



**Yavapai
Unified
Employee
Benefit
Trust**

Plan Document

July 2009
Revised



For claims information contact:

5810 West Beverly Lane

Glendale, AZ 85306

602-789-1170 800-762-2234

www.aeitpa.com

YAVAPAI UNIFIED EMPLOYEE BENEFIT TRUST

TO: All Covered Plan Members

The "YAVAPAI UNIFIED EMPLOYEE BENEFIT TRUST", has established this benefit Plan for the eligible employees and their eligible dependents. This plan of benefits is effective as of 12:01 a.m. Mountain Standard Time on July 1, 2009, at Prescott, Arizona.

Please read this booklet carefully as it will assist you in understanding the benefits provided by this Plan. This is a self-funded plan. All benefit payments are governed by this document and all future amendments. The purpose of this Plan document is to describe the provisions of the Plan which provide for payment of benefits for medical, dental and STD expenses. This Plan is maintained exclusively for the benefit of the Plan Members of the Yavapai Unified Employee Benefit Trust.

Your benefit Plan has been designed with cost containment features to ensure that coverage can continue to be provided to you at a reasonable cost. Not all health care services ordered by a Physician will be covered under the provisions of this Plan. Health care services may be subject to review by the designated medical review firm for medical necessity and appropriateness. You can assist in controlling costs by using this Plan and medical services responsibly and effectively.

Some of the ways you can help are:

- ◆ Receive approval from American Health Group prior to all surgical and diagnostic procedures.
- ◆ Receive care from a provider in the PPO network.
- ◆ Have surgery and x-ray/laboratory work done on an outpatient basis whenever possible.
- ◆ Review all Hospital and Physician billings and the Explanation of Benefits, to be sure you and the Plan have only been billed for the services you received.
- ◆ **TAKE CARE OF YOURSELF!** Eat right, control your weight, exercise, stop smoking, never drink and drive, and always wear your seat belt. Good habits will help you live a long happy life and will save money too!

Please become familiar with these benefits before you need them. Feel confident that should an accident or illness occur, this Plan is here to help you and your covered family members.

TO YOUR GOOD HEALTH

QUICK REFERENCE INFORMATION

Group Number	AEI 4100
Plan Sponsor / Plan Administrator	Yavapai Unified Employee Benefit Trust 146 South Granite Street Prescott, Arizona 86303 (928) 445-5400
Participating Employers <i>(Enrollment Changes / Contributions)</i>	Prescott Unified School District 146 South Granite Street Prescott, Arizona 86303 (928) 445-5400 Humboldt Unified School District 8766 East Highway 69 Prescott Valley, Arizona 86314 (928) 759-4000
Claims Administrator <i>(Claims Information)</i>	Administrative Enterprises, Inc. (AEI) 5810 West Beverly Lane Glendale, Arizona 85306-1800 (602) 789-1170 (800) 762-2234
<i>(Eligibility & Benefit Descriptions)</i>	AEI On-Line www.aeitpa.com Fax: (602) 789-9369
Medical Review <i>(Pre-certification, Second Opinions)</i>	American Health Group (AHG) 2152 South Vineyard #103 Mesa, Arizona 85210 (602) 265-3800 (800) 847-7605
Preferred Provider Organization <i>(Names of Physicians & Hospitals in the PPO Network)</i>	Blue Cross Blue Shield of Arizona P.O. Box 13466 Phoenix, AZ 85002 (800) 232-2345 www.azblue.com
Prescription Drug Program <i>7/1/09-12/31/09</i>	Caremark (800) 966-5772
<i>Effective 1/1/2010</i>	Informed Rx (800) 880-1188

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PREFERRED PROVIDER ORGANIZATION (PPO)

This Plan has incorporated the BlueCross BlueShield of Arizona Preferred Provider Organization (PPO) as part of the benefit design. PPOs are a group of hospitals, physicians, and other health care providers contracted to furnish medical care and supplies at negotiated rates. The PPO providers are listed as BC/BS "Preferred Care" providers" and the BC/BS "Participating Only" providers.

Use of BlueCross BlueShield of Arizona "Preferred Care" providers is referred to as "In-Network". By receiving your care and services from a "Preferred Care" provider, you will receive a higher level of benefits, and therefore have less out-of-pocket expense. **Please note:** BlueCross BlueShield of Arizona "Participating Only" providers are **NOT** considered "In-Network" and therefore would be payable at the lower benefit percentage.

A current listing of the BlueCross BlueShield of Arizona network providers will be given to you. Your employer's participation the PPO does not mean that your choice of providers will be restricted. You may still seek medical care from any eligible provider you wish. However, in order to avoid higher charges and reduced benefit payments, you are encouraged to obtain care from BlueCross BlueShield of Arizona "Preferred Care" providers whenever possible.

When you need medical care select a provider from your PPO directory and call BlueCross BlueShield of Arizona at (800)-232-2345 or at www.azblue.com to verify the doctor's current status as a network provider. Your ID card identifies the BlueCross BlueShield of Arizona network and it should always be presented when obtaining services. All BlueCross BlueShield of Arizona providers will submit your claim to Administrative Enterprises, Inc. (AEI) for payment consideration. AEI will process your benefits at the appropriate level and send you an "Explanation of Benefits" showing the payment calculation and the amount of "patient responsibility".

If the need for emergency medical care, due to a life threatening emergency, occurs outside of the Plan's PPO network, benefits may be paid at the higher PPO percentage if determined by the administrator that immediate medical attention was required due to an accident or illness which is serious enough to constitute an "emergency" as defined in this document.

If your PPO physician needs to refer you to another physician, admit you to a hospital, or obtain lab work, be sure that you are referred to a provider that participates in your PPO network. A referral from an in-network provider to any out-of-network provider (i.e., laboratory, radiology, physician, etc.) does NOT make the claim from the out-of-network provider payable at the in-network rate.

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

(BlueCross® BlueShield® of Arizona, an independent licensee of BlueCross BlueShield Association, does not provide administrative or claim payment services for Yavapai Unified Employee Benefit Trust, the Trust has assumed all liability for claims payment.)

MEDICAL REVIEW / PRE-CERTIFICATION

This Plan has contracted with American Health Group (AHG) to provide medical review and pre-certification of selected services. AHG will review proposed medical services to determine their medical necessity and appropriateness. This program is designed as a cost containment measure to maximize the Plan benefits and reduce unnecessary hospitalizations, surgical procedures and other diagnostic services. Once a pre-certification is received, it will be valid for ninety (90) days.

IMPORTANT: Pre-certification of a procedure does not guarantee benefits. All benefit payments are determined by AEI in accordance with the provisions of this Plan. Failure to comply with the pre-certification requirements will result in a twenty percent (20%) reduction in benefits (up to a maximum of \$1,000) or may disqualify the Covered Person for benefits.

1. *Pre-certification is required on the following:*
 - All diagnostic and all surgical procedures over one thousand dollars (\$1,000)
 - All non-emergency Hospital/Facility admissions
 - Air ambulance transfers from facility to facility
 - Psychological and neuropsychological testing
2. *Procedure for obtaining pre-certification:*
 - a. For non-emergency procedures and Hospital or Facility admissions, the Covered Person or their Physician must contact AHG prior to the admission or in advance of the procedure. AHG will review the request for services and contact your Physician for any records or additional information necessary for them to thoroughly evaluate the need for services.
 - b. For emergency Hospital/Facility admissions or emergency procedures the Covered Person, their Physician, the Hospital admissions clerk, or anyone associated with the Covered Person's treatment must notify AHG by telephone within forty-eight (48) hours of the procedure or the admission.
3. *Second Surgical Opinions*

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

In certain complex medical situations case management may become necessary. A case manager would be assigned to work with the patient, the family, the Physicians and the claims payor to coordinate a quality, timely and cost effective treatment plan.
5. *Appeal / Reconsideration Procedures*

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

American Health Group can be reached at: (602) 265-3800 or (800) 847-7605
2152 South Vineyard #103
Mesa, Arizona 85210

Benefit Eligibility Determinations can be obtained on AEI's website at www.aeitpa.com or through AEI's Benefit Fax Line at (602) 789-9369.

ARTICLE I

YAVAPAI UNIFIED EMPLOYEE BENEFIT TRUST SCHEDULE OF BENEFITS

MEDICAL BENEFITS Refer to your enrollment selection for applicable plan (1.01 or 1.02)

1.01 Standard Health Plan Option (PPO)

BASIC BENEFITS (No Deductible)	<u>In-Network</u>	<u>Out-Network</u>
Second Surgical Opinions: <i>(when required by American Health Group)</i>	100%	100%
Diagnostic X-Ray and Laboratory		
Illness/Injury: \$50 per Calendar Year	100%	100%
Routine Physicals/Tests: \$300 per Calendar Year	100%	100%
Routine Mammogram: <i>(age 35+)</i> \$82 per Calendar Year	100%	100%
Well Baby Care: <i>(birth to 18 mos)</i> \$1,000 per Newborn	100%	80%
Prostate Screening Test (PSA): <i>(age 50+)</i>	100%	100%
Colonoscopy: <i>(age 50+, one every 10 yrs, In-Network only)</i>	100%	N/A
Additional Colonoscopies: <i>(Major Medical co-insurance after deductible)</i>	80%	60%

MAJOR MEDICAL BENEFITS (Subject to Deductible)

Deductibles: *(In-Network and Out-of-Network Combined)*

Individual Deductible per Calendar Year	2009	\$ 250
Individual Deductible per Calendar Year	2010	\$ 350
Family Deductible per Calendar Year	2009	\$ 750
Family Deductible per Calendar Year	2010	\$ 1,050

Covered Percentages for Eligible Medical Expenses: 80% 60%

Co-insurance Maximum: When the total eligible medical charges exceed \$10,000 (**\$15,000 for Calendar Year 2010**) for In-Network and \$40,000 for Out-of-Network in a Calendar Year, eligible charges for the remainder of the Calendar Year will be paid at 100%, up to the Plan maximums.

(Deductibles, pre-cert penalties, mental health, substance abuse and chemical dependency are not included)

MENTAL HEALTH CARE and Substance Abuse or Chemical Dependency:

Inpatient:	80%	60%
Outpatient:	70%	50%

PRESCRIPTION DRUGS

Retail Drug Card:	30 day supply; Generic or Brand Name	
Co-Payment:	25% of the purchase price: Minimum \$15	
Mail Order Prescription Program:	For each 100 day supply	
Co-Payment:	Generic: \$30	Brand Name: \$60

1.02 High Deductible Health Plan Option (HSA)

Major Medical Benefits *(All eligible charges, including prescriptions, subject to Deductibles)*

Deductibles: Individual Deductible per Calendar Year		\$2,500
Family Deductible per Calendar Year		\$5,000
Out of Pocket Maximum: Individual per Calendar Year	\$2,500	\$10,000
Family per Calendar Year	\$5,000	\$20,000
Covered Percentages for Eligible Medical Expenses*:	100%	50%

*The above dollar limits shown under Basic Benefits for routine services also apply to this plan.

1.03 Lifetime Medical/Rx Plan Maximum: (applies to both Plans combined) \$2,000,000

1.04 Maximum Medical Benefits: (applies to both Plans)

Durable Medical Equipment		\$5,000 per item
Spinal Manipulations/Chiropractic		\$300 per Calendar Year
TMJ Treatment		\$2,000 per Lifetime
Home Health Care		\$10,000 per Calendar Year
Skilled Nursing Care		60 days per Calendar Year
Hospice Care		\$20,000 per Lifetime
Mental & Nervous Disorders, and Substance Abuse:	Inpatient	30 days per Calendar Year
		Two (2) confinements per Lifetime
	Outpatient	26 visits per Calendar Year
Rehabilitation Services:	Outpatient Maximum	\$1,500 per condition
	Inpatient Maximum	60 days per condition
	Total payable	\$1,000 per day

1.05 DENTAL BENEFITS

DIAGNOSTIC & PREVENTIVE CARE (not subject to the Deductible)

First examination, x-rays, cleaning, sealants and fluoride treatment in a Calendar Year 100%

INDIVIDUAL DENTAL DEDUCTIBLE PER CALENDAR YEAR \$100

BENEFITS SUBJECT TO DEDUCTIBLE:

Additional examinations / cleanings / x-rays	80%
Restorative Care	80%
Endodontics	80%
Oral Surgery	80%
Periodontics	50%
Prosthodontic/Prosthetics	50%
Orthodontics	50%

DENTAL BENEFIT MAXIMUMS:

Calendar Year Maximum - Includes all Dental Services \$1,500

Lifetime Maximum Orthodontic Benefit \$1,500

1.06 SHORT TERM DISABILITY BENEFIT

WAITING PERIOD: 90 Calendar days of Total Disability

BENEFITS PAYABLE:	Percentage Payable	60% of Salary
	Maximum Payable	\$925 per week
	Minimum Payable	\$50 per week
	Maximum Days Payable	90 Calendar days

OFFSETS: State Disability / Other Group Short Term Disability
Rehabilitation Income / No Fault Auto Insurance Benefits

ARTICLE II

ELIGIBILITY / EFFECTIVE DATE

2.01 Eligible Employee: An eligible employee shall include all full-time employees receiving a paycheck from their School District, provided they work the required hours per week, as defined by their employer, on a permanent basis at their customary place of employment. Employees who work with homebound disabled/handicapped students may be eligible with the approval of their District's Governing Board. The Districts require various premium contribution percentages depending on the number of hours an employee works.

If an employee has successfully completed his/her contract for the school year, coverage will continue based on each Participating Entity's policy. Dependent coverage can also be continued based on each Participating Entity's policy, provided the required contributions are made for each month.

2.02 Eligible Retiree: Retired employees are eligible to continue under the Plan provided:

- a] They are eligible for benefits under the Arizona Retirement System, and they have met the terms and conditions of retirement eligibility from their School District, or the employee is participating in the District's early retirement incentive program.
- b] They have accumulated the required number of years of service; and
- c] They were covered under the Plan on the day before retirement; and
- d] Any required contributions have been made; and
- e] The Retiree is not eligible for coverage under another group medical plan; and
- f] The Retiree is under age sixty-five (65).

Dependents of a Covered Retiree are eligible for coverage provided they were covered dependents of this Plan immediately prior to the date of the covered Employee's retirement. If a Retiree's coverage terminates or the Retiree's dependent coverage terminates for any reason, coverage cannot be reinstated at a later date.

2.03 Initial Enrollment: All new employees will be covered on the first of the month following their district's designated waiting period. For coverage under this Plan to begin, Employees must:

- a] Complete the proper enrollment forms; and
- b] Authorize any required contributions; and

All new enrollees are subject to the pre-existing limitations described in Article VII. Failure to enroll at Initial Enrollment means the individual must follow the Open Enrollment or Late Enrollment provisions to enroll in the Plan.

2.04 Declining Coverage: The Yavapai Unified Employee Benefit Trust allows eligible Employees to decline all or part of the coverage provided under this Plan. If an Employee wants to waive any of the coverage, the Employee will need to sign a waiver of coverage form with their District. If the Employee declines any coverage at Initial Enrollment, he/she may be able to enroll at a later date if they qualify under the Special Enrollment provisions or during the District's annual Open Enrollment.

2.05 Open Enrollment: The District provides an open enrollment period during which an employee may add or drop dependents to the Plan. Any changes requested during Open Enrollment will be effective based on each Participating Entity's policy. All new plan members/dependents are subject to the pre-existing limitation as described in Article VII.

2.06 Leave of Absence: If a Covered Employee is granted a leave of absence by the Governing Board, eligibility under this Plan will be extended to the Employee and his/her Covered Dependents during the continuance of the leave, provided the Covered Persons are not and do not become covered under any other Plan which entitles them to medical benefits. Eligibility will be extended for a maximum of twelve (12) months provided the required contributions are made.

2.07 Eligible dependents: The following dependents are eligible under this Plan provided the dependent can provide proof of their legal status in the United States. An eligible dependent shall include a Covered Employee or Covered Retiree's*:

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

If both a husband and a wife are Covered Employees, dependent children can be covered under this Plan by either parent, but **not** by both parents.

*The above dependents of a Covered Retiree can be covered under this Plan only if they were on this Plan prior to the date of the Employee's retirement. If a Retiree's coverage terminates or the Retiree's dependent coverage terminates for any reason, coverage cannot be reinstated at a later date. Covered Retirees are not allowed to add dependents

2.08 OBRA/QMCSO: This Plan adheres to the Federal OBRA and Qualified Medical Child Support Orders (QMCSO), rules and regulations. If an employee's separated or divorced spouse or any state child support or Medicaid agency has obtained a QMCSO, the employee will be required to provide coverage for any child(ren) named in the QMCSO. If a QMCSO requires that the employee provide health coverage for his/her child(ren) and the employee does not enroll them, the employer must enroll the child(ren) upon application from the separated/divorced spouse, the state child support agency or Medicaid agency and withhold from the employee's pay the cost of such coverage. The employee may not drop coverage for the child(ren) unless the employee submits written evidence that the QMCSO is no longer in effect. The Plan may make benefit payments for the child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such child(ren).

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

- a] Incapable of self-support due to a mental or physical handicap; and
- b] Became so disabled prior to the attainment of age twenty-four (24); and
- c] The Plan is provided with proof of the child's handicap and continued dependency within thirty-one (31) days prior to termination of the child's dependent status.

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

2.10 Dependent's Effective Date: If an employee has eligible dependents when his or her coverage begins, dependent coverage will begin on the same day as the employee's, provided:

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

2.11 Newborn Dependents: Newborn children will be covered from the time of birth for necessary medical care **only if:** a) the employee is carrying dependent coverage on the date of the baby's birth, or b) enrollment for dependent coverage is made *prior* to the baby's birth, or c) enrollment is made and required contributions are paid within thirty-one (31) days of the date of birth. When enrolling for the dependent coverage, coverage is effective from the baby's date of birth and contributions for the dependent coverage are required beginning the first day of the month following the date of birth.

"Routine" newborn charges incurred at a Hospital (DRG 795) at the time of birth will be considered under the mother's coverage and paid as part of the mother's claim, whether or not dependent coverage is in effect.

2.12 Special Enrollments for newly acquired Spouse or Dependent Child:

- a) If there are no eligible dependents when the employee's coverage begins, the employee can enroll a newly acquired spouse by marriage, or child by birth or adoption and/or any dependent children within thirty-one (31) days after he/she acquires the first eligible dependent.
- b) If the employee is not enrolled in the Plan and then acquires an eligible dependent by marriage, birth or adoption, they can enroll themselves and/or any eligible dependent.
- c) If the employee did not enroll their spouse when the spouse was initially eligible for coverage and the employee subsequently acquires an eligible dependent child, the spouse may be enrolled along with any dependent child.

For a, b & c above, coverage will be effective on the date the dependent is acquired, provided enrollment is completed within thirty-one (31) days of the acquisition of the eligible dependent.

Except for newborns and newly adopted children, anyone enrolling under the Special Enrollment provisions will be subject to the pre-existing limitation. If not enrolled within the thirty-one (31) day requirement, the Open Enrollment or Late Enrollment provisions must be followed to enroll in this Plan.

2.13 Special Enrollments due to Loss of Other Coverage: Individuals that do not enroll in the Plan during their initial eligibility period because at the time they have other creditable coverage, and then they subsequently lose that coverage as a result of certain events such as termination of spouse's employment, loss of eligibility for coverage, expiration of COBRA coverage, reduction in the number of hours of employment, or employer contributions towards such coverage terminated, may now enroll in this Plan. Enrollment in this Plan must be completed within thirty-one (31) days of coverage termination from the other Plan. Coverage under this Plan will become effective on the first of the month following receipt of the enrollment with Yavapai Unified Employee Benefit Trust. Failure to enroll under this Special Enrollment provision means you must follow the Open Enrollment or Late Enrollment provisions to enroll in this Plan.

2.14 Late Enrollment: If an employee or an eligible dependent are not entitled to Special Enrollment provisions as described above, they may enroll at anytime by completing the enrollment form with their employer and paying any required contributions. Coverage will be effective on the first of the month following the date the late enrollment form is received by their employer. The late enrollees will be subject to the pre-existing limitations for late enrollees described in Article VII.

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

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

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

Three rules apply to making changes to the benefit selections during the year otherwise the eligible employee or dependent will have to wait until Open Enrollment to make any change in coverage;

- a] Any changes to be made to the benefit selections must be necessary, appropriate to, and consistent with the change in status, and approved as such by the Plan Administrator its designee.
- b] The Plan must be notified in writing within thirty-one (31) days of the qualifying change in status
- c] For changes related to 2.15(g) in this Section, the Plan must be notified in writing within sixty (60) days of the qualifying change in status.

If a Covered Employee ceases to be an Employee and then returns to work, they will be required to take the same benefit election for the remaining portion of the Plan Year as they had before they terminated. Participation will be effective the first of the month following such election.

2.16 FMLA: In accordance with the "Family and Medical Leave Act of 1993" (FMLA), qualified employees are entitled to twelve (12) weeks of unpaid leave and can continue to maintain coverage under this Plan for the duration of the leave. During the leave the Yavapai Unified Employee Benefit Trust will continue Plan contributions for the Employee on the same terms as prior to the beginning of the leave. If the Employee has dependent coverage, the Employee will be responsible for making the required monthly dependent premium contributions.

If coverage for dependents is terminated for failure to make payments while the Covered Employee is on an approved family or medical leave, coverage for the eligible dependents can be automatically reinstated on the date the Covered Employee returns to active employment. The returning dependent will be subject to the pre-existing limitation as a "late enrollee". All accumulated annual and lifetime maximums will apply.

2.17 USERRA: The Uniformed Services Employment and Reemployment Rights Act (USERRA) may entitle qualified employees to continue their coverage. If called to active military service for up to thirty-one (31) days, coverage under this Plan will be continued. If called to active military service for a period exceeding thirty-one (31) days, coverage may be continued for up to eighteen (18) months. If the election to continue coverage was made after December 10, 2004, coverage may be continued for up to twenty-four (24) months. Any questions regarding this should be directed to the employer.

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

ARTICLE III

TERMINATION

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

- a] The date of termination of his/her employment;
- b] The date the employee ceases to be in a class of employees eligible for the coverage;
- c] The due date the employee fails to make any required contributions;
- d] The date the class of employees the employee belongs to is no longer considered an eligible class under this Plan;
- e] The date the employee voluntarily elects to be terminated from the Plan;
- f] The date the Fund or Plan terminates.

If an employee has successfully completed his/her contract for the school year coverage will continue based on each Participating Entity's policy. Dependent coverage can also be continued based on each Participating Entity's policy, provided the required contributions are made for each month.

3.02 If a Covered Certified Employee is granted a sabbatical leave, coverage may be extended to the Covered Employee and his/her Covered Dependents, provided they are not or do not become eligible for coverage under another group medical plan. Coverage will continue for up to twelve (12) months and contributions will be based on your districts policy. If the Employee continues dependent coverage, the Employee is responsible to pay the monthly cost of the dependent coverage. If the Employee fails to pay the required premium in any given month, the dependent coverage will be automatically terminated.

3.03 If a Covered Employee's coverage terminates while the employee is on a granted leave of absence or temporarily laid off, coverage will be reinstated on the first day of the month following the employee's return to active service in an eligible status provided:

- a] The employee returns to work immediately after cessation of either of the above events; and
- b] Contributions for his/her coverage are continued.

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

- a] The due date the retiree fails to make any required contribution;
- b] The date this Plan is discontinued with respect to the Employer;
- c] The date this Plan is discontinued with respect to the class of retirees to which such retiree belongs;
- d] The date the Covered Retiree voluntarily elects to be terminated from the Plan;
- e] The date the Covered Retiree becomes eligible for coverage under another group plan/policy;
- f] The date the Covered Retiree turns sixty-five (65); or
- g] The date the Fund or Plan terminates.

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

- a] The date the Employee's or the Retiree's coverage terminates;
- b] The date ending the period for which the last contribution is made for the dependent coverage;
- c] The date of termination of all or any dependent coverage under this Plan;
- d] The date on which he/she ceases to be an eligible dependent under this Plan;
- e] The date the dependent becomes eligible for coverage as an employee;
- f] The date the dependent of a Covered Retiree turns age sixty-five (65); or
- g] The date the dependent of a Covered Retiree becomes eligible for coverage under another group plan.

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

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

3.08 Upon termination of coverage, the Plan will issue a "Certificate of Creditable Coverage" that indicates the dates the Plan Member had coverage under this Plan.

ARTICLE IV

CONTINUATION OF COVERAGE (COBRA)

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

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

4.01 QUALIFIED BENEFICIARY

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

4.02 QUALIFYING EVENT

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

- a] If the employee is terminated for any reason other than gross misconduct;
- b] If the employee is made ineligible due to a reduction in work hours which puts him/her below the minimum hour requirements stated in the eligibility section of the Plan.

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

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

4.03 NOTIFICATION AND ELECTION

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

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

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

4.04 DURATION OF COVERAGE

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

- a] Employees and Qualified Beneficiaries who lose their coverage due to employment termination (for other than gross misconduct) or reduction of hours worked that makes them ineligible for coverage, are allowed continuation of coverage for a maximum period of eighteen (18) months.

If a Covered Employee or Covered Dependent is entitled to the eighteen (18) months of COBRA, that period can be extended for an additional eleven (11) months if a Qualified Beneficiary is determined to be entitled to Social Security disability benefits. The eleven (11) month extension is available to all the Qualified Beneficiaries in the family who have elected COBRA coverage (not just the disabled person). The following conditions must be satisfied:

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

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

- 1) The end of twenty-nine (29) months from the date of the qualifying event; or
- 2) The date the disabled person becomes entitled to Medicare; or
- 3) The date Social Security determines the individual is no longer considered disabled under Title II or XVI of the Social Security Act. Note: The disabled person is required by law to notify the Plan Administrator within thirty (30) days of any change in disability status.

- b] Qualified Beneficiaries due to any other Qualifying Event are allowed a continuation of coverage for a maximum period of thirty-six (36) months.
- c] If the employee's qualifying event is termination of employment or reduction of hours, and it occurred within eighteen (18) months of becoming entitled to Medicare, the COBRA coverage period for the qualified dependents will be either eighteen (18) months from the termination of employment or thirty-six (36) months from the earlier Medicare entitlement date whichever is longer. If Medicare entitlement occurred more than eighteen (18) months before termination of employment, this rule does not apply.
- d] If an individual was covered under Medicare due to End Stage Renal Disease (ESRD) at the time of the Qualifying Event, the Qualified Beneficiary would be eligible for COBRA for the full time allowed by law, however Medicare would become primary on the thirty-first (31st) month of the Medicare eligibility. If the COBRA participant becomes eligible for Medicare due to ESRD after their COBRA effective date COBRA would terminate on the date Medicare becomes effective.

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

4.05 *COBRA and FMLA*

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

- a] When the employee informs their employer that he/she is not returning at the end of the leave; or
- b] At the end of the leave, assuming the employee does not return; or
- c] When the FMLA entitlement ends.

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

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

4.06 *COVERAGE TERMINATION*

Coverage under COBRA will cease on:

- a] The last day of the month for which premiums have been paid;
- b] The date the Qualified Beneficiary becomes covered under another group health plan (whether as an employee or otherwise) provided that the other group plan does not contain an exclusion or limitation with respect to any pre-existing condition of such individual. In the event a pre-existing condition limitation applies, all Qualified Beneficiaries can remain on this Plan's continuation of coverage;
- c] The date the Qualified Beneficiary becomes entitled to Medicare Part A, Part B or both;
- d] The last day of the maximum period of continuation the Beneficiary qualified for;
- e] The date the employer ceases to maintain any group health plan for any employee;
- f] The 30th day following the month in which SSA determines the Qualified Beneficiary is no longer disabled, for those on the extended eleven (11) month continuation of coverage.

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

4.07 *COST OF COBRA CONTINUATION OF COVERAGE*

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

- a] The employee or the Qualified Beneficiary must make the initial payment within forty-five (45) days of notifying the Plan Administrator of their election to continue coverage. The initial payment must include all monthly premiums due back to the date regular coverage terminated.
- b] Future payments must be made within thirty (30) days of the scheduled due date.
- c] The due date for COBRA premiums is the first day of each month.
- d] Rates and payment schedules are established by your employer and may change when necessary due to Plan modifications.
- e] The cost to continue coverage is computed from the date coverage would have normally ended due to the Qualifying Event.
- f] Failure to make the first payment within forty-five (45) days or any subsequent payment within thirty (30) days of the established due date will result in the permanent cancellation of continuation coverage. Coverage will terminate retroactively to the last day of the month for which the last premium was paid.

- g] When a premium check is received timely, and that check subsequently is not honored by the bank (i.e.: the check bounces due to insufficient funds), the premium will not be treated as timely paid. The Qualified Beneficiary will be allowed to correct the payment provided it is done within the original thirty (30) day period following the premium due date.
- h] Payment of benefit claims filed during the sixty (60) day COBRA election period and the period before the first COBRA premium payment by an individual eligible to make an election, will be denied by the Plan until the individual both timely elects COBRA continuation coverage and pays the first required COBRA premium. Once a timely election is made and required premium payments are received, previously denied claims will be processed as if coverage had not been terminated. These benefit claims will not be paid if timely COBRA continuation coverage election and premium payments are not made.
- i] Legislative changes introduced in the American Recovery and Reinvestment Act (ARRA) included a provision to provide reduced COBRA premiums for "Assistance Eligible Individuals". This legislation provides for a sixty-five percent (65%) reduction in premium for a maximum period of nine (9) months for plan members who experience a COBRA-qualifying event between September 01, 2008 and December 31, 2009. To be considered an "Assistance Eligible Individual," plan members are required to meet **all** of the following requirements:
- You must lose coverage under this Plan as a result of an involuntary termination other than gross misconduct; and
 - The loss of coverage must occur between September 01, 2008 and December 31, 2009; and
 - You must timely elect to continue your benefit through COBRA; and
 - The reason your health benefits were terminated must be due to an involuntary termination of employment. An employer-imposed reduction of hours, which prompts a voluntary termination, may be a qualifying event.
 - You must not be eligible for Medicare; and
 - You must not be eligible for coverage under any other group health plan, such as a health plan sponsored by a new employer or your spouse's health plan.

For further information about ARRA or to determine whether you are an Assistance Eligible Individual, please contact the COBRA Administrator.

ARTICLE V

BASIC MEDICAL BENEFITS

If a Covered Person incurs charges for services and supplies described in this Article, the Plan will pay benefits at the percentage indicated in the Schedule of Benefits, not subject to the Plan Deductible. For the purpose of these benefits, for a charge to be considered eligible the charge must be: a) administered or ordered by a Covered Provider; b) medically appropriate; c) not of an experimental/investigational nature.

The Basic Benefits payable shall not exceed the maximums specified in the Schedule of Benefits. Unless otherwise indicated, Eligible Expenses that exceed the Basic Benefits will **not** be considered for benefits under the Major Medical section of the Plan.

5.01 *OUTPATIENT DIAGNOSTIC X-RAY AND LABORATORY*

Charges for outpatient X-ray and Laboratory services are payable when incurred for diagnostic or examination purposes related to an illness or injury, will be payable at one hundred percent (100%), up to the amounts specified in the Schedule of Benefits. Eligible charges in excess of the Basic Benefit will be eligible for coverage under the Major Medical Benefits section.

5.02 *ROUTINE PHYSICAL / WELLNESS BENEFIT*

Charges incurred for routine wellness care such as routine physicals and/or routine laboratory tests and x-rays will be payable at one hundred percent (100%) up to the amount specified in the Schedule of Benefits. This wellness benefit is to encourage routine annual checkups. Charges in excess of this Basic Benefit will be considered eligible under Major Medical **if** there is a medical diagnosis.

5.03 *ROUTINE MAMMOGRAMS*

Charges incurred for routine mammography screening procedures will be payable up to the amount shown in the Schedule of Benefits in accordance with the following guidelines:

Under age 35: One baseline mammogram will be eligible if the Covered Person has a family history of breast cancer, or had her first child after the age of thirty (30).

Age 35 and over: Annual Mammogram

Charges are payable at one hundred percent (100%), up to the amount specified in the Schedule of Benefits. Mammogram charges in excess of this Basic Benefit will be considered eligible under Major Medical **if** there is a medical diagnosis.

5.04 *ROUTINE PROSTATE SCREENINGS*

Charges incurred for routine prostate screening "Prostate Specific Antigen (PSA) test, will be considered an eligible expense for men age fifty (50) and older. Charges will be payable at one hundred percent (100%).

5.05 *ROUTINE WELL BABY CARE*

Charges incurred for well baby care (examinations and immunizations) during the eighteen (18) month period following the child's birth will be covered at one hundred percent (100%) up to the amount shown in the Schedule of Benefits.

5.06 *SECOND SURGICAL OPINIONS*

Charges incurred for a second surgical opinion prior to a proposed surgery are payable when a second opinion is required by the medical review company. The medical review company will direct the Covered Person to a surgeon that is not associated with the original Physician and one who specializes in treating the specific surgical problem.

5.07 *COLONOSCOPIES*

Colonoscopy benefits are provided at 100% with no deductible for covered persons over the age of 50, once every ten (10) years when performed by an in-network provider. Additional colonoscopies are payable at normal Plan co-insurance after the deductible is met.

ARTICLE VI

MAJOR MEDICAL BENEFITS

If, as a result of a covered injury or illness a Covered Person incurs charges for services and supplies described in this Article, the Plan will pay benefits, after the Deductible has been satisfied, at the percentage indicated in the Schedule of Benefits. For the purpose of these benefits, for a charge to be considered eligible the charge must be: a) administered or ordered by a Covered Provider; b) medically necessary; c) not of an experimental/investigational nature; d) not of a custodial nature; e) Reasonable and Customary treatment relative to the diagnosis; and f) a Usual and Customary amount for the service that is rendered or the item that is purchased, as determined by the Plan or its designee.

Any amounts charged that are in excess of what the Plan determines to be the Usual, Reasonable and Customary amount will not be eligible under this Plan. All expenses are subject to the exclusions, limitations and conditions stated elsewhere in this Plan. The Major Medical Benefits payable shall not exceed the maximums specified in the Schedule of Benefits and are subject to the specified deductible provisions. Unless otherwise stated, all benefits are calculated on a per Covered Person per Calendar Year basis.

PLAN DEDUCTIBLES:

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

6.02 Family Deductible: When the total eligible medical expenses that apply to the satisfaction of the Individual Deductibles exceeds the Family Deductible amount shown in the Schedule of Benefits, no further deductibles for any family member will be required for the remainder of the Calendar Year. If both husband and wife are Covered Employees, credit will be given towards the "Family Deductible".

6.03 Carry-Over Provision: Eligible Expenses incurred during the last three (3) months of the Calendar Year which are actually applied toward satisfaction of the deductible may be "carried over" towards satisfying the subsequent Calendar Year's Deductible. This provision applies only to the PPO plan, not to the High Deductible Health Plan Option (H.S.A.) plan.

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

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

6.06 Co-insurance Maximum: Co-insurance maximum is the total dollar amount shown in the Schedule of Benefits which is accumulated per person per Calendar Year in eligible expenses and paid at the co-insurance percentage, after which the Plan will pay eligible expenses for the remainder of the Calendar Year at one hundred percent (100%). Deductibles, expenses for mental health/substance abuse/chemical dependency, and penalties for noncompliance with precertification requirements do not accumulate toward the co-insurance maximum. The co-insurance maximums are separate for In-Network and Out-of-Network.

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

HOSPITAL / FACILITIES

6.07 Emergency Room: Charges by the Hospital for the use of the Hospital emergency room for appropriate medical charges necessitated by an acute medical emergency.

6.08 Hospice: Charges incurred for hospice care provided by an institution or agency licensed as a Hospice and certified to receive payment under Medicare, when it has been determined that the Covered Person has less than six (6) months to live. The care must be certified by the attending Physician, documenting the necessity of such care when traditional medical treatment and cure-oriented services are no longer medically appropriate due to the Covered Person's terminal condition. The plan of Hospice Care must be renewed in writing by the attending Physician every thirty (30) days. Hospice benefits are limited to twenty thousand dollars (\$20,000) per lifetime. Hospice care benefits cease if the terminal illness enters remission.

6.09 Inpatient Hospital: Inpatient Hospital charges for semi-private room and board, intensive care and miscellaneous Hospital services directly related to the treatment of the injury or illness that necessitated the confinement. Charges for a private room that exceed the cost of a semi-private room, are eligible only if prescribed by a Physician and the private room is medically necessary.

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

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

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

6.13 Urgent Care Centers: Services rendered at a freestanding urgent care facility when immediate medical attention is necessary.

SURGERY / ANESTHESIA

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

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

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

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

6.17 Organ Transplants: Charges incurred for non-experimental human to human organ or tissue transplants such as: Kidney; Cornea; Liver; Heart; Lung; Heart/lung; Pancreas; or Bone Marrow. Stem cell transplants for breast cancer are considered experimental/investigational by this Plan. Eligible transplants will only be covered if:

- a) The Covered Person is a likely candidate for a successful outcome of the procedure; and
- b) The Covered Person properly pre-certifies and maintains case management services throughout the course of the transplantation and post transplantation period as directed and coordinated by the Plan's medical review firm; and
- c) The procedure is performed at an In-Network facility known to have an effective program for doing such procedure. If there isn't an In-Network facility that is equipped to perform the transplant, Out-of-Network facilities may be eligible, if approved in advance by the Claims Administrator and if it is at a facility approved by the re-insurance carrier.

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

6.18 Reconstructive Surgery: Charges for reconstructive surgery provided:

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

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

If during the same surgical session multiple surgeries are performed through separate incisions, the allowable expense shall be calculated at the full Usual and Customary amount of the primary procedure, and at fifty percent (50%) of the Usual and Customary amount of each of the lessor procedure(s) that are through their own separate incision(s).

MEDICAL / PHYSICIAN SERVICES

6.20 Acupuncture: Charges incurred for acupuncture administered by a Medical Doctor (MD) or a Doctor of Osteopathy (DO) licensed for acupuncture.

6.21 Allergy Testing/Injections: Charges for initial allergy testing, and the cost of the resultant serum preparation and its administration, when rendered by a Physician, or in the Physician's office. Injections of food allergy antigens and the like are **not** considered eligible medical expenses. The allowance for antigens will be based on a three (3) month supply and a per vial cost.

6.22 Chiropractic: Charges for chiropractic care / spinal manipulations for the correction of structural imbalance, distortion, misalignment or subluxation of or in the vertebral column, by manual or mechanical means. Adjunctive modalities (massage therapy, hot / cold therapy etc) are not eligible expenses.

Eligible charges are limited to a maximum benefit payable of three hundred dollars (\$300) per person per Calendar Year. The initial examination and the initial set of x-rays for diagnosis of the condition are eligible but do not count towards the annual maximum.

6.23 Dialysis: Charges for dialysis are eligible medical expenses.

6.24 Home Health Care: Charges for home health care/home infusion services rendered by a licensed Home Health Care Agency which a Physician has prescribed and which is determined by the Plan or its designee to be medically necessary and the most appropriate care. Mileage charges may be eligible if the Covered Person resides in a remote area that does not have a local Home Health Care Agency. Charges for custodial care, mental health care, or substance abuse or chemical dependency treatment would not be eligible under this provision. Benefits under this provision are limited to ten thousand dollars (\$10,000) per Calendar Year.

6.25 Nutritional Counseling/Classes: Charges for diabetic nutritional counseling or classes will be payable up to two hundred dollars (\$200) per Plan Year.

6.26 Pathology / Radiology: Charges by a laboratory, a pathologist or a radiologist for diagnostic or curative services related to an illness or injury, when ordered by a Physician.

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

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

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

6.29 Speech Therapy: Charges made by a qualified speech therapist for restoration of normal speech or to correct dysphasic or swallowing disorders, when the loss or impairment is due to an injury, illness or surgery. The therapy must be prescribed by a qualified Physician. Speech therapy is **not** covered for the correction of stuttering, stammering, myofunctional or conditions of psychoneurotic origin.

6.30 TMJ: Surgical and/or nonsurgical care or treatment of jaw joint problems including Temporomandibular Joint Dysfunction or Syndrome (TMJ) and other craniomandibular disorders and reconstructive jaw and/or reconstructive orthognathic surgery, will be limited to a lifetime maximum payable of two thousand dollars (\$2,000). All treatment of jaw joint problems is subject to Plan approval **prior** to any services being rendered.

MATERNITY / FAMILY PLANNING

6.31 Abortions: Charges incurred for a *medically required* abortion for a Covered Employee or Covered Dependent Spouse when the continuation of the pregnancy would be life threatening to the mother. Complications of an abortion (including non-covered abortions) will be considered eligible expenses.

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

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

6.34 Newborns: Charges incurred at a Hospital for "routine" newborn care (DRG 795), including charges for a routine in-hospital exam by a pediatrician and routine circumcisions will be covered as part of the mother's maternity claim.

Any charges incurred by the newborn for other than routine care or for any routine care after discharge will only be covered if dependent coverage is in effect, or is added within thirty-one (31) days of the date of birth. These charges are subject to the newborn's own maximums and deductibles.

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

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

AMBULANCE

6.37 Charges by a licensed professional **ambulance** service as follows:

- a] Ground ambulance to the nearest appropriate Hospital within twenty-four (24) hours of an accident or of sudden onset of severe symptoms of an illness;
- b] Transfer by ground ambulance to the nearest Hospital with the necessary equipment, staff and facilities to treat the patient's condition if treatment cannot be performed at the initial Hospital;
- c] Ground ambulance service from the Hospital to the Covered Person's permanent place of residence will be covered if medically necessary as determined by the Plan or its designee;
- d] Transport by air ambulance will be an eligible expense as described in a & b above but only when medically necessary due to a life threatening condition.

MEDICATIONS / EQUIPMENT / SUPPLIES

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

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

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

6.41 Corrective Appliances / Prosthetics: Charges for corrective appliances and prostheses including the original fitting are eligible when medically necessary and ordered by a Physician. Charges will only be allowed for the standard model of the Corrective Appliance. The rental or purchase of a Corrective Appliance is at the option of the Plan, rental is payable only to the allowed purchase price. Charges will be allowed for replacement, adjustment and servicing of the appliance or prosthesis when necessary due to the growth of a covered child, or when the appliance has exceeded its maximum life expectancy.

6.42 Durable Medical Equipment: Charges for necessary Durable Medical Equipment (DME) as prescribed by a Physician. Charges will only be allowed for the standard model of the particular piece of equipment. The rental or purchase of DME is at the option of the Plan, and rental is only payable up to the allowed purchase price.

Charges will also be allowed for medically necessary adjustments, repairs or replacements, as determined by the Plan or its designee. Charges in excess of the five thousand dollars (\$5,000) Plan allowance may be considered eligible, however the item must be reviewed by the Claims Administrator and a determination made *prior* to the purchase or rental.

6.43 Medications: Prescription drugs and medicines, obtainable only upon a Physician's written prescription, approved by the U.S. Food and Drug Administration for the condition, dose, route and frequency, identified by a prescription number and dispensed by a licensed Pharmacist. Medications that can be purchased over-the-counter, including those that can be purchased in lesser strength (i.e. Ibuprofen, Motrin IB, Monistat etc.) or the generic of an over-the-counter are not eligible.

The Plan has contracted with a Prescription Benefit Manager (PBM) to provide Covered Persons an Rx card for purchasing prescriptions. Covered Persons present their Rx card to the Pharmacist and pay the co-pay percentage indicated in the Schedule of Benefits.

In addition, the Plan provides a mail order prescription plan. Covered Persons mail their prescriptions to the Prescription Benefit Manager (PBM), along with the co-pay indicated in the Schedule of Benefits, and then receive their drugs via the mail.

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

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

6.46 Oxygen: Charges for oxygen and the rental or purchase of the equipment to use it. The equipment is subject to the Plan's Durable Medical Equipment rules and maximum stated in 6.42.

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

MENTAL HEALTH CARE / SUBSTANCE ABUSE

6.48 Charges for Mental Health care and treatment of any type of substance abuse and chemical dependency are considered Eligible Expenses.

Facility charges for inpatient or residential treatment of mental and nervous disorders, chemical dependency or substance abuse, will be eligible when care is received at a licensed Hospital or a licensed treatment facility. Coverage is limited to thirty (30) days per Calendar Year and two (2) confinements per lifetime, subject to the annual and lifetime maximums shown in the Schedule of Benefits. Alternative outpatient facility/day programs/intensive outpatient programs (IOP) may be eligible under the inpatient benefit when provided in lieu of inpatient care and approved by the medical review company.

Out-of-pocket expenses related to the mental health care/chemical dependency/substance abuse do not count towards the Covered Person's co-insurance limit. Co-insurance limits do not apply to this provision and therefore benefit percentages would never increase.

Outpatient treatment for mental health care, treatment of chemical dependency or substance abuse or family counseling will be eligible when rendered by a licensed Psychiatrist or licensed Psychologist or by one of the following licensed counselors; Licensed Professional Counselor (LPC) or a Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Independent Substance Abuse Counselor (LISAC) or Licensed Psychiatric Nurse Practitioner (PSYNP). Treatment is eligible when rendered by the following counselors, provided the counselor is employed by and working under the direct supervision of a Psychiatrist or Clinical Psychologist:

- a] Master Social Worker (MSW)
- b] Master Science Nurse (MSN)
- c] Master of Arts in Guidance & Counseling (MA)
- d] Master of Education in Guidance & Counseling (MED)
- e] Master in Counseling (MA)
- f] Properly certified Behavioral Health Counselors and Family Therapists holding a Masters or Doctorate degree and accredited by the "American Association of Marriage and Family Therapists" accredited by the "National Academy of Counselors and Family Therapists, Inc."

Outpatient treatment is limited to twenty-six (26) visits per Calendar Year. Psychological testing and neuropsychological testing are only covered if it is mandated by the condition and is pre-certified by the medical review company. Medically necessary testing will be payable at a fifty percent (50%) benefit level.

ARTICLE VII

PRE-EXISTING CONDITIONS

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

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

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

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

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

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

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

ARTICLE VIII

GENERAL LIMITATIONS AND EXCLUSIONS

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

8.01 Services and supplies which are not medically necessary, as determined by the Plan or its designee, or are not necessitated as the result of existing symptoms of an illness or injury, or are not considered the standard medical treatment for the diagnosed condition.

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

8.03 Expenses associated with complications of a non-covered condition, illness, procedure or service.

8.04 Charges in excess of the Usual, Reasonable and Customary charge for services and supplies, or charges which exceed any Plan benefit limitation or maximum allowable benefit.

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

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

8.07 Charges for an illness or injury deemed to have arisen out of or in the course of doing any work for wage or profit whether or not such claim has been reported in accordance with the Worker's Compensation rules. No work related claim shall be payable under this Plan unless the injury or illness has been adjudged as non-occupational by the appropriate Worker's Compensation Board.

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

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

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

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

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

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

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

8.15 Examinations, vaccinations, inoculations or immunizations related to employment, premarital or pre-adoptive requirements, issuance of insurance, obtaining a license, judicial or administrative procedures, medical research or travel to foreign countries.

8.16 Examinations or visits not incidental to or necessary to diagnose an injury or illness except the coverage for the routine care specifically allowed in Article V.

8.17 Charges or treatment provided as a benefit under a program of the United States Government or State agency or political subdivision, including but not limited to active duty in the armed forces, Medicare, Medicaid, TriCare or any treatment paid for by any governmental program unless the Covered Person is legally required to pay.

8.18 Services received in a U.S. Department of Veterans Affairs (VA) Hospital or VA facility on account of a military service-related illness or injury are not payable by this Plan. Services received in a VA Hospital or VA facility for a non-military service related illness or injury are eligible under this Plan at the out-of-network benefit level.

8.19 Treatment of an illness or injury resulting from an act of war (whether declared or undeclared), invasion or aggression, or any atomic explosion or release of nuclear energy (except when used solely for the purpose of medical treatment).

8.20 Treatment of an illness or injury caused by participating in a civil insurrection or a riot.

ADDITIONAL EXCLUSIONS:

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

8.21 Abortions / elective termination of pregnancy and any complications thereof (except as covered under Article V, section 6.31).

8.22 Adoption charges and/or charges incurred by a surrogate mother.

8.23 Assistant surgeon charges when the need for an assistant is not documented.

8.24 Assistive / self-help devices which do not serve a primary medical purpose and instead ease the performance of activities of daily living, including but not limited to feeding utensils, reaching tools, devices to assist with dressing and undressing, etc.

8.25 Autologous blood donations are not covered unless the blood is actually used during a scheduled surgery.

8.26 Autopsies (unless required by the Plan).

8.27 Behavior modification type therapy, hypnosis, biofeedback, or charges considered educational (i.e. stress management, weight reduction, nutrition classes, etc.).

8.28 Breast reduction, breast augmentation, prophylactic breast removal, or breast reconstruction (except as covered under Article VI, Section 6.18). Charges related to the removal of breast implants that were inserted for cosmetic purposes, regardless of the reason for removal.

8.29 Chelation therapy, except when necessary for treatment of heavy metal poisoning.

8.30 Comfort items / Cosmetic; Charges incurred for surgery, supplies or any services which are primarily for personal comfort or cosmetic reasons, including, but not limited to, collagen injections, sclerotherapy, liposuction, tattoos or tattoo removal.

8.31 Cochlear implants or charges related to cochlear implants or any similar hearing implants or devices.

8.32 Cosmetic, plastic surgery, or reconstructive surgery or any complications thereof, except as covered under Article VI, Section 6.18.

8.33 Counseling charges incurred for career, sexual, social adjustment, financial or religious counseling.

- 8.34** Custodial care, charges made by an institution or part thereof which is primarily a place for rest, the aged, a hotel, health spa, fitness or weight reduction resort or similar institution or childcare, homemaker services or maintenance care.
- 8.35** Dental procedures or dental treatment of any kind, except as provided for under Article VI, Section 6.16 or under Article IX, Dental Benefits.
- 8.36** Disposable (non-durable) supplies, including but not limited to diapers, incontinence pads and bandages, except as covered under Article VI, Section 6.47.
- 8.37** Educational; Charges related to education, including but not limited to computers, software, books, special education tutoring, visual/auditory/speech aides, etc.
- 8.38** Elevators, chairlifts or other modifications to home, stairs or vehicles.
- 8.39** Exercise; Charges incurred or related to health club/exercise/gym memberships, aerobic and strength conditioning, back schools or back strengthening programs, massage therapy, rolfing, and exercise equipment rental or purchase.
- 8.40** Experimental / Investigational; Charges for services, procedures, equipment or supplies which are considered experimental or investigational as defined in Article XII, Section 12.31.
- 8.41** Eye care/Vision; Charges incurred for diagnosis or treatment relating to eye refractive error, orthoptic or visual training, vision therapy, testing for visual acuity, field charting or for eyeglasses or contact lenses or the fitting of such items, except as provided under Article VI, Section 6.40.
- 8.42** Eye surgery (Kerato-refractive surgery) to correct nearsightedness or farsightedness and/or astigmatism, including but not limited to Radial Keratotomy and keratomileusis surgery and refractive keratoplasties and LASIK surgery.
- 8.43** Genetic testing/screening due to family history or genetic services rendered during pregnancy (or in anticipation of a pregnancy), including tests and procedures performed for the purpose of detecting, evaluating or treating chromosomal abnormalities or genetically transmitted characteristics, except alpha-fetoprotein analysis.
- 8.44** Hair Loss; Services or supplies for the prevention or restoration of natural hair loss (i.e.: Rogaine, Minoxidil), or charges for hair transplants, wigs, toupees or hair weaving.
- 8.45** Health Maintenance Organization (HMO) providers when services are rendered to a covered HMO plan member.
- 8.46** Hearing examinations or examinations and charges related to the purchase, servicing or fitting of hearing aides.
- 8.47** Holistic services, supplies or accommodations provided in connection with holistic or homeopathic treatment or medicine.
- 8.48** Infertility; Charges related to the treatment of infertility, infertility drugs, artificial insemination, in-vitro fertilization, embryonic transfer, sperm banking, sperm washing or any other similar procedures (charges to diagnose the condition of infertility will be considered eligible expenses).
- 8.49** Learning / Developmental Disorders; Charges related to treatment or testing of learning disabilities, developmental disorders, dyslexia, ADHD, autism or mental retardation or any similar conditions. Charges for medications and for medical checkups to monitor medications for these conditions will be eligible.
- 8.50** Magnet therapy.
- 8.51** Maintenance rehabilitation therapy or therapy for coma stimulation, inpatient or outpatient.
- 8.52** Massage therapy (unless it is in conjunction with physical therapy and is performed by an eligible practitioner), rolfing and related services.

- 8.53** Maternity related charges for dependent daughters or any complications thereof.
- 8.54** Medical students, interns or residents.
- 8.55** Medications; Charges for experimental or non-prescription medications or charges for prescriptions to be used for an application that has not been approved by the FDA. Medications that can be purchased over-the-counter, including those that can be purchased in lesser strength (i.e., Ibuprofen, Motrin, Monistat etc.). Non-smoking aids, drugs for cosmetic purposes, weight control drugs or fertility agents.
- 8.56** Music therapy.
- 8.57** Myofunctional therapy or the treatment of tongue thrusts.
- 8.58** Naturopathic treatment or services rendered by a Naturopath.
- 8.59** Nutrition counseling, except as covered under Article VI, Section 6.25.
- 8.60** Occupational therapy, except as covered under Article VI, Sections 6.24 or 6.28.
- 8.61** Organ or tissue transplants (except as provided in Article VI, Section 6.17), including insertion or maintenance of an artificial heart or organ and charges for artificial, experimental or non-human body organs or tissue transplants.
- 8.62** Orthognathic surgery, except as covered under Article VI, Section 6.30.
- 8.63** Pain control services or supplies for treatment of chronic, intractable pain by a pain control center or under a pain control program.
- 8.64** Pediatrician charges for services as a standby pediatrician during childbirth unless a high risk factor was indicated during the covered pregnancy. To be eligible, the pediatrician must actually be present during the delivery.
- 8.65** Personal comfort items or devices which do not meet the definition of Durable Medical Equipment or Corrective Appliances including but not limited to air conditioners, air purifiers, dehumidifiers, water purification systems, waterbeds, airbed systems, cervical pillows, whirlpools, spas and the like.
- 8.66** Personal service items while confined in a Hospital or health care facility (i.e. guest meals, television, telephone, etc.).
- 8.67** Private duty nursing services while Hospital confined.
- 8.68** Prosthesis replacement unless necessitated by the growth of a child or the prosthesis has exceeded its maximum life expectancy.
- 8.69** Reversal surgery of any kind.
- 8.70** Sexual dysfunction or sexual inadequacy, including but not limited to sex change operations, medications, sex therapy, penile prosthetic implants or similar devices.
- 8.71** Sleep disorders; charges related to the diagnosis and treatment of sleep disorders, except in the case of sleep apnea.
- 8.72** Smoking cessation programs, aids, devices or drugs (i.e. Nicorette and Nicoderm).
- 8.73** Special Education; Charges made by a special education facility, tutor, behavior specialist or provider of any kind for testing or treatment of learning disabilities or developmental disorders.
- 8.74** Surrogate Mothers; Any and all costs for and relating to surrogate motherhood, or charges incurred by a Covered Person acting as a surrogate mother.

8.75 TMJ; charges for surgical or non-surgical care or treatment related to Temporomandibular Joint Dysfunction or Syndrome (TMJ), craniomandibular disorders, reconstruction of the maxilla or mandible for micrognathism, or retrognathism or orthognathic surgery, except as covered under Article VI, Section 6.30.

8.76 Transportation charges except for ambulance provided in Article VI, Section 6.37.

8.77 Travel charges (transportation, lodging, meals and related expenses) by a Covered Person, a Physician or any healthcare provider except as provided in Article VI, Section 6.24.

8.78 Vaccinations, inoculations or immunizations, except when necessary for treatment of exposure such as antirabies, tetanus, antivenin or immunoglobulin or except as covered under Article V, Section 5.02 and 5.05.

8.79 Vision; Charges incurred for diagnosis or treatment relating to eye refractive error, orthoptic or visual training, vision therapy, testing for visual acuity, field charting or for eyeglasses or contact lenses or for the fitting of such items.

8.80 Vitamins, nutritional supplements, minerals, diets, foods, infant formula and naturopathic or homeopathic services and/or substances whether prescribed by a Physician or purchased over-the-counter.

8.81 Virtual office visits, telephone or internet consultations.

8.82 Vocational training services or supplies

8.83 Weight Control/Obesity; Charges incurred for the care and treatment of obesity or primarily for weight control, including weight control drugs, supplies, supplements, substances, weight reduction programs or surgery, bariatric surgery including but not limited to gastric and/or intestinal bypass, gastric stapling or gastric balloon implants. Bariatric surgery may be eligible if the Covered Person;

- a) Is confirmed to be morbidly obese by two legally qualified Covered Physicians; and
- b) Has been one hundred (100) pounds over ideal weight for five (5) or more years; and
- c) Has tried weight reduction diets and/or medications under a Physician's care and failed to maintain weight loss and can provide proof of same; and
- d) Has underlying medical problems such as arthritis, hypertension, diabetes, or a strong family history of same, which present a life threatening situation; and
- e) The Covered Person has been on this Plan for a minimum of twenty-four (24) months; and
- f) The procedure is performed by In-Network providers (surgeons, assistant surgeons, anesthesiologists, etc.) at an In-Network facility.

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

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

The benefits payable for a bariatric surgery, gastric bypass, or any other type of surgical weight loss procedure are limited that such a Covered Person is only eligible for such benefits one (1) time during the life of the Covered Person.

ARTICLE IX

DENTAL BENEFITS

The Dental Benefits are payable in accordance with the Dental Schedule of Benefits in Article I and are subject to the Deductible, the Dental Limitations and Exclusions herein, and all other Plan provisions. The Calendar Year dental maximum stated in the Schedule of Benefits is the total of benefits payable for all dental services combined, including orthodontia.

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

9.01 DENTAL DEDUCTIBLE

The Dental Deductible is the amount of eligible Dental charges which must be incurred by each Covered Person each Calendar Year before benefits are payable. The Family Deductible amount applies collectively to all Covered Persons in the same family. When the Family Deductible is satisfied, no further Deductible will be applied for the remainder of the Calendar Year. The Dental Deductible does not apply to the initial exam, x-rays, cleaning, scaling and fluoride treatments.

9.02 INCURRED DATE

An eligible dental charge is considered incurred as follows:

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

9.03 DIAGNOSTIC AND PREVENTIVE Services

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

- a] Routine Oral Examinations
- b] Prophylaxis / Cleanings (periodontic cleanings can be substituted at the U&C of a routine cleaning)
- c] Topical fluoride treatments
- d] Full mouth and bitewing x-rays
- e] Sealants on permanent bicuspid and molars on children under age fifteen (15)
- f] Palliative treatment / emergency care to relieve pain when no other dental treatment is given.
(If other treatment, other than x-rays, is given, the amount of benefits paid for the pain care will be based on the category of that treatment.)

Diagnostic and Preventive Services - Limitations

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

9.04 RESTORATIVE Services

Charges incurred to restore teeth to normal contour and function.

Fillings: amalgam, synthetic, porcelain, plastic or composite materials.

9.05 ENDODONTIC Services

Charges incurred for the necessary examinations and procedures for diagnosis and treatment of diseases of the tooth pulp and/or infections of the root canal and periapical area.

- a) Pulp therapy and root canal treatment.

9.06 PERIODONTIC Services

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

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

Periodontic Services: Limitations / Exclusions

- a) Periodontal Prophylaxis are limited to once every six (6) months, not to exceed two (2) per Calendar Year.
- b) Surgical periodontal treatment is limited to once in a twenty-four (24) month period for each quadrant.
- c) Non-surgical periodontal treatment is limited to once per quadrant every twenty-four (24) months.
- d) Crown lengthening or single tooth gingivectomy are allowed once in conjunction with crown preparation.

9.07 ORAL SURGERY

Charges incurred for the necessary examination and procedures for treatment by extraction or other oral surgery not covered under periodontic services.

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

9.08 ORTHODONTIC SERVICES

Charges incurred for the detection, and active treatment and appliance for the correction of abnormalities of the teeth and malocclusion. All orthodontic services are subject to a separate orthodontic lifetime maximum.

- a) Active course of treatment shall mean any services for diagnostic casts, x-rays, records, tooth extraction or the placement of active orthodontic appliances. The active course of orthodontic treatment is the period which begins when the first orthodontic service is performed and ends when the last active appliance is removed.
- b) The initial banding will represent twenty-five percent (25%) of the total allowable charge for the total orthodontic treatment. Payments for the balance of the active orthodontic treatment will be processed on a monthly basis prorated over the total period of the orthodontic treatment plan.
- c) The orthodontic benefit maximum for a Covered Person for any one course of treatment will include the charges incurred for diagnosis, evaluation, pre-care and x-rays.

Orthodontic Services – Limitations

(All orthodontic services are subject to the lifetime maximums)

- a) Orthodontic treatment which commenced before the date the Covered Person became eligible under this Dental Plan will not be covered.
- b) Orthodontic treatment that will occasion major restorative dental work not ordinarily performed in general dentistry.
- c) Orthodontic treatment for cases in which the desired results are unlikely to be obtained, such as those with severe periodontal problems, poor bone structure or extremely short roots.
- d) Orthodontic treatment for patients with severe medical disabilities which may prevent satisfactory orthodontic results.
- e) Orthodontic treatment plans, which, in the opinion of the Plan, are unlikely to produce professionally accepted corrections of existing malocclusion.

- f] Charges for, to related to, Invisalign are not covered.
- h] Charges for orthodontia services furnished to an eligible dependent who becomes covered for Dental benefits more than thirty-one (31) days after he or she was eligible for such coverage will not be covered until the dependent has been covered under this Plan for twenty-four (24) months. The twenty-four (24) month waiting period can be reduced by providing a Certificate of Creditable Coverage from the Plan Member's prior dental carrier.

9.09 **PROSTHODONTIC Services**

Charges incurred for the necessary procedures or techniques concerned with the restoration and replacement of teeth. Dental prostheses may be either fixed or removable.

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

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

1. Placement is due to the extraction of one or more natural, injured or diseased teeth, which occurs on or after the Covered Person's effective date on the Plan; and
2. Placement of bridge or denture includes replacement of extracted tooth; and
3. Bridge or denture is placed within twelve (12) months after the extraction.

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

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

Prosthodontic Services - Limitations / Exclusions

- a] Temporary full or partial dentures are not covered.
- b] Charges for replacement due to loss or theft of denture or fixed bridge is **not** covered.
- c] Implants are only payable up to the benefit that would be allowed for a comparable partial denture.
- d] Anterior space maintainers are not covered.
- e] Replacement of an existing bridge or denture that can be made satisfactory is not covered.
- f] Replacement of a denture for which benefits were paid under this Plan, if such replacement occurs in a period which is less than five (5) years from date of initial placement unless:
 - a. Such replacement is necessary due to the initial placement of an opposing full denture or extractions of natural teeth; or
 - b. The denture is a stayplate or a similar temporary partial denture, and is being replaced by a permanent denture; or
 - c. The denture, while in the oral cavity, has been damaged beyond repair as a result of injury while the individual is a Covered Person.
- g] Dependents who become covered for Dental benefits more than thirty-one (31) days after he or she was eligible for such coverage, will not be eligible for dentures or bridges for the first twenty-four (24) months of coverage. The twenty-four (24) month waiting period can be reduced by providing a Certificate of Creditable Coverage from the Plan Member's prior dental carrier.

9.10 GENERAL DENTAL LIMITATIONS AND EXCLUSIONS

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

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

ARTICLE X

SHORT TERM DISABILITY

If a Covered Employee becomes "Totally Disabled" and is unable to perform all the duties of his/her job, the Covered Employee will be eligible for Short Term Disability (STD) Benefits, provided he/she is under the regular care of a Physician and all terms and conditions of this program have been met. Benefits payable are listed in Article I, Schedule of Benefits.

10.01 *SHORT TERM DISABILITY TERMS*

Benefit Period shall mean the maximum number of days during which disability benefits are payable. The benefit eligibility period is from the first day of disability through the one hundred and eightieth (180th) day of disability.

Contract Year and Contract Day(s) shall refer to the employee's employment contract with their School District.

Covered Employee shall include active employees that have met all probation requirements and have been employed on a full-time permanent basis for ninety (90) days.

Earnings shall mean the basic weekly compensation exclusive of overtime, bonuses or commissions, or any other compensation outside of their employment with their School District. Benefit payments will be calculated in accordance with each Covered Employee's employment contract. Disability benefits will not be paid during any period that an employee is not under contract or during any period when an employee would not have normally received a paycheck.

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

Regular Physician Care shall mean the Covered Employee is being seen by his/her Physician on a regular basis of a frequency deemed appropriate for the disabling condition and at intervals necessary for the Physician to verify the continuing state of disability. For the purpose of this benefit, the Covered Employee must be seen by his/her Physician a minimum of once every thirty (30) days.

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

Waiting Period shall mean the number of consecutive contract days a Covered Employee must be Totally Disabled before benefit payments begin.

10.02 *REQUIREMENTS TO ESTABLISH A SHORT TERM DISABILITY CLAIM*

1. The disabled employee must submit a disability claim form to the Claims Administrator, completed by the employee, the employer and the attending Physician. All three sections must be completed and signed by the persons indicated. The initial claim form must be submitted within ninety (90) days of the date the disability began.
2. In order for benefit eligibility to be established, the employee may be required to furnish copies of his/her medical records.
3. Any employee claiming disability may be subject to medical review at the Claims Administrator's request. Case review may be done by a Utilization Review company who may require the employee to submit to a medical evaluation for the purpose of a second opinion.
4. During the course of the disability benefit period, periodic requests will be made for updated medical information to establish continued disability status.
5. A Waiting Period of ninety (90) days must be met before disability benefits can be considered.
6. If a disabled employee returns to full-time work for ten (10) days or less during his/her Waiting Period, and then becomes disabled for the same condition, the Waiting Period will be extended by the number of days the employee returned to work (plus any weekends in between).
7. If a disabled employee returns to full-time work for more than ten (10) days during his/her Waiting Period, and then becomes disabled for the same condition, the employee will be required to satisfy a new Waiting Period in its entirety.
8. If an employee returns to work for at least one (1) full day and becomes disabled for a new and totally unrelated condition, a new Waiting Period must be satisfied and a new benefit period may be payable.

10.03 *BENEFIT CALCULATIONS*

1. The disability benefit will be calculated at sixty percent (60%) of the Covered Employee's weekly earnings. The weekly earnings will be the amount the Covered Employee was earning at the time the disability began. Disability benefit payments will not be affected by statutory or cost of living increases. Benefits payable are subject to the minimum and maximum amounts stated in the Schedule of Benefits.
2. Disability benefit calculations and waiting periods will be based on the same time period as the Covered Employee's employment contract. Benefits will not be payable prior to the beginning date of an employment contract nor after the termination of an employment contract.
3. Disability benefits will begin after the Waiting Period of ninety (90) days has been met.
4. Disability benefits will be payable for up to a maximum of ninety (90) days or until the employee returns to work, or the Covered Employee is eligible for the Arizona State Long Term Disability benefits, or until the Covered Employee is no longer disabled (whichever occurs first).
5. Benefits will not be payable concurrently with retirement benefits.
6. Disability benefits shall be reduced by income received from any of the following sources:
 - Disability benefits provided by no-fault auto insurance
 - Social Security disability benefits
 - Rehabilitation Income
 - Any salary, wages, commission or similar compensation payments
 - Loss of time benefits provided by any other group insurance contract

If any of the above sources of income are received in a lump sum, the offset amount will be prorated over the number of weeks for which it represented. In no event will the benefits payable under this Plan be less than fifty (\$50) dollars per week after the above offsets are applied.

10.04 *SHORT TERM DISABILITY CONTINUATION OF BENEFITS*

1. Disability benefits will continue to be paid up to the maximum of days indicated in the Schedule of Benefits, provided the Covered Employee is continuously and Totally Disabled and meets all the eligibility requirements of this Plan.
2. Any employee claiming disability benefits may be subject to medical review at the request of the Claims Administrator, and a second medical opinion may be required.
3. If during the course of a disability benefit period the employee returns to active full-time or part-time work for thirty (30) days or less and then becomes disabled for the same or related condition, the reoccurrence will be considered a continuation of the original disability and therefore part of the same benefit period. A new Waiting Period will not be required and the benefits payable will be the remaining balance of the total allowable benefit days.
4. If the disabled employee returns to active employment for more than thirty (30) days and becomes disabled due to the same or related condition, benefits will only be payable if the reoccurrence of the disability is separated by six (6) months or more. Benefits will be subject to a new Waiting Period and a new benefit may be payable.

10.05 *SHORT TERM DISABILITY LIMITATIONS AND EXCLUSIONS*

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

- A disability that began prior to the commencement of the employee's employment contract.
- Any disability that is considered to be due to a pre-existing condition as defined in Article VII.
- Injury or illness which arises out of, or occurs in the course of doing any work for wage or profit.
- Any injury or illness for which the employee is entitled to benefits under the Workers Compensation Act or similar legislation.
- Civil disorder or riot, war or service in the Armed Forces.
- Commission of an illegal act.
- Self-inflicted injury or illness.
- Disability related to elective cosmetic surgery.
- Treatment received for an injury or illness sustained while incarcerated or sustained during the commission of, or the attempted commission of, an assault, a felony or other criminal act whether or not there is a criminal charge or a conviction of a crime, if the offense is defined as a criminal act by the state in which the incident occurred, including injuries received while operating a motor vehicle in an illegal manner, driving while under the influence of alcohol or illegal drugs, negligent driving or driving at excessive speeds.

10.06 *SHORT TERM DISABILITY TERMINATION OF BENEFITS*

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

- The date the Covered Employee is no longer disabled; or
- When the consensus of medical experts determine that the employee is no longer disabled; or
- The date the Covered Employee fails to furnish the proper documentation that he/she continues to be disabled; or
- The date the maximum number of benefit days has been paid; or
- The date the Covered Employee is eligible for the State of Arizona Long Term Disability Plan; or
- The date the employee becomes eligible for retirement benefits; or
- The date the employee fails to make any required contributions

ARTICLE XI

COORDINATION OF BENEFITS

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

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

11.01 GENERAL TERMS / PROVISIONS

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

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

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

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

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

11.02 ORDER OF BENEFIT DETERMINATION

This Plan follows the COB guidelines established by the National Association of Insurance Commissioners (NAIC):

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

2. When Dependent children are covered under more than one plan as a result of a divorce or legal separation, the Primary Plan order of responsibility will be determined as follows:
 - a] First: The plan where the dependent child is covered as a result of a divorce decree or court ordered "Qualified Medical Child Support Orders" (QMCSO) which establishes financial responsibility for the medical or dental expenses.
 - b] Second: The plan of the natural or adoptive parent who has custody of the Dependent child.
 - c] Third: The plan of the stepparent, provided the child's permanent primary residence is with the stepparent.
 - d] Fourth: The plan of the natural or adoptive parent who does not have custody.
 - e] Fifth: Joint Custody; When the court decree does not specify which parent is responsible for the child's health care expenses, the "Birthday Rule" as defined above will apply.
 - f] If none of the above determine which plan is Primary, the plan covering the Dependent child the longest will be Primary.

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

11.03 COORDINATION WITH MEDICARE

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

Medicare Order of Benefit Determination:

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

11.04 PAYMENT TO THIRD PARTIES

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

ARTICLE XII

DEFINITIONS

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

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

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

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

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

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

12.06 CHIROPRACTOR is a practitioner duly licensed by the state (and acting within the scope of such license) to practice the science of chiropractic medicine.

12.07 CLAIMS ADMINISTRATOR means the company employed by the Plan who is responsible for the processing of claims and payment of benefits, administration, accounting and reporting as contracted for by the Plan. This Plan's Claims Administrator is Administrative Enterprises, Inc. (AEI).

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

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

12.10 CO-INSURANCE MAXIMUM means the total dollar amount of eligible charges shown in the Schedule of Benefits which is accumulated per person and paid at the co-insurance percentage, after which the Plan will pay eligible charges for the remainder of the Calendar Year at one hundred percent (100%). Expenses for deductibles, mental health care / substance abuse / chemical dependency, and penalties for noncompliance with pre-certification requirements do not accumulate toward the co-insurance maximum.

12.11 CORRECTIVE APPLIANCE means items which are prosthetic or orthotic and necessary for the restoration of function or replacement of body parts as:

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

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

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

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

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

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

12.16 COVERED RETIREE shall refer to a Covered Employee who has met the terms and conditions for retirement eligibility or early retirement eligibility of their School District.

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

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

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

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

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

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

12.23 ELIGIBLE EXPENSES shall mean expenses for services and/or supplies prescribed by a Physician for an injury or illness covered under this Plan. For the purpose of these benefits, for a charge to be considered eligible the charge must be: a) administered or ordered by a Covered Provider; b) medically necessary; c) not of an experimental/investigational nature; d) not of a custodial nature; e) Reasonable and Customary treatment relative to the diagnosis; and f) a Usual and Customary amount for the service that is rendered or the item that is purchased, as determined by the Plan or its designee. Charges for routine wellness will also be considered eligible expenses to the extent they are covered under Article V, Sections 5.02, 5.03, 5.04, and 5.05. Eligible charges shall not include expenses which are specifically excluded or reduced as a result of specific Plan requirements not satisfied.

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

12.25 EMERGENCY HOSPITALIZATION OR CONFINEMENT shall mean a Hospital admission which takes place within twenty-four (24) hours of the onset of a sudden and unexpected severe symptom of an illness or within twenty-four (24) hours of an accidental injury during a life threatening situation.

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

12.27 EMPLOYER as used herein shall mean the participating School District the employee works for.

12.28 ENROLL means to make written application for coverage on the prescribed forms within the stipulated timeframes.

12.29 ENROLLMENT DATE is the Covered Person's effective date on this Plan or if earlier, the first day of the waiting period for this coverage.

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

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

- a] Is considered by any governmental agency, such as the Food and Drug Administration (FDA), the National Institute of Health (NIH), or The Centers for Medicare and Medicaid Services (CMS) as noted in the Medicare Coverage Issue Manual, to be experimental or investigational; or
- b] Cannot be lawfully marketed without approval of the Food and Drug Administration and approval for marketing has not been given at the time a drug or device is furnished; or
- c] "Reliable evidence" shows that the drug, device or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; or
- d] "Reliable evidence" shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; or
- e] Do not have a documented success ratio of fifty percent (50%) for a period of two (2) years.

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

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

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

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

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

12.34 HOME HEALTH SERVICES shall mean the items and services which are furnished to a Covered Person who is under the care of a Physician. Such items and services may be furnished by a licensed Home Health Agency or by others under arrangements made by such an agency, under a plan established and periodically reviewed by such Physician. Such items and services shall be furnished on a visiting basis in the Covered Person's home or, if necessary, at the nearest facility equipped to provide such services when not available at the Covered Person's place of residence, and shall consist of:

- a] A visit by a representative of a Home Health Agency of four (4) hours or less shall be considered as one (1) Home Health care visit.
- b] Part-time or intermittent nursing care provided by or under the supervision of a Registered Nurse; physical therapy, occupational therapy, speech therapy, and part-time or intermittent services of a home health aide, all of whom must be licensed to perform such services. Such items and services may further consist of any or all of the following:
 - 1) Medical social services under the direct supervision of a Physician;
 - 2) Medical supplies (other than drugs and biologicals), and the use of medical appliances while under such a plan;
 - 3) In the case of a Home Health Agency which is affiliated or under common control with a Hospital, medical services provided by an intern or resident in-training of such Hospital.

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

- a] Inpatient or outpatient care, home care, nursing care, counseling and other supportive services and supplies provided to meet the physical, psychological, spiritual and social needs of the dying Covered Person; and
- b] Instructions for care of the patient, counseling and other supportive services for the family of the dying Covered Person.

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

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

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

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

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

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

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

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

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

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

12.43 IN-NETWORK for medical services refers to the BlueCross BlueShield of Arizona "Preferred Care" providers.

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

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

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

12.46 LIFE THREATENING means unexpected, acute, sudden and serious conditions (including maternity related conditions) which require *immediate* medical treatment.

12.47 LIFETIME means the period of time an eligible Plan Member has been covered under this Plan or any other medical plan sponsored by the Yavapai Unified Employee Benefit Trust.

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

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

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

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

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

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

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

12.53 NEWBORN NURSERY CHARGES means the room and board and miscellaneous charges made by a Hospital for the care (DRG 795), other than for an illness or injury, of a newborn baby immediately following birth.

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

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

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

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

12.58 *ORTHOTICS* means a corrective appliance customized and dispensed by a certified orthotics laboratory to support weakened feet.

12.59 *OUT OF POCKET MAXIMUM* means the total dollar amount that is accumulated per person per calendar year in eligible expenses and paid at the co-insurance percentages (shown in the Schedule of Benefits), after which the Plan will pay eligible expenses for the remainder of the Calendar Year at one hundred percent (100%). Deductibles, pre-certification penalties, substance abuse, chemical dependency, mental health care and any charge that is not eligible under this Plan do not apply to the out-of-pocket maximum.

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

12.61 *OUT-OF-NETWORK* means medical services rendered by a provider that is not a BlueCross Blue Shield of Arizona "Preferred Care" provider.

12.62 *PARTICIPATING or PREFERRED CARE PROVIDER* means a provider who is under contract with the BlueCross BlueShield of Arizona PPO to provide services to Covered Persons at negotiated rates. Only "Preferred Care" providers are considered "In-Network".

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

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

- a] M.D. - Doctor of Medicine; or
- b] D.O. - Doctor of Osteopathy.
- c] P.A. - Physician's Assistant
- d] N.P. - Nurse Practitioner

An eligible Physician shall not include the Covered Person, or a Physician who is part of the Covered Person's family. Services of a Physician's Assistant (P.A.) will be eligible provided they are operating under the direct supervision of an M.D. or a D.O..

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

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

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

12.68 *PRACTITIONER* shall mean a person acting within the scope of applicable state licensure/certification requirements and holding the degree of Certified Nurse Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA), Registered Physical Therapist (RPT), Occupational Therapist, Speech Therapist, Physician's Assistant (PA), Nurse Practitioner (NP), Certified Surgical Assistant (CSA) Registered Nurse First Assistant (RNFA) or Registered Respiratory Therapist. Eligible Mental Health/Behavioral Health practitioners are limited to psychiatrists, psychologists and professional counselors as described in Article VI, Section 6.48. Optometrists administering topical pharmaceutical agents or removing superficial foreign bodies from the eye must be appropriately licensed and meet any additional state requirements for such services. An eligible practitioner shall not include the Covered Person, or anyone who is a member of the Covered Person's family or resides with the Covered Person.

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

12.70 PRE-EXISTING CONDITION means any condition for which an individual was diagnosed, received medical care or treatment (including but not limited to diagnostic testing, consultation, or consumption of prescribed medication, or self-administered drugs or biologicals) during the six (6) month period immediately preceding his/her enrollment date of coverage with this Plan. Under this plan condition means any disease, illness, ailment or bodily malfunction of a Covered Person. Under this plan treatment means medical or surgical management of a Covered Person. Under this plan consultation means the seeking or rendering of medical treatment by or from a physician or doctor. Under this plan biologicals means any natural compound processed and used for the treatment and/or cure of a medical condition.

12.71 PREFERRED PROVIDER ORGANIZATION (PPO) is a network of health care providers (ie: Hospitals, Physicians, Laboratories, etc.) that have been contracted to provide services at a reduced rate.

12.72 PROSTHETICS means a corrective appliance customized to replace all or part of a missing body part as an artificial limb.

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

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

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

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

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

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

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

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

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

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

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

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

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

12.83 SURGERY means any of the following medical procedures:

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

In the case of multiple surgeries performed through the **same incision** the maximum allowable expense shall be equal to the Usual and Customary amount for the procedure with the greatest scheduled amount. Additional allowances (modifiers) may be given when the additional surgeries add significant complexity to the surgical session.

If during the same surgical session multiple surgeries are performed through **separate incisions**, the allowable expense shall be calculated at the full Usual and Customary amount of the primary procedure, and at fifty percent (50%) of the Usual and Customary amount of each of the lesser procedure(s) that are through their own separate incision(s).

12.84 SURGICAL CENTER, FREESTANDING OR AMBULATORY CENTER means hospital based or freestanding legally operated center which;

- a] Has permanent operating rooms and at least one (1) recovery room, and all necessary equipment for use before, during and after surgery; and
- b] Is other than a private office or clinic of a Physician; and
- c] Has full-time Registered Nurses available for care in an operating room or recovery room; and
- d] Has a contract with at least one (1) nearby Hospital for immediate acceptance of patients who require Hospital care following care in the freestanding facility; and
- e] Is supervised by an organized staff of medical professionals.

12.85 TOTAL DISABILITY means a condition present whereby a person is unable to engage in the duties of their regular occupation at their normal place of employment for their regularly scheduled amount of hours, or in the case of a dependent being unable to perform the normal activities of a person of like age and sex who is in good health as a result of a non-occupational injury or illness, and is under the regular care and attendance of a Physician who certifies the person's disability, and the person is not performing work of any kind for compensation or profit.

12.86 TREATMENT shall mean having received a diagnosis, consultation, or taking prescribed drugs/medication (including self-administered drugs or biologicals not requiring a Physician's prescription)

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

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

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

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

ARTICLE XIII

GENERAL PROVISIONS

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

13.01 PURPOSE

Your Employer has established and maintains the Plan contained herein to provide for the payment or reimbursement of eligible medical expenses incurred by its Covered Employees and their Covered Dependents. The name of the Plan is the "Yavapai Unified Employee Benefit Trust", herein referred to as the "Plan". The purpose of this Plan Document is to set forth the provisions of the Plan which provide and/or affect such payment or reimbursement. It is intended that the benefits provided by the Plan be "accident and health benefits" as that phrase is defined in Section 105(e) of the Internal Revenue Code of 1986. It is not intended that all benefits be offered to all Employees, or that all benefits be funded, or that all benefits be offered solely under this Plan.

13.02 EFFECTIVE DATE

This Plan is effective as of July 1, 2009, as of 12:01 a.m., Mountain Standard Time at Prescott, Arizona. Eligibility for benefits and the amount of benefits payable for charges incurred prior to the effective date, shall be determined in accordance with any applicable group benefit plan maintained by the Employer at that time. As of the revision date of this Plan Document, eligibility for benefits and the amount of benefits shall be determined pursuant to the terms and conditions of this Plan Document.

13.03 AMENDMENTS

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

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

13.04 SUMMARY PLAN DESCRIPTIONS

Each member covered under this Plan will receive a copy of this Plan Document describing the benefits to which Covered Persons are entitled, to whom benefits are payable, and stating the provisions of the Plan.

13.05 FUNDING POLICY

The Trust Board shall, pursuant to the Trust and after consultation with the Plan Administrator, establish and direct the Plan Administrator or its delegate to carry out a funding policy consistent with the purpose of the Plan and requirements of applicable law.

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

13.07 MISSTATEMENT OF AGE

If age is a factor in determining eligibility or amount of benefits, or both, the amount for which the person is covered shall be adjusted in accordance with the covered individual's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force.

13.08 DISCLAIMER OF LIABILITY

The Plan has no control over any diagnosis, treatment, care (or lack thereof), or other services delivered to you by a provider (or not delivered to you), and disclaims liability for any loss or injury caused to you by any provider by reason of negligence or failure to provide treatment or otherwise.

13.09 INDEMNIFICATION OF TRUSTEES

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

13.10 SETTLEMENT OF DISPUTE

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

13.11 PRIVACY, CONFIDENTIALITY, RELEASE OR RECORDS OR INFORMATION

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

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

13.12 RIGHT TO RECEIVE AND RELEASE INFORMATION

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

13.13 REGULATORY REPORTING

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

ARTICLE XIV

MISCELLANEOUS PLAN PROVISIONS

14.01 FACILITY OF PAYMENT

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

14.02 ASSIGNMENT

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

14.03 FILING OF INFORMATION

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

14.04 PROOF OF CLAIM and TIMELY FILING REQUIREMENTS

Written notice and proof of claim hereunder must be given to the Plan with the particulars sufficient to identify the Covered Person and the medical necessity for the services rendered, within twelve (12) months of the date such claim was incurred. The Covered Person must submit properly completed claim forms, itemized original statements, and other medical documentation as required by the Plan. If a claim has been closed for lack of response to requests for information, the Covered Person has a maximum of one hundred and eighty (180) days from the date the claim was closed to provide the additional information. Any exceptions to these filing requirements are subject to approval by the Board of Trustees.

14.05 PREFERRED PROVIDER ARRANGEMENT

The Board shall have the right to contract with Providers or existing networks of Providers in order to establish a Preferred Provider Network. Participants elect to utilize the Participating Providers in order to obtain greater levels of reimbursement for Eligible Expenses as established by the Plan. All other Plan restrictions and limitations will remain the same.

14.06 INDEPENDENT PHYSICIAN EXAMINATION

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

14.07 MANAGED CARE RECOMMENDATIONS

This Plan, together with the Utilization Review firm, and the Claims Administrator have the option of overriding certain Plan limitations, exclusions or pre-certification requirements when it is in the best interest of the Plan to allow a more cost effective type of alternative care.

14.08 RIGHT OF RECOVERY

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

14.09 THIRD PARTY RECOVERY/SUBROGATION

This provision applies, when legally permissible, if a Covered Person is injured or has an illness resulting from or caused by the act or omission of a third party. The Plan is not obligated to pay benefits due to this illness/injury unless the Covered Person agrees **in advance** to the items listed below with respect to any recovery from the third party, the third party's insurance carrier(s), or the third party's personal representative:

- a] In the event of a recovery from a third party, the Covered Person shall agree to repay or assign to the Plan Administrator such portion of the recovery that equals the lesser of:
 - 1. the dollar amount of benefits that have been, and will be, provided to the Covered Person under this Plan on account of such injury or illness, or
 - 2. the amount of the recovery remaining after deducting reasonable and necessary expenditures (including attorney fees) incurred by the Covered Person in obtaining the recovery. The term "recovery" includes any amount received, whether by judgment, settlement or otherwise.
- b] Sign an agreement to repay the Plan an amount [not exceeding the amount described in clause (a)(1) above] that is recovered from the third party, the third party's personal representative, or the third party's insurance carrier.
- c] To instruct their attorney to repay the Plan from any such recovery in a form satisfactory to the Plan Administrator.
- d] Cooperate fully and assist the Plan in asserting its rights against the third party.

The Claims Administrator's failure to receive an agreement from the Covered Person, or the Covered Person's personal representative to repay the Plan shall not limit in any manner the Plan's right to all or part of a Covered Person's financial recovery. For purposes of the Plan's subrogation provision, the value of the benefits provided under the Plan shall be conclusively presumed to be the cost to the Plan of providing such benefits.

Repayment to the Plan is to be made within sixty (60) days of the receipt of settlement from the third party. In the event a covered person or his personal representative fails or refuses to execute whatever assignment, agreement or documents requested by the administrator, the Plan shall, notwithstanding any other provisions of the Plan to the contrary, be relieved of any and all legal, financial, or contractual obligation contained in the Plan to pay for any benefits or otherwise eligible charges incurred by the Covered Person.

14.10 BENEFITS EXEMPT FROM ATTACHMENT

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

ARTICLE XV

CLAIM FILING PROCEDURE

15.01 This Plan has incorporated the BlueCross BlueShield of Arizona Preferred Provider Organization (PPO) into the benefit program. Administrative Enterprises, Inc. (AEI) has partnered with BCBSAZ for electronic claims submission. In-Network claims are sent electronically to BCBSAZ for pricing, and then are forwarded to AEI for processing. All In-Network medical claims submitted, are reviewed and repriced in accordance with the BlueCross Blue Shield of Arizona negotiated fee schedule. Claims generated on paper are submitted directly to AEI for processing at the address below.

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

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

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

15.02 If the Covered Person must file a claim directly to AEI, obtain and complete an AEI claim form. Claim forms can be obtained directly from Administrative Enterprises, Inc.

15.03 The completed claim form should be attached to the itemized bills, and submitted to AEI for processing.

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

15.05 Claims must be submitted to AEI on a timely basis (as stated in Article XIV, Section 14.04) in order to be eligible for benefit consideration. AEI will accept charges that are submitted within twelve (12) months of the date the charge was incurred.

15.06 AEI's mailing address is:

**Administrative Enterprises, Inc.
5810 West Beverly Lane
Glendale, Arizona 85306-1800**

15.07 For claim inquiries:

**Administrative Enterprises, Inc.
(602) 789-1170 / (800) 762-2234
www.aeitpa.com**

15.08 For eligibility information and benefit descriptions:

**Administrative Enterprises, Inc.
www.aeitpa.com
Fax: (602) 789-9369**

ARTICLE XVI

CLAIMS APPEAL PROCEDURE

16.01 In the event that your claim is denied in whole or in part, you or your duly authorized representative may:

- a] File a written request for review of a denied claim. Such request must be filed with Administrative Enterprises, Inc. (5810 West Beverly Lane, Glendale, Arizona 85306) no later than sixty (60) days after written receipt of a denial.
- b] Inspect documents pertaining to the denial;
- c] Submit additional documentation to substantiate your request for review.

16.02 Upon receipt of your written request for the claim review, the Claims Administrator will:

- a] Review the claim to determine if additional benefits are in order;
- b] Set forth to you, in writing, the decision made, stating specific reasons for the determination, and making specific reference to the Plan provisions pertaining to the decision.

16.03 If the claim is again denied, the Covered Person may request further review of the denial by the Plan Administrator. The request for appeal must be made in writing within sixty (60) days of the first level appeal denial notification and sent to the Claims Administrator. The appeal, along with all supporting documents, to the Yavapai Unified Employee Benefit Trust . The Covered Person will receive written notice from the Yavapai Unified Employee Benefit Trust Employee Benefit Plan of their decision within thirty (30) days following the review meeting.

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

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

ARTICLE XVII

PRIVACY OF PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

- The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the Plan and to the U.S. Department of Health and Human Services.
- The Plan Sponsor will, if feasible, return or destroy all of your protected health information in the Plan Sponsor's custody or control that the Plan Sponsor has received from the Plan or from any business associate when the Plan Sponsor no longer needs your protected health information to administer the Plan. If it is not feasible for the Plan Sponsor to return or destroy your protected health information, the Plan Sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The Trustees of the Yavapai Unified Employee Benefit Trust may be given access to your protected health information for the purposes set forth in this document.

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

ARTICLE XVIII

PRIVACY NOTICE

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

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of Yavapai Unified Employee Benefit Trust (the "Plan") to protect the privacy of your medical information. The Plan provides health and/or dental benefits to you as described in your summary plan description(s). The Plan receives and maintains your medical information in the course of providing these health benefits to you. The Plan hires business associates, such as Administrative Enterprises, Inc., to help it provide these benefits to you. These business associates also receive and maintain your medical information in the course of assisting the Plan. The Plan is sponsored by Yavapai Unified Employee Benefit Trust (the "Plan Sponsor").

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

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

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

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

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

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

Uses and Disclosures with Your Permission

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

Your Rights

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

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

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

Complaints

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

Contact Office

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

Contact Office: Administrative Enterprises, Inc.

Telephone: 602-789-1170 or 1-800-762-2234

Address: 5810 W. Beverly Lane

Fax: 602-789-9369

Glendale AZ 85306-1800

ARTICLE IX

NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

This coverage is subject to the same deductibles and co-payments consistent with those established for other benefits under your plan.

ARTICLE XX

NOTICE OF PRESCRIPTION DRUG COVERAGE AND MEDICARE

Important Notice about your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your prescription drug coverage available through Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage. You may ask for another copy of this notice from the Yavapai Unified Employee Benefit Trust (YUEBT) at any time. Key points for you to remember:

1. Medicare prescription drug coverage (sometimes called Medicare Part D) is available to everyone with Medicare.
2. The prescription drug coverage offered to you by YUEBT is generally better than the standard Medicare prescription drug coverage.
3. If you decide to keep your coverage through YUEBT's plan, you do not have to do anything.
4. If you keep your prescription drug coverage through YUEBT and then later decide to buy prescription drug coverage through Medicare, you will not have to pay a penalty (that is, pay a higher Medicare premium.)
5. If you have questions about this notice or would like more information about your coverage options, please contact your benefits office.

For the upcoming year you have several coverage options:

1. You may stay with your current plan offered by YUEBT. Because YUEBT's coverage is, on average for all plan participants, expected to pay out more than standard Medicare Part D prescription drug coverage will pay, you can keep this coverage and not pay extra (that is, there is no penalty) if you later decide to enroll in a Medicare Part D plan. If you decide to keep your existing coverage through YUEBT's plan, you do not have to do anything. You will continue to be enrolled in YUEBT's plan and receive the same benefits you currently have.
2. You may enroll in a stand-alone Medicare prescription drug plan to obtain Medicare Part D coverage. All Medicare Prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

If you want to enroll in a Medicare prescription drug plan, open enrollment for the Medicare prescription drug plans runs from November 15th through December 31st of each year. Before enrolling in a Medicare prescription drug plan, please contact YUEBT's benefit manager to discuss what health insurance coverage you have through YUEBT to avoid duplicate coverage.

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

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

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

If you have questions about this notice or would like more information about your options, please contact your benefits office.

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

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date: July 01, 2007

Name of Entity/Sender: Yavapai Unified Employee Benefit Trust
Address: 146 South Granite Street
Prescott, Arizona 86303

Phone Number: (928) 445-5400