* includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:
1. Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);
 2. Coordination of benefits;
 3. Adjudication of health benefits claims (including appeals and other payment disputes);
 4. Subrogation of health benefit claims;
 5. Establishing employee contributions;
 6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
 7. Billing, collection activities and related health care data processing;
 8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;
 9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
 10. Medical necessity reviews or reviews of appropriateness of care or justification of charges;
 11. Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;
 12. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of provider and/or health Plan; and

13. Reimbursement to the Plan.

(b) *Health care operations* include, but are not limited to, the following activities:

1. Quality assessment;
2. Population-based activities relating to improving health or reduction health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
3. Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
4. Underwriting (except as prohibited under 45 C.F.R. Section 164.502(a)(5)(i)), premium rating and other activities relating to the creation , renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
5. Conducting or arranging for medical review, legal services and auditing function, including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
7. Business management and general administration activities of the Plan, including, but not limited to:
 1. Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;
 2. Customer service, including data analyses for policyholders;
8. Resolution of internal grievances.
9. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity under HIPAA or following completion of the sale or transfer, will become a covered entity.

14.2 Employer's Obligations. Under HIPAA, the Plan may not disclose PHI to the Plan Sponsor (as defined in the Privacy Rules under HIPAA) unless the Plan Sponsor agrees to certain conditions. As the Plan Sponsor, the Employer agrees to the following conditions, thereby allowing the Plan to disclose PHI to the Employer. The Employer will:

1. Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
2. Ensure that any agents, including a subcontractor, to whom the Plan provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Not use or disclose PHI for employment related actions and decision unless authorized by an individual;
4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
5. Report to the Plan any PHI use or disclosure, that is inconsistent with the uses or disclosures provided for, of which it becomes aware;
6. Make available to an individual for inspection and copying PHI about the individual as allowed by and in accordance with 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 disclosures;
9. Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and,
10. If feasible, return or destroy all PHI received for the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

14.3 Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained. In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

1. Human Resources Analyst – Benefits
2. HR Manager

The Plan Sponsor shall identify, by name, these persons in writing to the Claims Administrator.

14.4 Limitation of PHI Access and Disclosure. The persons described in Section 14.3 above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

14.5 Noncompliance Issues. If the person described in Section 14.3 above does not comply with this Article XIV, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including, but not limited to, disciplinary action against such person.

14.6 HIPAA Security. Effective April 20, 2006, the Security Rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") apply to this Plan.

(a) **Definitions.** For the purposes of this Article, the following terms shall have the meanings set forth in this Section.

- (1) **ePHI** means PHI maintained or transmitted in electronic media, including, but not limited to, electronic storage media (i.e., hard drives, digital memory medium) and transmission media used to exchange information in electronic storage media (i.e., internet, extranet,

and other networks). PHI transmitted via facsimile and voice over the telephone is not considered to be transmissions via electronic media.

- (2) **Summary Health Information** means “summary health information” as defined in 45 C.F.R. Section 164.504, which generally defines “summary health information” to include information, which may be PHI, that summarizes claims history, claims expenses, or the type of claims experienced by individuals receiving benefits under the Plan from which certain identifiers have been deleted.
 - (3) **Security Incident** means “security incident” as defined in 45 C.F.R. Section 164.304, which generally defines “security incident” to include attempted or successful unauthorized access, use, disclosure, modification, or destruction of ePHI.
 - (4) **Security Rule** means the Security Standards published on February 20, 2003 at 68 Fed. Reg. 8334 et seq. (45 C.F.R. Parts 160, 162 and 164) as hereinafter amended.
- (b) **Employer’s Obligations.** If the Employer creates, receives, maintains, or transmits ePHI (other than enrollment and disenrollment information and Summary Health Information, which are not subject to these restrictions), the Employer will:
- (1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI;
 - (2) Ensure that any agents, including subcontractors, who create, receive, maintain, or transmit ePHI on behalf of the Plan implement reasonable and appropriate security measures to protect the ePHI;
 - (3) Report to the Plan any Security Incident of which it becomes aware; and
 - (4) Implement reasonable and appropriate security measures to ensure that only those persons identified in Section 14.3 have access to ePHI and that such access is limited to the purposes identified in Section 14.4.

IN WITNESS WHEREOF, the MAYOR of the Employer has executed the foregoing Plan on behalf of the Employer on this 14 day of APRIL, 2016.

Town of Gilbert

BY:



Signature

John Lewis

Type or Print Name

Mayor

Title