YUMA AREA BENEFIT CONSORTIUM (YABC)

PLAN DOCUMENT

describing the

MEDICAL PLAN (including Prescription Drugs),

DENTAL AND VISION PLANS

Amended, Restated and Effective July 1, 2023

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INTRODUCTION

WHAT THIS DOCUMENT TELLS YOU

This Plan Document describes the self-funded medical and dental plan benefits for participants of the Yuma Area Benefit Consortium (herein referred to as the "Consortium" or "YABC"). The document also outlines the insured vision plan benefits. The plan described in this document is effective as of July 1, 2023, and replaces all other plan documents previously provided to you.

- To determine if you may be eligible for benefits under this Plan, refer to the Eligibility chapter in this document. If you have declined any of the coverages described in this document, the chapters pertaining to those declined coverages do not apply to you.
- Note that your eligibility or right to benefits (including workers' compensation coverage) under this Plan should not be interpreted as a guarantee of employment.
- No individual shall have accrued or vested rights to benefits under this Plan. A vested right refers to a benefit that an individual has earned a right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed.

This document will help you understand and use the benefits provided by the Consortium. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give you an understanding of the coverages provided, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the Plan.

Be sure to read the Schedule of Medical Benefits, the Schedule of Dental Benefits, the Medical and Dental Exclusions chapters and the Definitions chapter of this document, as they set forth the coverages and limitations of this Plan. Remember, not every expense you incur for health care is covered by the Plan.

Keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find them.

All provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears in this chapter.

IMPORTANT INFORMATION

Yuma Area Benefit Consortium is committed to maintaining health care coverage for employees and their families at an affordable cost, however, because future conditions cannot be predicted, the Plan reserves the right to amend or terminate
coverages at any time and for any reason.

As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

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

The medical and dental plan benefits are self-funded with contributions from Eligible Employees and Retirees held in a Trust. An independent Claims Administrator pays benefits out of Trust assets. The vision plan benefits are fully insured with an insurance company whose name is listed on the Quick Reference Chart in this document.

The self-funded benefits offered by this Plan do not constitute the act of insurance. The self-funded benefits of this Plan are not guaranteed and may be amended or withdrawn at any time by a participating employer of the Consortium, without the consent of any participant or other party.

SPANISH LANGUAGE ASSISTANCE

Si usted no entiende la información en este documento, por favor de ponerse en contacto con personal del departamento de Human Resource a la dirección y teléfono en el (Quick Reference Chart) de este documento.

SUGGESTIONS FOR USING THIS DOCUMENT

This document provides the details about your Plan. We suggest that you:

- Read through this Introduction and look at the **Table of Contents** that immediately precedes it. If you don't understand a term, look it up in the Definition chapter. The Table of Contents provides you with an outline of the chapters. The Definitions chapter explains many technical, medical and legal terms that appear in the text.
- This document contains a **Quick Reference Chart** following this Introductory text. This is a handy resource for names, addresses and phone numbers of the key contacts for your benefits such as the Claims Administrator.
- The **Eligibility chapter** outlines who is eligible for coverage and when coverage ends. The COBRA Continuation of Coverage chapter discusses your options if coverage ends for your or a covered Spouse or Dependent Child.
- Review the Medical Expense Benefits, Schedule of Medical Benefits and the Medical Exclusions chapters.
- Review the **Medical Network and Utilization Management chapter**. It describes how you can maximize plan benefits by following the provisions explained in these chapters.
- Review the Dental Expense Benefits, Schedule of Dental Benefits and Dental Plan Exclusions chapters for an explanation of the dental benefits.
- Review the **Vision Expense Benefits,** and the Schedule of Vision Plan Benefits chapters for details about the vision benefits.
- Refer to the **Claim Filing and Appeals Information** chapter to find out what you must do to file a claim and how to seek review (appeal) if you are dissatisfied with a claims decision.
- Refer to the chapter on **Coordination of Benefits (COB)** for information regarding the handling of situations where you have coverage under more than one group health care plan, Medicare and other government plan, personal injury protection under mandatory no-fault automobile insurance coverage, workers' compensation, or where you can recover expenses from any other source.
- Refer to the **Definitions** chapter at the back of the document. Words that appear throughout the text have specific meanings that are set forth in the Definitions chapter. You may also encounter technical terms that are also defined in the Definitions chapter.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Plan Administrator information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in status of a Dependent Child, Medicare enrollment or disenrollment or the existence of other coverage.

Failure to give this Plan a timely notice (as noted above) may:

a. cause your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage, or
b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability, or
c. cause claims to not be able to be considered for payment until eligibility issues have been resolved, or
d. result in a participant's liability to repay the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future health benefits.

YOUR CONTRIBUTIONS FOR COVERAGE

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

QUESTIONS YOU MAY HAVE

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Claims Administrator at their phone number and address located on the Quick Reference Chart in this document. As a courtesy to you, the claims staff may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. Your most reliable method is to put your questions into writing and fax or mail those questions to the Claims Administrator and obtain a written response from the Claims Administrator.

FOR HELP OR INFORMATION

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

QUICK REFERENCE CHART	
If you need information on:	**Contact the following:**
Claims Administrator for Medical and Behavioral Health Claims • Medical and Behavioral Health claims and appeals • Eligibility and Benefits • Plan Benefit Information • COBRA Administration • Summary of Benefits and Coverage (SBC)	**AmeriBen** P.O. Box 7186 Boise ID 83707 Phone: 1-602-231-8896 or 1-866-365-9198 Website: www.myameriben.com
In-Network Providers for the Medical Plans • In-Network Providers Directory for Preferred Medical Plan (PPO) Providers • Additional/deletion of providers • (Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price) CAUTION: Use of a non-PPO network hospital, facility or Health Care Provider could result in you having to pay a substantial balance of the provider's billing. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or Deductibles) that exceed the plan's payment for a covered service. (See definition of "balance billing" in the Definition chapter of this document). **Your lowest out of pocket costs will occur when you use In-Network PPO providers**.	**Blue Cross Blue Shield of Arizona (BCBSAZ)** 1-602-231-8896 or 1-866-365-9198 Provider Directory: www.azblue.com/chsnetwork EDI Payor ID#53589 Blue Cross® Blue Shield of Arizona, an independent licensee of the Blue Cross and Blue Shield Association, provides network access only and does not provide administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. Yuma Area Benefit Consortium has assumed all liability for claims payment based on provisions and limitations stated in this plan document. No provider network access/benefits are available from Blue Cross Blue Shield of Arizona **outside** Arizona.
Mayo Clinic Arizona, an In-Network Provider (including Mayo Primary Care Centers and Mayo Hospital in Phoenix, AZ)	**Mayo Clinic Arizona** Appointment Office: 480-301-1735 http://www.azblue.com/chsnetworkmayo
Medical Plan In-Network Providers in Mexico • In-Network Providers Directory for Preferred Medical Plan (PPO) Providers • Addition/deletion of providers • (Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price)	**International Medical Solutions (IMS)** 2671 4th Ave. Yuma, AZ 85364 US: 928-446-6179 Mexico: 653-690-1874 http://www.internationalmedsolutions.com

QUICK REFERENCE CHART

If you need information on:	Contact the following:
Telemedicine Nationwide Network of Physicians • Employees enrolled in a medical plan option have access to Teladoc's web or phone-based consultation with a board-certified Physician (an electronic visit called an e-visit) including diagnosis and treatment of medical and/or mental health issues. Physicians are available 24/7/365. • Employees in the HDHP/HSA Plan Option must follow the rules related to that plan before they can use the Teladoc service. • Teladoc is a convenient, lower cost alternative to a physician office visit, urgent care visit or non-emergency care in an emergency room. Teladoc lets you consult with a doctor over the phone or on-line video, day or night when your regular doctor is not available. You can use Teladoc when you're traveling, too. • The physician will review your medical history, diagnose the condition and can prescribe necessary medications. The Physicians can diagnose non-emergency medical problems, like ear infection, colds, pink eye or sore throat, and recommend treatment. They can call in necessary medication to your preferred pharmacy. The US-based Physicians are board-certified in internal medicine, family practice, emergency medicine or pediatrics. • To use this electronic visit service, you must register online at www.teladoc.com and can set up your account to be web, phone or mobile app. • All Teladoc doctors: • Are U.S. board-certified in internal medicine, family practice, emergency medicine or pediatrics. • Are U.S. residents and licensed in your state. • Average 15 years of practice experience. **Please note:** Due to certain state laws, Teladoc is not available if you are physically located in the states of AR, ID or MO when you place your call. But, if you have a plan from one of these states and are outside of these states when you call, Teladoc is available to you. Online doctors are not able to prescribe controlled substances or lifestyle drugs.	**Teladoc** Available 24/7/365 Phone: 1-800-Teladoc (835-2362) E-mail: membersupport@teladoc.com www.teladoc.com Mobile App (App Store and Google Play): www.teladoc.com/mobile **Remember, in an emergency, call 911**.
Utilization Management (UM) Company • Precertification and Medical Review • Appeal of a Denied UM request • Case Management	**American Health Group (AHG)** 2152 S. Vineyard Ave, Suite 103 Mesa, AZ 85210 1-602-265-3800 or 1-800-847-7605
Employee Assistance Program (EAP) • Confidential information, support and referral to help individuals cope with personal problems that impact their home and work life. EAP counselors can help you with stress, marriage, family, work-related problems, substance abuse, financial and legal problems.	**Jorgensen Brooks Group (JBG)** Toll Free: 1-888-520-5400 Tucson: 520-575-8623 www.jorgensenbrooks.com

QUICK REFERENCE CHART

If you need information on:	Contact the following:
Prescription Drug Program • Retail Pharmacies • Mail Order (Home Delivery) Service • Direct Member Reimbursement (for Non-network retail pharmacy use) • Specialty Drug Program: Precertification and Ordering • Formulary of Preferred Drugs • Precertification (pre-approval) of certain prescription drugs • Appeal of a denied Drug request	**Magellan Rx** Customer Service: 1-800-424-0472 www.magellanrx.com For Prior authorization: 1-800-424-0472 For Specialty Drugs: 1-800-424-0472 For Mail Order: 1-800-424-0472 Magellan Rx Mail Order P. O. Box 620968 Orlando, FL 32862 For Direct Member Reimbursement: Magellan Rx Management 4801 East Washington, Suite 100 Phoenix, AZ 85034 For Drug Claim Appeals: 1-800-424-0472 Magellan Rx Management Attention: Appeals Department 4801 East Washington, Suite 100 Phoenix, AZ 85034
Dental Claims Administrator • Dental claims and appeals	**AmeriBen** P.O. Box 7186 Boise ID 83707 Phone: 1-602-231-8896 or 1-866-365-9198 Website: www.myameriben.com
Vision Plan Insurance Administrator • Vision network providers • Vision claims and appeals	**Vision Service Plan (VSP)** 3333 Quality Drive Rancho Cordova, CA 95670 1-800-877-7195 www.vsp.com
Level Two Claim Appeals	**Board of Trustees for YABC regarding Claim Appeal** c/o **AmeriBen** P.O. Box 7186 Boise ID 83707 Phone: 1-602-231-8896 or 1-866-365-9198 Website: www.myameriben.com
COBRA Administrator • Information About Coverage • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments • Second Qualifying Event and Disability Notification	**AmeriBen** P.O. Box 7186 Boise ID 83707 Phone: 1-602-231-8896 or 1-866-365-9198 Website: www.myameriben.com
Health Flexible Spending Account Administrator	**PayFlex** Phone number:(800) 284-4885 Website: www.mypayflex.com (New Users need to establish a user name and password. Then, through the website you can order additional debit cards, review claim documents, submit claims, sign up for direct deposit, etc.)

QUICK REFERENCE CHART	
If you need information on:	**Contact the following:**
Health Savings Account (HSA) Administration • General information • Opening an HSA account • Contributions to an HSA account • Reimbursement from an HSA account	**HealthEquity** Phone number:(866) 346-5800 www.HealthEquity.com
Plan Administrator for YABC • Medicare Part D Notice of Creditable Coverage • YABC Board of Trustees	**Plan Administrator** c/o Chief of Finance & Operations, Crane Schools 4250 West 16th Street Yuma, AZ 85364 1 928 373 3405 **YABC Website: www.yabc.net** YABC tax ID#: 35-6906297
Privacy Officer **Security Officer** • HIPAA Notice of Privacy Practices	**Arizona Western College** Office of Human Resources P.O. Box 929 Yuma, AZ 85366-0929 1-928-344-7505
Privacy Officer **Security Officer** • HIPAA Notice of Privacy Practices	**Crane Elementary School District No. 13** Director, Human Resources 4250 W. 16th Street Yuma, AZ 85364 1-928-373-3420
Privacy Officer **Security Officer** • HIPAA Notice of Privacy Practices	**City of Yuma** Accounting Supervisor One City Plaza Yuma, AZ 85364 1-928-373-5085

ELIGIBILITY
HOW AND WHEN COVERAGE BEGINS, IS MAINTAINED, AND ENDS

WHO IS ELIGIBLE FOR COVERAGE

EMPLOYEE ELIGIBILITY

The employers participating in the YABC plan reserve the right to use a **Monthly Measurement Method** and/or a **Look Back Measurement Method** to determine if an employee reaches the level of a **full-time employee**, in accordance with IRS regulations under the Affordable Care Act.

- The Monthly Measurement Method identifies full-time employees based on the hours of service achieved for each calendar month.
- The Look-Back Measurement Method determines the status of a new employee or an ongoing employee as full-time or not for a future period (called a stability period) based on the average number of hours of service per week the employee attained in a prior period (called a measurement period). See the definition of Look Back Measurement Method in the Definitions chapter.
- The specific duration of periods under the Look Back Measurement Method (when used) are addressed in policies/procedures in the Human Resource/Payroll department of the participating employer, and can be changed on an annual basis as determined by the participating employer.

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

- Crane Elementary School District No. 13: Eligible employees include contracted and non-contracted employees who are full-time averaging at least 30 hours of service per week (at least 130 hours of service per month), as measured by the District.
- Arizona Western College: Full-time employees averaging at least 30 hours of service per week (at least 130 hours of service per month), as measured by the College, are eligible for benefits.
- City of Yuma: Employees are eligible if they average at least 30 hours of service per week (at least 130 hours of service per month), as measured by the City, or they are elected officials of the City. Additionally, employees participating in the City's job-sharing program and Critical Part-time "hard to fill" employee positions, as designated by the City Administrator, are also eligible for benefits.
- Hour(s) of Service: means (1) each hour for which an employee is paid, or entitled to payment, for the performance of duties for an employer; and (2) each hour for which an employee is paid, or entitled to payment by an employer on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. An hour of service does not include any hour of service performed as a bona fide volunteer, as part of a Federal Work-Study Program (or a substantially similar program of a State or political subdivision thereof) or (according to the final Shared Responsibility regulations) to the extent the compensation for services performed constitutes "income from sources without the United States".
- Refer to the Initial Enrollment section in this chapter for information on any waiting period for coverage once an employee becomes eligible to enroll for coverage.

DEPENDENTS' ELIGIBILITY

Your eligible dependents are allowed to enroll in this Plan on the later of the day you become eligible for your own benefit coverage or the day you acquire an eligible dependent, either by marriage, birth, adoption or placement for adoption, provided that benefit coverage is in effect for you on that day.

Your eligible dependents include your lawful Spouse and your Dependent Child(ren) as those terms are defined in the Definitions chapter of this document.

- Dependents without a valid social security number (SSN) may not be able to have claims processed under this plan. See the Enrollment Procedure in this chapter for information on providing a Social Security Number to this Plan in compliance with law.
- Anyone who does not qualify as a Dependent Child or Spouse as those terms are defined by this Plan has no right to any coverage for Plan benefits or services under this Plan.

Eligible Retirees and When Coverage Begins

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

Individuals who are enrolled under this Plan as Retirees must enroll in Medicare Part A and B when eligible.

See the section of this chapter titled "Events Causing Coverage to End" and also the Definitions chapter for information on Entitled to and Eligible for Medicare.

EXTENSION OF ELIGIBILITY FOR CERTAIN SURVIVING SPOUSE AND SURVIVING DEPENDENT CHILD(REN) OF DECEASED LAW ENFORCEMENT OFFICERS

The surviving lawful spouse and surviving Dependent Child(ren) of a deceased law enforcement officer who was employed with a participating employer of YABC, are entitled to continue health coverage under the Plan after the death of the law enforcement officer, unless they no longer are eligible (see the section on "When Coverage Ends" for termination provisions).

"Law enforcement officer" means (1) a peace officer who is certified by the Arizona peace officer standards and training board, (2) a firefighter, detention officer, corrections officer, probation officer or surveillance officer who is employed by the State of Arizona or a political subdivision of this State, or (3) a corrections officer or firefighter who works on behalf of State of Arizona or a political subdivision of this State through a contract with a private company.

To be eligible for this extended benefit, the law enforcement officer must have been killed in the line of duty or died from injuries suffered in the line of duty while employed with a participating employer of YABC.

Premiums for this extended coverage will continue to the surviving lawful spouse and dependents at the same rate that applies to active employees (if single) or active employees and their families (if family coverage).

Upon termination of extended coverage, the surviving lawful spouse and dependent(s) will have the opportunity to elect COBRA continuation of coverage.

The participating employer of YABC is responsible for collecting and submitting the appropriate premium in a timely manner to the YABC.

PROOF OF DEPENDENT STATUS

Specific documentation to substantiate Dependent status will be required as part of the process to enroll for coverage, and may include (see the list below) a birth certificate, marriage certificate, proof of the dependent's age, the dependent's social security number, proof of the dependent's age, and other documents deemed necessary by the Plan.

- Marriage: copy of the certified marriage certificate.
- Birth: copy of the certified birth certificate.
- Stepchild: copy of the certified birth certificate plus marriage certificate, plus divorce decree or spouse death certificate (if applicable).

- Adoption or placement for adoption: court order paper signed by the judge showing that employee has adopted or intends to adopt the child, plus a copy of the certified birth certificate.
- Foster Child: a copy of the foster child placement papers from a qualified state agency/court order documents signed by a judge verifying legal custody of the foster child (e.g., placement papers from a qualified state placement agency), or proof of judgment, decree or court order from a court of competent jurisdiction, plus the child's birth certificate.
- Legal Guardianship: a copy of your court-appointed legal guardianship documents and a copy of the certified birth certificate.
- Disabled Dependent Child: Current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically Disabled (as that term is Disabled defined in this document) and is incapable of self-sustaining employment as a result of that disability; and that disability existed before the attainment of this Plan's age limit and is dependent chiefly on you and/or your Spouse for support and maintenance. The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child.
- Qualified Medical Child Support Order (QMCSO): Valid QMCSO document or National Medical Support Notice.

An employee must reimburse the Plan for any benefits that were paid by the Plan for a Dependent at a time when that Dependent did not satisfy the definition of a Dependent or was not otherwise eligible for benefits under this Plan.

ENROLLMENT PROCEDURE

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

Procedure to request enrollment:

Generally, you must call or walk into your Human Resource/Payroll department and indicate your desire to enroll in the Plan (address and phone number for the Human Resource/Payroll department is listed on the Quick Reference Chart in the front of this document.) Note that the Open Enrollment procedure can differ from this process and if so, the procedure on how to enroll at this time will be announced by the Plan at the beginning of the Open Enrollment period.

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

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

Proper enrollment is required for coverage under this Plan.

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

Failure to Provide Proof of Dependent Status: See also the section on Proof of Dependent Status above. Claims for newly added dependents (e.g., Spouse, children) will not be considered for payment by this Plan until the Plan Administrator receives verification/proof of dependent status.

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your Eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

Failure to provide the SSN or complete the CMS model form (form is available from the Claims Administrator or http://www.cms.gov) means that claims for eligible individuals will not be considered a payable claim for the affected individuals.

DECLINING MEDICAL COVERAGE

- **Employees may decline** medical, dental and vision expense coverage under this Plan for yourself, your Spouse and/or Dependent Child(ren), but to do so you must submit the completed written (or as applicable, online) portion of the enrollment form that pertains to declining coverage. If you decline coverage because you or any of your eligible dependents have other medical and/or dental coverage, you must complete that portion of the enrollment form related to that other coverage. If, at a later date, you want the coverage you declined for yourself, your Spouse and/or Dependent Child(ren), you may enroll under the Special or Open Enrollment provisions appearing later in this chapter.
- **Retirees may decline** coverage upon becoming eligible for retirement or during an Open Enrollment period. If you decline coverage for yourself, you will not be allowed to enroll your Spouse or Dependent Children under the coverage you declined.
- Once a Retiree declines (opts-out of) coverage under this Plan, the Retiree will not be eligible to re-enroll in a YABC-sponsored program again.
- Note that no compensation is made to individuals who waive/decline/opt out of benefit coverage.

INITIAL ENROLLMENT

Enrollment: You must enroll within **30** days of the date on which you become eligible for coverage by submitting a completed written (or as applicable, online) enrollment form (that may be obtained from your Human Resource/Payroll department), providing proof of Dependent Status (as appropriate) and paying any required contributions for coverage. If you want dependent coverage, you must enroll your eligible dependents at the same time.

When Coverage Begins:

- **Crane Elementary School District No. 13:** For **contracted and non-contracted new full-time** employees, coverage becomes effective on the first day of the month following 30 days of continuous service with the District.
- **Arizona Western College:** For new full-time employees, coverage becomes effective on the first day of the month following the date of full-time employment. When the date of employment is the first day of the month coverage will be effective on the date of employment.
- **City of Yuma:** For benefits eligible City employees, coverage becomes effective on the first day of the month following one month of full-time employment. Retiree coverage becomes effective on the first of the month following the employee's retirement from the City.

Coverage of your enrolled Spouse and/or Dependent child(ren) begins on the date your coverage begins.

Failure to Enroll During Initial Enrollment: CAUTION: If you do not enroll yourself or your eligible dependents within 30 days of the date on which they first become eligible for coverage, unless your eligible dependent(s) qualify for Special Enrollment described in this chapter, you will have to wait for the next Open enrollment period.

OPEN ENROLLMENT

Open Enrollment Period: Open enrollment is the period of time during the spring of each year to be designated by your employer during which eligible employees may make the elections specified below. Enrollment forms (or as applicable, online enrollment information) may be obtained from your Human Resource/Payroll department.

Elections Available During Open Enrollment: During the open enrollment period, you may elect, for yourself and your eligible dependents to enroll in the medical, dental and vision coverage offered by the Plan, or add or drop eligible

dependents to the medical, dental and vision coverage, or discontinue medical, dental and vision coverage for yourself and/or any of your eligible dependents.

Restrictions on Elections during Open Enrollment:

- No Dependent may be covered unless you are covered.
- You and all your covered Eligible Dependents must be enrolled for the same medical, dental, vision coverages.
- All relevant parts of the enrollment form (or as applicable, online enrollment application) must be completed and the form must be submitted before the end of the Open Enrollment period to your Human Resource/Payroll department along with proof of Dependent status (as required).
- See also the Enrollment Procedures section of this chapter for more information.

Start of or Changes to Coverage Following Open Enrollment:

- If you or your Spouse or Dependent child(ren) are enrolled for the first time during an Open Enrollment period, that person's coverage will begin on the first day of the Plan year following the Open Enrollment period.
- If you or your Spouse or Dependent child(ren) are changing or discontinuing coverage during Open Enrollment, such changes will become effective on the first day of the Plan year following the Open Enrollment period.

Failure to Make a New Election during Open Enrollment:

If you have been enrolled for coverage and you fail to make a new election during the Open Enrollment period, you will be considered to have made an election to retain the same medical, dental and vision coverage you had during the preceding Plan year. However, you will not have any part of your pay reduced to cover your contribution toward the cost of coverage and/or to be allocated to the Plan's flexible spending account for a Plan year unless you affirmatively elect to do so for that Plan year, even if that was part of your medical coverage for the previous year.

Failure to Enroll During Open Enrollment (Very Important Information):
If you fail to enroll yourself and/or any of your eligible dependents within 30 days after the date on which you or they become eligible for Open Enrollment, unless your eligible dependents qualify for the Special Enrollment described in this chapter of this document, you will have to wait until the next Open enrollment period.

SPECIAL ENROLLMENT

There are three HIPAA Special enrollment opportunities to enroll in the Plan's benefits mid-year: a) upon gaining (acquiring) a new dependent, b) loss of other coverage, and c) on account of Medicaid or a State Children's Health Insurance Program (CHIP). These opportunities are explained below:

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

1. **If you are enrolled for coverage** and if you acquire a Spouse by marriage, or if you acquire any Dependent Children by marriage, birth, adoption or placement for adoption, you may request enrollment for your newly acquired Spouse and/or Dependent Child(ren) and any other eligible Dependents, within 30 days after the date of marriage, birth, adoption or placement for adoption. (Note: A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.)
2. **If you are eligible for coverage but not enrolled for coverage** under this Plan and if you acquire a Spouse by marriage, or if you acquire any Dependent Child(ren) by marriage, birth, adoption or placement for adoption, you may request enrollment for yourself and your newly acquired Spouse and/or Dependent Child(ren) and any other eligible dependents within 30 days after the date of marriage, birth, adoption or placement for adoption. If you, the employee, are not already enrolled for coverage, you must request enrollment for yourself in order to enroll a newly acquired dependent.
3. **If you did not enroll your Spouse for coverage** within 30 days of the date on which he or she became eligible for coverage, and if you subsequently acquire a Dependent Child(ren) by marriage, birth, adoption or placement for adoption, you may request enrollment for your Spouse together with your newly acquired Dependent Child(ren), and any other eligible Dependents, within 30 days after the date of your newly acquired Dependent child(ren)'s birth, adoption, or placement for adoption. If you, the Employee, are not already enrolled for coverage, you must request enrollment for yourself in order to enroll a newly acquired Dependent.

To request Special Enrollment, follow the procedures described under the section titled "Enrollment Procedure" earlier in this chapter. To obtain more information about Special Enrollment contact your Human Resources Department.

This Special Enrollment for birth, adoption and marriage also applies to a retiree who is covered under this Plan. However, a Retiree who declines coverage at retirement and later acquires a new Dependent will not be entitled to special enrollment under this Plan, and neither will the retiree's dependents.

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

- If you did not request enrollment under this Plan for yourself, your Spouse and/or any Dependent Child(ren) within 30 days after the date on which coverage under the Plan was previously offered because you or they had health care coverage under any other health insurance policy or program or employer plan including COBRA continuation coverage, individual insurance, Medicare, or other public program; and
- If your Spouse and/or any Dependent Child(ren) lose coverage under that other health insurance policy or plan, and you are eligible for coverage under this Plan, you may enroll that Spouse and/or Dependent Child(ren) within 30 days after the termination of their coverage under that other health insurance policy or plan, either as a result of:

    - loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause); or
    - termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
    - the health insurance was provided under COBRA Continuation Coverage, and the COBRA coverage was "exhausted" or
    - moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
    - the other plan ceases to offer coverage to a group of similarly situated individuals; or
    - the loss of dependent status under the other plan's terms; or
    - the termination of a benefit package option under the other plan, unless substitute coverage offered.

COBRA Continuation Coverage is **"exhausted"** if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
- when the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
- when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
- because the 18-month, 29-month or 36-month (as applicable) period of COBRA Continuation Coverage has expired.

A retiree who declines coverage at retirement and later loses other coverage will not be entitled to special enrollment due to a loss of coverage and neither will the retiree's dependents.

C. Special Enrollment Due to Medicaid or a State Children's Health Insurance Program (CHIP):

You and your dependents may also enroll in this Plan if you (or your eligible dependents):

- have coverage through **Medicaid or a State Children's Health Insurance Program (CHIP)** and you (or your dependents) **lose eligibility for that coverage**. However, you must request enrollment in this Plan within **60 days** after the Medicaid or CHIP coverage ends; or

- become **eligible for a premium assistance program through Medicaid or CHIP**. However, you must request enrollment in this Plan within **60 days** after you (or your dependents) are determined to be eligible for such premium assistance.

When Special Enrollment Coverage Begins:

- Coverage of an individual enrolling because of loss of other coverage because of marriage: If the individual Special Enrollment within 30 days of the date of the event that created the Special Enrollment opportunity, except with respect to coverage of a newborn or newly adopted Dependent Child(ren) or on account of Medicaid or a State Children's Health Insurance Program (CHIP), your coverage, your Spouse's coverage, and/or the coverage of your Dependent Child(ren) will become effective on the first day of the month following the date the Plan receives the request for Special Enrollment.
- If the individual requests Special Enrollment within 60 days of the date of the Special Enrollment opportunity related to Medicaid or a State Children's Health Insurance Program (CHIP), generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity.
- Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options (when such options exist) at the same costs and the same enrollment requirements, as are available to similarly situated employees at Initial Enrollment.

Failure to Enroll During Special Enrollment: If you fail to request enrollment for yourself and/or any of your eligible dependents within 30 days (or as applicable 60 days) of the date on which they first become eligible for Special Enrollment, you must wait to enroll at the next Open Enrollment period.

NEWBORN DEPENDENT CHILD(REN) (Special Rule for Coverage)

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

Remember that you may not enroll a newborn Dependent Child(ren) for coverage unless you, the employee, are also enrolled for coverage. See also the Special Enrollment provisions and the Enrollment Procedure in this chapter.

Submitting a claim to the Plan for maternity care/delivery or for care of a newborn child(ren) is not considered proper enrollment of that child(ren) for coverage under this Plan.

ADOPTED DEPENDENT CHILD(REN) (Special Rule for Coverage)

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

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

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

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

(Special Rule for Enrollment)

1. No individual may be covered under this Plan both as an employee and as a dependent, nor may any Dependent Child be covered as the dependent of more than one employee or retiree. No individual may be covered under this Plan as both an employee and a retiree.

2. **If both you and your Spouse are eligible employees of a participating employer in the YABC Consortium**:

   - Each of you may be designated as the eligible employee who can file his or her own medical coverage choices. However, only one of you may elect dependent coverage, in order for your Dependent Children to be covered.
   - The Plan's Out-of-Pocket limits and family Deductibles will be combined, if the Plan is informed that the employee who did not elect dependent coverage is your Spouse.

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

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

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

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

EVENTS CAUSING COVERAGE TO END (TERMINATION PROVISIONS)

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

- Your employment ends.
- Your contract ends.
- You are no longer eligible to participate in the Plan.
- You cease to make any contributions required for your coverage.
- The Plan is discontinued.

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

- Employee or Retiree coverage ends.
- The Employee or Retiree's covered Spouse or Dependent Child(ren) no longer meet the definition of Spouse or Dependent Child(ren).
- he expiration of the period of coverage stated in a QMCSO.
- You cease to make any contributions required for dependent coverage.
- The Plan is discontinued.

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

- Is no longer eligible to participate in the Plan (such as if the Retiree fails to maintain their eligibility for Retiree coverage by completing any required substitute services as outlined in this Eligibility chapter or the Retiree dies).
- Retirees are eligible until the earlier of age 65 of Medicare eligibility.
- Fails to make any contributions required for coverage.

- Meets any provision set forth in each YABC participating employer's Human Resource/Payroll policies related to termination of Retiree health coverage.
- The Plan is discontinued.

Coverage of a Surviving Lawful Spouse and Surviving Dependent Child(ren) ends on the earliest of the last day of the month in which:

- they are no longer are eligible to participate in the Plan (including the surviving Dependent Child(ren) no longer meet the definition of Dependent Child(ren) as provided in the Definitions chapter of this document).
- the Surviving Spouse remarries, becomes Medicare eligible or dies.
- contributions required for coverage cease.
- the Plan is discontinued.

OPTIONS WHEN COVERAGE UNDER THIS PLAN ENDS

When coverage under this Plan terminates you may have the option to buy temporary continuation of this group health plan coverage by electing COBRA, or you can look into your options to buy an individual insurance policy for health care coverage from the Health Insurance Marketplace.

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

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

NOTICE REQUIRED TO THE PLAN

You, your Spouse, or any of your Dependent Child(ren) must notify the Plan preferably within 30 days but no later than 60 days after the date of:

1. a Spouse ceases to meet the Plan's definition of a Spouse, such as with a divorce;
2. a Dependent Child ceases to meet the Plan's definition of a Dependent Child;
3. the existence of any physical or mental disability of a Dependent Child or the child ceases to have any physical or mental disability.

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

WHEN THE PLAN CAN END YOUR COVERAGE FOR CAUSE (RESCISSION)

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when premiums and contributions are not timely paid in full, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan, as discussed below:

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

   1. **engages in an act, practice or omission that constitutes fraud or an intentional misrepresentation of a fact** in any enrollment, claim or other form in order to obtain coverage, services or benefits under the Plan; or
   2. **allowed anyone else to use the identification card** that entitles you or your covered dependent to coverage, services or benefits under the Plan; or
   3. **altered any prescription** furnished by a Physician or other Health Care Practitioner.

If your coverage is terminated for any of the above reasons, it may be terminated retroactively to the date that you or your covered Dependent performed or permitted the acts described above.

B. The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause **30 days** after it gives you written notice of its finding that you or your covered Dependent(s)

engaged in **conduct that was abusive, obstructive, or otherwise detrimental to a Physician or Health Care Practitioner**. If your coverage is terminated for this reason, it will be terminated on a going forward basis.

C. The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause **15 days** after it gives you written notice of its finding that you have failed to pay your premium payment. In this instance, your coverage may be terminated retroactively to the date of the delinquent premium payment. In addition, your coverage may be suspended during the 15-day notice period.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

This Plan will provide benefits in accordance with a **National Medical Support Notice**. In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan.

The QMCSO typically requires that the plan recognize the child as a dependent even though the child may not meet the plan's definition of dependent. A QMCSO usually results from a divorce or legal separation and typically:

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

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any benefit option that the Plan does not otherwise provide, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent Child of the employee, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the employee, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO, and if the employee is covered by the Plan, and advise them of the procedures to be followed to provide coverage of the Dependent Child(ren).

Enrollment Related to a Valid QMCSO: If the Plan has determined that an order is a valid QMCSO it will accept enrollment of the alternate recipient as of the earliest possible date following the date the Plan determined the order was valid, without regard to typical seasonal enrollment restrictions.

If the employee is already a Plan Participant, the QMCSO may require the Plan to provide coverage for the employee's Dependent Child(ren) and to accept contributions for that coverage from a parent who is not a Plan participant. The Plan will accept a Special Enrollment of the alternate recipient specified by the QMCSO from either the employee or the custodial parent. Coverage of the alternate recipient will become effective as of the first day of the month after the Special Enrollment request is received, and will be subject to all terms and provisions of the Plan, including any requirements for authorization of services, as permitted by applicable law.

If the employee is not a Plan Participant when the QMCSO is received and if the QMCSO orders the employee to provide coverage for the alternate recipient, the Plan will accept a Special Enrollment of the employee and the alternate recipient specified by the QMCSO. Coverage of the employee and the alternate recipient will become effective as of the first day of the month after the Special Enrollment request is received, and will be subject to all terms and provisions of the Plan, including any requirements for authorization of services, as permitted by applicable law.

Contributions for Coverage: No coverage will be provided for any alternate recipient under a QMCSO unless the applicable employee contributions for that alternate recipient's coverage are paid, and all of the Plan's requirements for enrollment and coverage of that alternate recipient have been satisfied. Contributions required for coverage under a QMCSO are the total employer contributions required for coverage of the employee and all members of the employee's family who are enrolled in the Plan, minus the contributions otherwise actually being paid by the employee.

Termination of Coverage: Generally, coverage under the Plan terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the Plan for other Dependent children. This includes termination of coverage for failure to pay any required contributions. When coverage terminates, alternate recipients may be eligible for COBRA continuation coverage. See also the COBRA chapter.

Additional Information: For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact your Human Resource/Payroll department. For additional information regarding QMCSOs and the procedures for payment of claims under them, see the Claim Filing and Appeals Information chapter of this document.

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

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

- **Change in employee's legal marital status**, including gaining a spouse through marriage, losing a spouse through divorce, legal separation (where permissible by law), annulment or death.
- **Change in number of employee's Dependents**, including gaining a child through birth, adoption, placement for adoption, or losing a child because of the death of that child.
- **Change in your, your Spouse's or Dependent Child's employment status or work schedule IF it impairs your, your Spouse's or your Dependent Children's eligibility for benefits**, including the start or termination of employment by you, your Spouse or any Dependent Child, an increase or decrease in hours of employment (including a switch in part-time and full-time employment), a strike or lockout, or the start of or return from an unpaid leave of absence that is either required by law (such as FMLA and military leave or, other leave permitted by your employer), or a change in work-site.
- **Change in Dependent status that satisfies or ceases to satisfy the Plan's eligibility requirements,** including changes due to attainment of age, start or loss of student status, or a change affecting a requirement described under the definition of Dependent Child in this document.
- **Change of residence or worksite** that allows or impairs your, your Spouse or Dependent Child's eligibility for benefits.
- **Change required under the terms of a Qualified Medical Child Support Order (QMCSO),** including a change necessary to add the child as a covered Dependent as specified in the order, or to cancel coverage for the child if the order requires your former Spouse to provide that coverage.
- **Change consistent with your right to Special Enrollment** as described in the section dealing with Loss of Coverage under Special Enrollment in the Eligibility chapter.
- **Change consistent with entitlement to (or loss of eligibility for) Medicare or Medicaid** affecting you, your Spouse or Dependent Child (except for coverage solely under the program for distribution of pediatric vaccines), including prospective cancellation of coverage of the person entitled to Medicare/Medicaid following such entitlement or prospective reinstatement or election of coverage following loss of eligibility for Medicare/Medicaid.
- **Change in the cost of your coverage:**
- **Automatic increase or decrease in your contributions for coverage.** under any of your employer's Health Care Plan options as a result of a change in the cost of coverage for all Plan participants, or as a result of a change in the number of your covered Dependents or a permitted mid-year change to another of your employer's Health Care Plan options, if the increase or decrease in contributions is or would be required from all similarly-situated employees. The Plan may automatically increase or decrease contributions on a reasonable and consistent basis.
- **Significant increase or decrease in your contributions for coverage**. under your employer's Health Care Plan options or your Spouse's employer's health care plans or programs. In such a case you may start coverage in the plan option with the decreased cost; or, revoke coverage in the plan option with an increased cost and either elect, on a prospective basis, coverage under another plan option providing similar coverage, if one is available, or drop the coverage if no other such plan option is available.

- **Significant curtailment of your (or your Spouse's) coverage.**
- **Significant curtailment**. If the coverage under the Plan is significantly curtailed or ceases during a Plan Year, you may revoke your elections under the Plan. In that case, you may make a new election on a prospective basis for coverage under another benefit package providing similar coverage. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to participants under the Plan so as to constitute reduced coverage to participants generally.
- **Addition or elimination of a benefit package option providing similar coverage.** If during a Plan Year the Plan adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option) you may elect the newly added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.
- **Addition or significant improvement of any Plan option** under the employer's Health Care Programs or your Spouse's employer's health care plans or programs. In such a case you may revoke coverage in the current plan and elect, on a prospective basis, coverage under a new or improved plan option.
- **Change in coverage under another employer's plan or program** that permits participants to make an election change that would be permitted by these mid-year changes, or that permits participants to make an election for a period of coverage that is different from the Plan Year of this Plan. In such a case you may elect, on a prospective basis, the same change in coverage under this Plan that was available under the other plan.
- **Reduction of Hours.** An employee who was expected to average at least 30 hours of service per week may prospectively drop group health plan coverage midyear if the employee's status changes so that the employee is expected to average less than 30 hours of service, even if the reduction of hours does not result in loss of eligibility for the plan. However, the mid-year change must correspond to the employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in other minimum essential coverage (MEC). The new MEC coverage must be effective no later than the first day of the second month following the month in which the original coverage is dropped. For example, other minimum essential coverage could mean intended enrollment in Health Insurance Marketplace coverage, minimum essential coverage through the spouse's group health plan, to change to a different medical plan option of the employee's own employer or to enroll in Medicaid/CHIP.
- **Exchange Coverage.** An employee who is eligible to enroll in Marketplace coverage (during a Marketplace special enrollment or open enrollment period) may prospectively drop YABC group health plan coverage midyear, but only if the change corresponds to the employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in Marketplace coverage that is effective no later than the day after the last day of the original coverage. This means that YABC group health plan coverage is not to be terminated until Marketplace coverage takes effect.

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

1. Any change you make to your benefits must generally be determined by the Plan Administrator or its designee to be necessary, appropriate to and consistent with the change in status; *(For example, if mid-year, the employee and Spouse deliver a newborn child they can add that child to this Plan but it would be inconsistent with a birth event to drop the Spouse from coverage at this time)* **and**
2. You must notify the Plan in writing within 31 days of the qualifying change in status, otherwise, the request will not be considered to be made on account of your change of status and you will have to wait until the next Open Enrollment period to make your changes in coverage (You have 60 days from the loss of eligibility for Medicaid or CHIP to request to enroll in this Plan as discussed under Special Enrollment); **and**
3. If benefits are not pre-tax you may drop coverage at any time; however, you may not re-enroll unless eligible at Open Enrollment or Special Enrollment times.
4. If you have a qualifying change in status, you are only allowed to make changes to your coverage that are consistent with the change of status event. Generally, only coverage for the individual who has lost eligibility as a result of a change of status (or who has gained eligibility elsewhere and actually enrolled for that coverage) can be dropped mid-year from this Plan; **and**
5. Coverage changes associated with a mid-year qualifying change of status opportunity **must be prospective** and are therefore effective the **first day of the month following** the qualifying change, provided you submit a completed written change form (or as applicable, online change application) to your Human Resource/Payroll department, except for:
   - Newborns, who are effective on the date of birth;
   - Child(ren) adopted or placed for adoption, who are effective on the date of adoption/ placement for adoption.

A Brief Summary of Common Change of Status Events and the Mid-Year Enrollment Changes Allowed Under the Medical Plan

Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code.
This chart is only a summary of some of the permitted medical plan changes.
This chart should NOT be referenced for Health FSA or Dependent Care Account Plan (DCAP).

If you experience the following Event...	**You may make the following change(s)* within 31 days of the Event…**	**YOU MAY NOT make these types of changes...**
REMINDER: *Failure to notify the Plan within 60 days of the date of a divorce or the date a child loses eligibility will cause the individuals losing coverage to forfeit the right to elect COBRA continuation coverage.*		
Family Events		
Marriage	• Enroll yourself, if applicable • Enroll your new Spouse and other eligible dependents • Drop health coverage (to enroll in your Spouse's plan) • Change health plans, when options are available	• Drop health coverage and not enroll in Spouse's plan; if you do, you won't receive coverage.
Divorce	• Remove your Spouse from your health coverage • Enroll yourself (and your children) if you or they were previously enrolled in your Spouse's plan	• Change health plans • Drop health coverage for yourself or any other Covered Individual
Gain a child due to birth or adoption	• Enroll yourself, if applicable • Enroll the eligible child and any other eligible dependents • Change health plans, when options are available	• Drop health coverage for yourself or any other Covered Individuals
Child requires coverage due to a QMCSO	• Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled) • Change health plans, when options are available, to accommodate the child named on the QMCSO	• Make any other changes, except as required by the QMCSO
Loss of a child's eligibility (*e.g.,* child reaches the maximum age for coverage)	• Remove the child from your health coverage • Child will be offered COBRA. You may pay for Dependent Child's COBRA coverage on a pre-tax basis.	• Change health plans • Drop health coverage for yourself or any other Covered Individuals
Death of a dependent (Spouse or child)	• Remove the dependent from your health coverage • Change health plans, when options are available	• Drop health coverage for yourself or any other Covered Individuals
Covered person has become entitled to (or lost entitlement to) Medicaid or Medicare	• Drop coverage for the person who became entitled to Medicare or Medicaid. • Add the person who lost Medicare/Medicaid entitlement.	• Drop health coverage for yourself or any other Covered Individuals
Employment Status Events		
Spouse becomes eligible for health benefits in another group health plan	• Remove your Spouse from your health coverage, with proof of other plan coverage • Remove your children from your health coverage, with proof of other plan coverage • Drop coverage for yourself only with proof that Spouse added you to the Spouse's new group health plan	• Change health plans • Add any eligible dependents to your health coverage
Spouse loses employment or otherwise becomes ineligible for health benefits in another plan	• Enroll your Spouse and, if applicable, eligible children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under your Spouse's plan • Change health plans, when options are available	• Drop health coverage for yourself or any other covered dependents
You lose employment or otherwise become ineligible for health benefits	• Enroll in your Spouse's plan, if available • Elect temporary COBRA coverage for the qualified beneficiaries (you and your covered dependents)	
Proof of a status change may be required to make a corresponding change in coverage/enrollment.		

FAMILY AND MEDICAL LEAVE (FMLA)

If you have worked for your employer for at least twelve months and a minimum of 1,250 hours within the last 12 months of employment and you work at a location where your employer employs 50 or more employees within 75 miles, you are entitled by law to up to 12 weeks each year (in some cases, up to 26 weeks) of unpaid family or medical leave for specified family or medical purposes, such as the birth or adoption of a child, or to provide care of a Spouse, child or parent who is seriously ill, or for your own serious illness.

For the calculation of the 12-month period used to determine employee eligibility for FMLA, Arizona Western College, City of Yuma and Crane Elementary use a rolling 12-month period measured backward in time from the date the employee uses any FMLA leave.

- While you are officially on such a family or medical leave, your employer is required to continue the employer contribution toward employee coverage. You can keep your dependent benefit coverage in effect during that family or medical leave period by continuing to pay your contributions during that period.
- Since you may not be paid while you are on a family or medical leave, there is the possibility that you may pay your dependent contributions as they come due, on the dates you would have paid them had you not taken family or medical leave, in which case your contributions will be made on an after-tax basis.
- Whether or not you keep your dependent coverage while you are on family or medical leave, if you return to work promptly at the end of that leave, your dependent benefit coverage will be reinstated without any additional limits or restrictions imposed on account of your leave. Any changes in the Plan's terms, rules or practices that went into effect while you were away on that leave will apply to you and your dependents in the same way they apply to all other employees and their dependents.
- Of course, any changes in the Plan's terms, rules or practices that went into effect while you were away on that leave will apply to you and your Dependents in the same way they apply to all other employees and their Dependents. To find out more about your entitlement to family or medical leave as required by federal and/or state law, and the terms on which you may be entitled to it, contact your Human Resource/Payroll department.

LEAVE FOR MILITARY SERVICE (UNIFORMED SERVICES & REEMPLOYMENT RIGHTS ACT - USERRA)

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA? USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.
An employee's coverage under this Plan will terminate when the employee enters active duty in the uniformed services.

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the last day of the month in which the employee stopped working.
- If the employee goes into active military service for **up to 31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.

Duty to Notify the Plan: The Plan will offer the employee USERRA continuation coverage only after the Plan Administrator has been notified by the employee in writing that they have been called to active duty in the uniformed services. The employee must notify the Plan Administrator (contact information is on the Quick Reference Chart in the front of this document) as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

When your coverage under this Plan terminates because of your reduction in hours due to your military service, you and your eligible dependents may also have COBRA rights. See also the COBRA chapter of this document. Questions

regarding your entitlement to this leave and to the continuation of benefit coverage should be referred to your Human Resource/Payroll department.

Plan Offers Continuation Coverage: Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). Unlike COBRA continuation coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact your Human Resource/Payroll department to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

- **Paying for USERRA Coverage:** If the employee goes into active military service for up to **31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.
- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the last day of the month in which the employee stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA chapter for more details.

In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces:

When the employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The employee must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated. Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to your Human Resource/Payroll department.

REINSTATEMENT OF COVERAGE AFTER LEAVES OF ABSENCE

- If your coverage ends while you are on an approved leave of absence <u>other than</u> family, medical, or military leave, and if you are benefits-eligible upon return, your coverage will be reinstated on the first day of the month following your return to active employment if you return immediately after your leave of absence ends, subject to any applicable exclusions or limitations as well as all accumulated maximum plan benefits that were incurred prior to the leave of absence.
- If your coverage ends while you are on an approved **leave of absence for family, medical or military leave**, and if you are benefits-eligible upon return, your coverage will be reinstated on the day you return to active employment if you return immediately after your leave of absence ends, subject to any maximum benefits that were incurred prior to the leave of absence.

Questions regarding your entitlement to such a leave and to the continuation of benefit coverage should be referred to your Human Resource/Payroll department.

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

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

MEDICAL EXPENSE BENEFITS

ELIGIBLE MEDICAL EXPENSES

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called "eligible medical expenses." Eligible medical expenses are determined by the Plan Administrator or its designee and are limited to those that are:

a. **"Medically Necessary,"** but only to the extent that the charges are not in excess of the **Allowed Amount** as that term is defined in the Definitions chapter of this document; and

b. **not services or supplies that are excluded** from coverage (as provided in the Medical Exclusions chapter of this document); and

c. **not services or supplies in excess** of a Maximum Plan Benefit; and

d. expenses **incurred while you are covered under the Plan** (An expense is incurred on the date you receive the service or supply for which the charge is made); and

e. **for the diagnosis or treatment of an injury or illness** (except where wellness/preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this document).

Generally, the Plan will not reimburse you for all eligible medical expenses. Usually, you will have to satisfy some **Deductibles**, pay some **coinsurance**, or make some **copayments** toward the amounts you incur that are eligible medical expenses. However, once you have incurred a maximum Out-of-Pocket cost each plan year, no further cost-sharing will be applied for that plan year.-

NON-ELIGIBLE MEDICAL EXPENSES

The Plan will not reimburse you for any expenses that are not Eligible Medical Expenses. That means you are responsible for paying the full cost of all expenses that are not determined to be Medically Necessary, determined to be in excess of the Allowed Amount, not covered by the Plan, or in excess of a Maximum Plan Benefit.

IN-NETWORK (PPO) HEALTH CARE PROVIDER SERVICES

- **In-Network:** If you receive medical services or supplies from a Health Care Provider that is contracted with the Plan's PPO, you will be responsible for paying less money out of your pocket. Health Care Providers who are under a contract with the PPO have agreed to accept the discounted amount the Plan pays for covered services, plus any additional copayments or coinsurance you are responsible for paying, as a payment in full, except with respect to claims involving a third-party payer, including auto insurance, workers' compensation or other individual insurance. In those cases, the contracts of Health Care Providers with the PPO do not require them to adhere to the discounted amount the Plan pays for covered services, and they may charge their usual and customary fees. While you must meet an annual Deductible, this **will be less than if you used a** non-PPO/non-network provider.

- **Out-of-Network (also called Non-Network, Non-PPO or Non-Participating):** refers to providers who are not contracted with the PPO Network and who do not generally offer any fee discount to the participant or to the Plan. These Out-of-Network Health Care Providers **may bill a Plan Participant a non-discounted amount** for any balance that may be due **in addition to** the allowed amount payable by the Plan, also called balance billing. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or Deductibles) that exceed the Plan's payment for a covered service. **To avoid balance billing, use in-network providers**. See also the Medical Network and Utilization Management chapter of this document.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)

The High Deductible Health Plan (HDHP) listed in this document is intended to comply with Code §223(c)(2) to allow your employer (when applicable) and eligible employees to make contributions to a Health Savings Account (HSA). The High Deductible Health Plan has a specific design for the Deductible and Out-of-Pocket Limit and this design is adjusted annually as necessary to comply with IRS rules and as appropriate for Plan administration.

A Health Savings Account is an account owned by an employee. Money deposited into the health savings account can be used (tax-free) by the employee only for qualified medical expenses. To be reimbursed on a tax-free basis, qualified medical expenses must be incurred **after** the HSA has been established.

The IRS determines the types of eligible medical expenses that are permitted for tax-free withdrawals from the HSA and it is ultimately your responsibility to assure that you are complying with IRS rules. The account can also be used to

buy non-qualified medical expenses but then the employee is required to pay applicable taxes and a financial penalty to the IRS.

The HSA Administrator (whose contact information including website is listed on the Quick Reference Chart in the front of this document) provides 24/7 toll-free access to HSA account services. Additionally, many questions about starting, contributing to an HSA and withdrawing funds from an HSA can be answered by going to the HSA Administrator's website.

THREE TAX SAVINGS OF A HEALTH SAVINGS ACCOUNT (HSA)

Health savings accounts (HSA) provide the HSA account owner with three tax savings:
(a) contributions to an HSA reduce their taxable income,
(b) earnings on the HSA account balance grows tax fee and
(c) distributions from an HSA are not taxed for qualified expenses.

Funds in the HSA never expire and can be invested. The HSA is a way to put money aside for short-term health expenses and also as a retirement savings option.

Note that the IRS code was not amended by ACA regulations to expand the definition of eligible dependents under Health Savings Accounts (HSA) to age 26. This means that employees may only be reimbursed from their tax-free HSA accounts for Dependent Children who meet the Internal Revenue Code definition of tax dependent (qualifying child or qualifying relative), which is a narrower definition than the applicable definition for federal Health Reform. Money withdrawn from the HSA account for Dependent Children who are not tax-qualified could cause the employee to be subject to income tax and a 20% penalty. The HSA participant is responsible for filing and payment of taxes on taxable amounts.

Under this Plan both you and your employer can contribute to the account. Annually, your employer reserves the right to start, stop or adjust any contributions to a Health Savings Account. The amount of your employer's contribution, if any, will be in accordance with permissible government guidelines and is announced at the Open Enrollment period each year.

Each tax year the IRS announces the maximum amount of money that can be contributed to an individual's account (e.g., in 2023, the maximum is $3,850/individual;$7,750 per family) and you can contact the HSA Administrator (noted on the Quick Reference Chart in the front of this document) each year for the updated information. Individuals ages 55 and older can make additional "catch-up" contributions (for example, in 2023, the catch-up contributions cannot exceed $1,000). Unused money in the health savings account can grow the account balance because it can be rolled over year after year. The HSA is portable, meaning that the account belongs to you even if you change employers or leave the workforce.

IMPORTANT:

In order to open a Health Savings Account (HSA) and have tax-free contributions made to that account, you must be "HSA Eligible."

By law, you are not eligible for HSA contributions if you:

- ✓are enrolled in Medicare* (Part A, Part B, Part C – Medicare Advantage Plans, Part D and Medigap, a Medicare supplemental insurance plan),
- ✓are covered by another health care plan that is not a qualified high Deductible health plan (HDHP),
- ✓can be claimed as a dependent on someone else's tax return,
- ✓are covered by a non-HDHP such as Medicaid, TRICARE and TRICARE For Life,
- ✓are enrolled in a general-purpose Health Care Flexible Spending Account (or covered by a spouse's FSA).

*With respect to being enrolled in Medicare, HSA contributions generally should be discontinued at least six months prior to filing for Medicare benefits, because Medicare enrollment (called Medicare entitlement) can occur retroactively. If you do not stop HSA contributions six months before you apply for Social Security (applying for Social Security is a first step toward Medicare coverage), you may have a tax penalty. The penalty is because you were not supposed to put money into your HSA while you had Medicare coverage. So be sure to stop all contributions to your HSA up to six months before you collect Social Security benefits.

You cannot be covered under your spouse's medical plan or any general-purpose Health Flexible Spending Account (Health FSA) that reimburses medical expenses before the Deductible is met under the HDHP, a Health Reimbursement Arrangement (HRA) or covered by another plan that pays medical benefits. You could be enrolled in a Dental Plan, Vision Plan, a "limited purpose" Health Flexible Spending Account (Health FSA) that reimburses only

dental and vision expenses, or a Dependent Care Flexible Spending Account Plan, and also could have automobile, disability or long-term care insurance coverage.

Note about Use of an HSA Account for Dependent Child Expenses: To use funds in a health savings account to reimburse eligible medical expenses for a Dependent Child, the IRS requires that an HSA account holder must be able to "claim" the child as a dependent on their tax return. If the account holder cannot claim the child as a dependent, then HSA dollars cannot be used to pay for/reimburse services provided to that child. This means that you could cover your 24-year-old child on the High Deductible Health Plan but not be able to use funds in your health savings account for that child if the child is not your tax-qualified dependent.

Note that individuals who have a health savings account and are enrolled in Medicare can no longer contribute (or have employer contributions made) to the health savings account but can use the money they have accumulated in that HSA account when they were HSA eligible.

In order to open a Health Savings Account (HSA) and have tax-free contributions made to that account, you must be "HSA eligible."

Information about Health Savings Account Contributions and Prorating the Maximum Yearly Contribution: If you aren't certain you'll be enrolled in a HDHP during the entire next tax year, you can contribute a prorated amount for the months you're actually eligible in the current tax year. To do this, divide the yearly allowable maximum contribution by 12, then multiply the result by the number of months you're enrolled in a HDHP during that tax year.

Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your HDHP. If you are enrolled in the HDHP as of December 1, you are considered to be an eligible individual for HSA contributions for the entire tax year and you are not required to prorate your contributions to your health savings account. However, if you base an entire tax year's contribution on your status on December 1 and you cease to be an eligible individual before the end of the following year, any funding of the health savings account over the prorated amount (for December) is considered an excess health savings account contribution and the excess amount is subject to a penalty and income tax.

The YABC plan administrator does not provide tax advice and no inference may be made that the information contained here constitutes tax advice. The tax information contained in this document is for general guidance only and is subject to change due to changes in IRS rules and regulations. You should consult a qualified tax advisor with regard to any questions you may have about the tax effects of an HSA on your individual circumstances. The plan administrator assumes no responsibility for the accuracy of tax statements expressed in this document in relation to an individual's tax situation

It is advisable to discuss with your tax advisor about joining a HDHP with HSA. Remember, **it is your responsibility to assure that you are an "HSA eligible" individual while contributions are made to your HSA account**.

Questions about the High Deductible Health Plan described in this document and Health Savings Accounts can be directed to your employer's Human Resource/Payroll Department.

DEDUCTIBLES

Deductible refers to the amount of money you must pay each Plan year before the Plan pays benefits. For the use of In-Network and Out-of-Network services, each year you are responsible for paying all of your eligible medical expenses until you satisfy the annual **Plan Year** Deductible. Then, the Plan begins to pay benefits. Only Eligible Medical Expenses can be used to satisfy the Plan's Deductible. Copayments do not accumulate to meet the Deductible.

There are two types of Deductibles: Individual and Family. **NOTE:** These Deductibles are NOT interchangeable, thus you may not use any portion of an In-Network Deductible to meet an Out-of-Network Deductible and vice versa. The Deductible amounts are displayed on the Schedule of Medical Benefits.

1. The individual Deductible is the maximum amount one covered person has to pay before Plan benefits begin. The Plan's Individual Deductible varies depending on the Plan design you select.
2. The family Deductible is the maximum amount that a family of two or more is responsible for paying before Plan benefits begin. The Plan's Family Deductible varies depending on the Plan design you select. **At least one family member must incur the individual Deductible, except if the family is enrolled in the HDHP (see below).**

NOTE: For families enrolled in the HDHP option, IRS regulations require that the family (including any individual in the family) must meet the IRS-mandated minimum family Deductible (e.g., $3,000 in 2023) before any reimbursement is made for eligible medical expenses (other than for preventive care).

Deductible rules when Enrolled in the HDHP Option: If you are enrolled in the HDHP option, this Plan option cannot pay ANY benefits (except certain preventive/wellness care outlined in the Wellness rows of the Schedule of Medical Benefits) until your annual Deductible has been met.

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

COINSURANCE

Coinsurance refers to how you and the Plan will split the cost of covered expenses. Once you have met your annual Deductible, the Plan generally pays a percentage of the eligible medical expenses and you are responsible for paying the rest. The part you pay is called the coinsurance.

1. **Coinsurance When You Use an In-Network Provider:** If you use the services of a Health Care Provider who is a member of the Plan's network (an In-Network provider), you may have a reduced coinsurance or just a copay for those expenses. Refer to the Schedule of Medical Benefits for a more detailed explanation of financial responsibility by type of service in the various medical plan options offered.
2. **Coinsurance When You Don't Comply With The Utilization Management Programs:** If you fail to follow certain of the Plan's Utilization Management programs, the Plan may pay a smaller percentage of the cost of those services, and you will have to pay a greater percentage of those costs, or a larger coinsurance. These features are described in the Medical Network and Utilization Management chapter of this document.

COPAYMENT

A Copayment (Copay) is a set dollar amount you (and not the Plan) are responsible for paying when you incur an Eligible Medical Expense. The Plan's Copayments are indicated in the Schedule of Medical Benefits.

Copayments are generally not used to satisfy the Deductible except under the High Deductible Health Plan.

OUT-OF-POCKET LIMIT

This Plan has an Out-of-Pocket Limit which limits your annual cost-sharing for covered essential health benefits related to Medical Plan Deductibles, Coinsurance, and Copayments to the amounts permitted under the Health Reform. The Out-of-Pocket Limit is the most you pay in Deductibles, Copayment and Coinsurance for covered services during a one-year period (the plan year) before your health plan starts to pay 100%.

- Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan.
- The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services.
- Out-of-Pocket Limits are NOT interchangeable, meaning you may not use a portion of an In-Network Out-of-Pocket Limit to meet an Out-of-Network Out-of-Pocket Limit and vice versa, **except** that emergency services performed in an Out-of-Network Emergency Room will apply to meet the in-network Out-of-Pocket Limit.
- The family Out-of-Pocket Limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual Out-of-Pocket Limit.
- The Out-of-Pocket Limit **does not include** or accumulate:

a. Premiums/Contributions for coverage,
b. Expenses for medical services or supplies that are not covered by the Plan,
c. Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for non-network providers,
d. Penalties for non-compliance with Utilization Management program requirements,
e. Charges in excess of the Medical Plan's maximum benefits,
f. Expenses that are not considered to be essential health benefits,
g. Dental Plan and Vision Plan expenses.

MAXIMUM PLAN BENEFITS

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

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

INFORMATION ABOUT MEDICARE PART D PRESCRIPTION DRUG PLANS FOR PEOPLE WITH MEDICARE

If you and/or your Dependent(s) are enrolled in either Part A or B of Medicare, you are also eligible for Medicare Part D Prescription Drug benefits. **It has been determined that the prescription drug coverage outlined in this document for Plan A, Plan B and the HDHP with HSA is "creditable."** "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Prescription Drug Plan during Medicare's annual enrollment period (generally October 15th through December 7th of each year).

You can keep your current medical and prescription drug coverage with this Plan and you do not have to enroll in Medicare Part D. If however you keep this Plan coverage and also enroll in a Medicare Part D prescription drug plan you will have dual prescription drug coverage Because outpatient drugs are managed by a Pharmacy Benefit Manager, this Plan does not coordinate its outpatient drug payments with Medicare. Outpatient drugs are processed as if you do not have other coverage, including as if you do not have Medicare drug coverage. See the Coordination of Benefit chapter for more details on how the Plan coordinates with Medicare. If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (generally October 15th through December 7th); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a Special Enrollment Period in which to sign up for a Medicare prescription drug plan

If you do not enroll in a Medicare prescription drug plan you may have a late enrollment fee on the premium you pay for Medicare coverage if and when you do enroll.

IMPORTANT NOTE: If you are enrolled in the High Deductible Health (HDHP) Plan with the Health Savings Account (HSA) **you and your employer may not continue to make contributions to your HSA** once you are enrolled in Medicare (including being enrolled in a Medicare Part D drug plan). If you want to continue to make contributions to your HSA account, you must not enroll in you must not enroll in Medicare, including a Medicare Part D plan.

Note that you may not drop just the prescription drug coverage under this Plan. That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this Plan's next Open Enrollment period.

For more information about creditable coverage or Medicare Part D coverage see the Plan's Notice of Creditable Coverage (a copy is available from your employer's Human Resource/Payroll department. See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

EMERGENCY SERVICES

Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided out-of-network;
- Without regard to whether the health care provider furnishing the Emergency Services is a Network Provider or a Network emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from Network Providers and Network emergency facilities;

- Without imposing Cost-Sharing Requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by a Network Provider or a Network emergency facility;
- By calculating the Cost-Sharing Requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
- By counting any Cost-Sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any in-network Deductible or in-network out-of-pocket maximums applied under the Plans (and the in-network Deductible and in-network out-of-pocket maximums are applied) in the same manner as if the Cost-Sharing payments were made with respect to Emergency Services furnished by a Network Provider or a Network emergency facility.

In general, you cannot be Balanced Billed for these items or services.

Your cost sharing amount for Emergency Services from Non-Network Providers will based on the lessor of billed charges from the provider or the Qualified Payment Amount (QPA).

NON-EMERGENCY ITEMS OR SERVICES FROM A NON-PPO PROVIDER AT A PPO FACILITY

With regard to non-emergency items or services that are otherwise covered by the Plans, if the covered non-emergency items or services are performed by a Non-Network Provider at a Network facility, the items or services are covered by the Plans:

- With a Cost Sharing Requirement that is no greater than the Cost-Sharing Requirement that would apply if the items or services had been furnished by a Network Provider,
- By calculating the Cost-Sharing requirements as if the total amount that would have been charged for the items and services by such Network Provider were equal to the Recognized Amount for the items and services,
- By counting any Cost-Sharing payments made by the participant or beneficiary toward any in-network Deductible and in-network out-of-pocket maximums applied under the Plans (and the in-network Deductible and out-of-pocket maximums must be applied) in the same manner as if such Cost-Sharing payments were made with respect to items and services furnished by a Network Provider,

Non-emergency items or services performed by a Non-Network Provider at a Network facility will be covered based your out-of-network coverage if:

- At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-Network Provider with respect to the Plans, of the estimated charges for your treatment and any advance limitations that the Plans may put on your treatment, of the names of any Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the Network Providers listed; and
- The participant or dependent gives informed consent to continued treatment by the Non-Network Provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-Network Provider may result in greater cost to the participant or beneficiary.

The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Network Provider satisfied the notice and consent criteria, and therefore these services will be covered:

- With a Cost-Sharing Requirement that is no greater than the Cost-Sharing Requirement that would apply if the items or services had been furnished by a Network Provider,
- With Cost-Sharing Requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services, and
- With Cost-Sharing counted toward any in-network Deductible and in-network out of pocket maximums, as if such Cost-Sharing payments were with respect to items and services furnished by a Network Provider.

Your Cost Sharing amount for Non-Emergency Services at Network Facilities by Non-Network Providers will based on the lessor of billed charges from the provider or the QPA.

AIR AMBULANCE SERVICES

If you receive Air Ambulance services that are otherwise covered by the Plans from a Non-Network Provider, those services will be covered by the Plans as follows:

- The Air Ambulance services received from a Non-Network Provider will be covered with a Cost-Sharing Requirement that is no greater than the Cost-Sharing Requirement that would apply if the services had been furnished by a Network Provider.
- The Cost-Sharing Amount will be calculated as if the total amount that would have been charged for the services by a Network Provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any Cost-Sharing payments you make with respect to covered Air Ambulance services will count toward your in-network Deductible and in-network out-of-pocket maximum in the same manner as those received from a Network Provider.

In general, you cannot be Balance Billed for these items or services.

PAYMENTS TO NON-NETWORK PROVIDERS AND FACILITIES

The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at Network Facilities by Non-Network Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Non-Network Provider. The 30-day calendar period begins on the date the Plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the Cost-Sharing Amount under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required Cost-Sharing Amount (also known as "Balance Billing").

The Plans will pay a total plan payment directly to the Non-Network Provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the Cost-Sharing Amount for the services, less any initial payment amount.

CONTINUITY OF COVERAGE

If you are a Continuing Care Patient, and the contract with your Network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

- You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and
- You will be allowed up to ninety (90) days of continued coverage at the Network Cost-Sharing Amount to allow for a transition of care to a Network provider.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

The medical plans in this document do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider; however, payment by the Plan may be less for the use of a non-network provider.

You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the PPO network at their website listed on the Quick Reference Chart.

NONDISCRIMINATION IN HEALTH CARE

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. In this context, discrimination means treating a provider differently based solely on the type of the provider's license or certification. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

COVERAGE OF CERTAIN PREVENTIVE CARE DRUGS

For a Preventive Care drug to be covered by the Plan, the drug must be:

1. obtained through the outpatient Prescription Drug Program at a participating network retail or mail order pharmacy and
2. presented to the pharmacist with a prescription for the drug from your Physician or Health Care Practitioner.

(Note that while these Preventive Care drugs require a prescription, certain types of insulin are payable by the Plan without a prescription).

The following chart outlines the Preventive Care drugs that are payable **at no charge when purchased at a network retail or mail order pharmacy location**, in accordance with Health Reform regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations. Where the information in this document conflicts with newly released Health Reform regulations affecting the coverage of OTC and prescription drugs, this Plan will comply with the new requirements on the date required.

Drug Name	Who Is Covered for this Drug?	Cost-Sharing?	Payment Parameters in addition to a prescription:
Aspirin	• For pregnant women who are at high risk for preeclampsia (a pregnancy complication). • Low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	None, if payment parameters are met	• For non-pregnant adults: since dosage is not established by USPSTF, plan covers up to one bottle of generic 100 tablets every 3 months. • For pregnant women who are at high risk for preeclampsia, the Plan covers a daily low-dose aspirin 81 mg as preventive medication after 12 weeks' gestation. • The use of aspirin is recommended when the potential benefit outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
FDA-approved contraceptives for females, such as birth control pills, spermicidal products and sponges.	All females	None, if payment parameters are met	Up to a month's supply of FDA-approved contraceptives per purchase (or 3-month supply of certain 90-day dosed contraceptives like Seasonale) are payable under the plan's Prescription Drug Program for females younger than 60 years of age. Generic FDA-approved contraceptives are at no cost to the plan participant. Brand contraceptives are payable only if a generic alternative is medically inappropriate as determined by the Physician or Health Care Practitioner. An exceptions process is available if an individual's health care provider recommends an item or service not covered under the plan's contraceptive coverage policies.
Folic acid supplements	All females planning or capable of pregnancy should take a daily folic acid supplement containing 0.4 - 0.8mg of folic acid.	None, if payment parameters are met	Excludes women >55 years of age, and products containing > 0.8mg or < 0.4mg of folic acid. Plan covers generic folic acid up to one tablet per day.
Tobacco cessation products (FDA approved)	Individuals who use tobacco products.	None, if payment parameters are met	FDA-approved tobacco cessation drugs are payable under the plan's Prescription Drug Program, up to two 12-week courses of treatment per year, which applies to all products. No precertification or prior authorization is required.

Drug Name	Who Is Covered for this Drug?	Cost-Sharing?	Payment Parameters in addition to a prescription:
Fluoride supplements	For children starting at age 6 months when recommended by provider because primary water source is deficient in fluoride.	None, if payment parameters are met	Plan covers generic versions of systemic dietary fluoride supplements (tablets, drops or lozenges) available only by prescription for children to age 6 years. Excludes products for individuals age 6 and older, topical fluoride products like toothpaste or mouthwash and excludes brand name fluoride supplements.
Preparation "prep" Products for a Colon Cancer Screening Test	For individuals receiving a preventive colon cancer screening test	None, if payment parameters are met	Plan covers the over the counter or prescription strength products prescribed by a physician as preparation for a payable preventive colon cancer screening test, such as a colonoscopy for individuals age 50-75 years.
Breast cancer preventive medication	Women who are at increased risk for breast cancer and at low risk for adverse medication effects.	None, if payment parameters are met	Plan covers generic breast cancer preventive drugs such as tamoxifen or raloxifene.
Statin preventive medication	Adults ages 40-75 years with: no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.	None, if payment parameters are met	For adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke), the Plan covers a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening (a lab test) in adults ages 40 to 75 years.
Pre-exposure Prophylaxis (PrEP)	Persons at increased risk of HIV acquisition.	None, if payment parameters are met	Offer pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy

SCHEDULE OF MEDICAL BENEFITS

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

All of the YABC medical plan design options are listed side by side.

Unless there is a specific statement in the Schedule of Medical Benefits, all benefits shown are subject to the Plan's Deductibles.

To determine the extent to which limitations apply to the benefits that are payable for any health care services or supplies you receive, you should also check to see if those services are listed separately in the Schedule of Medical Benefits, even if they seem to be included in Hospital Services or Physician and Health Care Practitioner Services, and you should also check the Exclusions chapter of this document to see if they are excluded.

The High Deductible Health Plan (HDHP) listed in this document is intended to qualify as a HDHP to comply with Code §223(c)(2) to allow eligible individuals to make contributions to a Health Savings Account (HSA).

TIME LIMIT FOR FILING CLAIMS

All medical, prescription drug, and dental claims must be submitted to the plan within 12 months after the expenses were incurred. No plan benefits will be paid for any claim not submitted within this period.

Vision Claims: If you use the services of a non-network vision provider, you will need to pay the provider for all services and then, at a later date but **within 12 months** of the date of service, submit the bill to the Vision Plan whose name and address are listed on the Quick Reference Chart in the front of this document.

Vision claims submitted beyond twelve months of the date of service may not be considered for reimbursement.

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after the stated timeframe.

How can I be a wise consumer of health care and get the most value out of my Medical Plan?

- ✓ **Use Network (PPO) providers.** They charge less, and you pay less. In addition, most Preventive Care is free when provided by Network PPO providers.
- ✓ **Choose Generic drugs and use the Mail Order Service when possible.** Ask your Doctor if a generic drug is appropriate for you. You'll pay less for generic drugs than for brand name drugs in most situations. Plus, filling your medication through the Mail Order service is a cost-effective way to obtain a 90-day drug supply.
- ✓ **Have a chronic health condition like diabetes, asthma, arthritis, heart disease, etc.?** One of the best things you can do for that condition is to take the medication your Doctor recommends for you. Make medication compliance your habit to a healthier life.
- ✓ **Keep current with your Preventive/Wellness care** to help identify any health risk factors (like high blood pressure, high blood sugar, weight creeping above the recommended range), get tips from your provider on how to reduce your health risks, and stay current on recommended immunizations and cancer screening tests.
- ✓ **Not feeling well?** Call your Network Doctor's office for help. Or, use the Telemedicine office visit service, or go to a Network Urgent Care facility instead of an emergency room (ER), if medically appropriate.
- ✓ **Precertify** your elective hospital admission, certain outpatient drugs, and certain other services, as explained in Medical Network and Utilization Management chapter, to help avoid a financial penalty.
- ✓ **Review Your Medical Bills.** If something on a medical bill just doesn't look right, contact the Medical Plan Claims Administrator if you think there might be an error on a bill.

These tips will help you make the most of your medical plan benefits.

SCHEDULE OF MEDICAL BENEFITS

This Schedule explains what this Plan pays. All benefits are subject to the Deductible except where noted. See also the Medical Exclusions and Definitions chapters for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you. Note: This does not apply to emergency services in an Out-of-Network hospital or Independent Freestanding Emergency Department center, certain non-emergency services by Out-of-Network-network providers at In-Network facilities, or Out-of-Network air ambulance services.**

Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible • The Deductible is the amount you must pay each Plan year before the Plan pays benefits. • REMINDER: If enrolled in the HDHP option, this plan option cannot pay any benefits (except preventive care) until the Deductible has been met. • If you have other family members on the plan, each family member must meet their own individual Deductible until the total amount of Deductible expenses paid by all family members meets the overall family Deductible.	• Note that Deductibles are NOT interchangeable, thus you may not use any portion of an In-Network Deductible to meet an Out-of-Network Deductible and vice versa. • **For Plan A and Plan B:** The family Deductible is the maximum amount that a family of two or more is responsible for paying before Plan benefits begin. At least one family member must incur the individual Deductible. • **For families enrolled in the HDHP option**, IRS regulations require that the family (including any individual in the family) must meet the IRS-mandated minimum family Deductible (e.g.,$3,000 in 2023) before any reimbursement is made for eligible medical expenses (other than for preventive care).	Individual: $750 Family: $1,500	Individual: $1,500 Family: $3,000	Individual: $1,000 Family: $2,000	Individual: $2,250 Family: $4,500	Individual: $1,500 Family: $3,000	Individual: $3,000 Family: $6,000

SCHEDULE OF MEDICAL BENEFITS

This Schedule explains what this Plan pays. All benefits are subject to the Deductible except where noted. See also the Medical Exclusions and Definitions chapters for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you. Note: This does not apply to emergency services in an Out-of-Network hospital or Independent Freestanding Emergency Department center, certain non-emergency services by Out-of-Network-network providers at In-Network facilities, or Out-of-Network air ambulance services.**

Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Out-of-Pocket Limit • This plan has an Out-of-Pocket Limit which limits your annual cost-sharing for covered essential health benefits related to medical plan Deductibles, coinsurance, and copayments • The Out-of-Pocket Limit is the most you pay in Deductibles, copayment and coinsurance during a one-year period (the Plan Year) before your health plan starts to pay 100% for covered essential health benefits. • Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. • Outpatient drugs accumulate to the medical plan Out-of-Pocket Limit. • Out-of-pocket limits are not interchangeable, meaning you may not use a portion of an in-network Out-of-Pocket Limit to meet an out-of-network Out-of-Pocket Limit and vice versa, **except** that Emergency Services performed in an out-of-network emergency room and air ambulance services from Non-network providers will apply to meet the in-network Out-of-Pocket Limit.	• The family Out-of-Pocket Limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual Out-of-Pocket Limit. • Covered outpatient prescription drug expenses accumulate to the Out-of-Pocket Limit. • The Out-of-Pocket Limit does not include or accumulate: a. Premiums/Contributions for coverage, b. Expenses for medical services or supplies that are not covered by the Plan, c. Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for non-network providers, d. Penalties for non-compliance with Utilization Management program requirements, e. Charges in excess of the Medical Plan's maximum benefits, f. Expenses that are not considered to be essential health benefits, g. Dental Plan and Vision Plan expenses.	Individual: $5,750 Individual in the family: $5,750 Family: $11,500	Each Individual: $9,000	Individual: $6,600 Individual in the family: $6,660 Family: $13,200	Each Individual: $10,000	Individual: $4,000 Individual in the family: $4,000 Family: $8,000	Individual: $8,000 Family: $16,000

SCHEDULE OF MEDICAL BENEFITS

This Schedule explains what this Plan pays. All benefits are subject to the Deductible except where noted. See also the Medical Exclusions and Definitions chapters for important information.

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospital Services (Inpatient) • Room & board in semiprivate room with general nursing services. • Specialty care units (*e.g.*, intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related Medically Necessary ancillary services (*e.g.,* prescriptions, supplies). • Newborn care. • Circumcision for newborn males ages birth to 10 weeks of age. • Under certain circumstances the medical plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by a Dental Plan if the utilization management firm determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the associated dental professional fee services provided while at a hospital or outpatient surgery facility.	• **Elective hospitalization is subject to precertification**. **All hospitalization is subject to concurrent review**. See the Medical Network and Utilization Management chapter for details. • Private room is covered only if Medically Necessary. • Charges for a newborn will be considered part of and payable under the mother's delivery admission charges until the mother is discharged. If the newborn cannot be discharged with the mother and needs continued confinement, the newborn's charges from the date of birth will be considered as separate from the mother. **See the Eligibility chapter for guidelines on how to properly enroll a newborn under this Plan**. • See also the Specialty Health Care Facilities row in this Schedule.	80% after Deductible is met	50% after Deductible is met	75% after Deductible is met	50% after Deductible is met	85% after Deductible is met	60% after Deductible is met

SCHEDULE OF MEDICAL BENEFITS

This Schedule explains what this Plan pays. All benefits are subject to the Deductible except where noted. See also the Medical Exclusions and Definitions chapters for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you. Note: This does not apply to emergency services in an Out-of-Network hospital or Independent Freestanding Emergency Department center, certain non-emergency services by Out-of-Network-network providers at In-Network facilities, or Out-of-Network air ambulance services.**

Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network

Physician & Other Health Care Practitioner Services
 	
• Benefits are payable for:
  • Office visits.
  • Hospital and other health care facility visits of physicians and other covered health care practitioners. See also the Emergency Services row for payment of providers in an emergency room.
• Medically necessary Physicians and Health Care Practitioner professional fees include:
  • Surgeon fees
  • Assistant surgeon (only if Medically Necessary)
  • Anesthesia fees from physicians and Certified Registered Nurse Anesthetists (CRNA)
  • Pathologist fees
  • Radiologist fees
  • Podiatrist (DPM)
  • Breastfeeding/Lactation Educator
  • Physician assistant, nurse practitioner and nurse midwife fees.
 	
• **PCP means a Primary Care Physician** and refers to any of the following physicians: family practitioner, general practitioner, pediatrician, internist, and OB/GYN. All other providers are specialists.
 	
• **Teladoc** web or phone-based Physician consultation (e-visit). See the Quick Reference Chart for more information.
	• **Some physician services are subject to precertification**. See the Medical Network and Utilization Management chapter for details.
	• The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of **"surgery"** in the Definitions chapter.
	• **Assistant surgeon fees** will be reimbursed for Medically Necessary services to a **maximum** of 20% of the eligible expenses payable to the primary surgeon except where services are provided by an out-of-network assistant surgeon at an in-network facility.
	• **Nurse Practitioner** and **Physician Assistant** fees will be reimbursed according to practice area of their overseeing physician.
	• Lab tests obtained and performed within the physician's office are payable under the office visit copay if an office visit occurs on the same date of service. All other lab services performed Out-of-Network are subject to coinsurance.
	• The coinsurance for "All other fees" applies to professional fees performed in a non-office setting such as surgeon's fees, anesthesia, assistant surgeon, pathologist/radiologist interpretation fees, etc.
	• **Anesthesia Services:** If both an anesthesiologist physician and a certified registered nurse anesthetist bill the Plan for anesthesia services on the same procedure, the Plan will allow, as total payment, the amount that would have been payable had just one professional performed the anesthesia services. Plan payment will be split 50/50 between the anesthesiologist and the CRNA.
	• Requests for prophylactic surgery, such as a prophylactic mastectomy, should be directed to the Utilization Management Company for precertification. See also the definition of prophylactic surgery in the Definitions chapter.
		Teladoc: No charge.
		
		If the place of service is the Physician office, charges are not subject to the Deductible and the Plan pays 100% after a **$25 copay** for the office visit code and all other services performed are paid at 80% except lab work performed along with an office visit is payable at 100%, no Deductible.
		
		Lab work performed without an office visit is payable at 100% after a **$25 copay** per day.
		
		All other fees: 80% after Deductible is met.
			Office Visit: 50% after Deductible is met
			
			Anesthesia fees: 80% after Deductible is met.
			
			All other fees: 50% after Deductible is met.
				Teladoc: No charge.
				
				If the place of service is the Physician office, charges are not subject to a Deductible and Plan pays: **PCP Visit**: 100% after a **$30 copay** for the office visit code and all other services are paid at 75%, except lab work performed along with an office visit is payable at 100%, no Deductible.
				
				Specialist Visit: 100% after a **$50 copay** for the office visit code and all other services are paid at 75%, except lab work performed along with an office visit is payable at 100%, no Deductible.
				Lab work performed without an office visit is payable at 100% after a **$30 copay** per day.
				All other fees: 75% after Deductible is met.
					Office Visit: 50% after Deductible is met.
					
					Anesthesia fees: 75% after Deductible is met.
					
					All other fees: 50% after Deductible is met.
						Teladoc: After Deductible met, you pay 15% coinsurance up to $45 per visit, thereafter no charge.
						
						Other services: 85% after Deductible is met.
							60% after Deductible is met.

SCHEDULE OF MEDICAL BENEFITS

This Schedule explains what this Plan pays. All benefits are subject to the Deductible except where noted. See also the Medical Exclusions and Definitions chapters for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you. Note: This does not apply to emergency services in an Out-of-Network hospital or Independent Freestanding Emergency Department center, certain non-emergency services by Out-of-Network-network providers at In-Network facilities, or Out-of-Network air ambulance services.**

Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Allergy Services • Allergy sensitivity testing, including skin patch or Rast/Mast blood tests. • Desensitization and hypo sensitization (allergy shots given at periodic intervals) • Allergy antigen solution.	• Covered only when ordered by a Physician. • Desensitization injections are covered only when provided by a licensed health care practitioner.	**Testing**: 100% after a $25 copay, (no Deductible) **Desensitization Injections**: 100% (no Deductible)	**Testing**: 50% after Deductible is met **Desensitization Injections**: 50% after Deductible is met	**Testing**: 100% after a $30 copay (no Deductible) **Desensitization Injections**: 100% (no Deductible)	**Testing**: 50% after Deductible is met **Desensitization Injections**: 50% after Deductible is met	**Testing:** 85% after Deductible is met **Desensitization Injections:** 85% after Deductible is met	**Testing:** 60% after Deductible is met **Desensitization Injections:** 60% after Deductible is met
Ambulance	• See Emergency and Ambulance Transportation Services row in this Schedule.						
Ambulatory Surgery Facility (also called Outpatient Surgery Facility/Center)	• See the Specialized Health Care Facility row in this Schedule.						

SCHEDULE OF MEDICAL BENEFITS

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you. Note: This does not apply to emergency services in an Out-of-Network hospital or Independent Freestanding Emergency Department center, certain non-emergency services by Out-of-Network-network providers at In-Network facilities, or Out-of-Network air ambulance services.**

Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Behavioral Health Services **(Mental Health and Substance Abuse Treatment)** • **EAP program:** For all participating employers, the EAP provides up to 12 free counseling sessions per person per year. • **Outpatient Visits** (individual and group) • **Other Outpatient Services** including, including intensive outpatient program services and partial day care) • **Inpatient Admission** (including acute inpatient hospital admission and residential treatment program). • Screening for tobacco use; and, for those who use tobacco products, the Plan covers at least two tobacco cessation attempts per year. Cessation support described to the right.	• **The Employee Assistance Program (EAP) provides 12 free confidential counseling sessions per problem, per person, per year** for you and your eligible dependents. Refer to the Quick Reference Chart in the front of this document for the EAP telephone number. • **Elective Hospitalization and Residential treatment programs are subject to precertification. and concurrent review**. See the Medical Network and Utilization Management chapter for details. • Behavioral health **residential treatment program** is payable for individuals needing treatment in a highly structured 24-hour therapeutic environment that cannot be safely, efficiently or effectively treated in a less intensive setting. A residential treatment facility must be properly licensed in the state in which the facility operates. **Precertification is required**. Behavioral health residential treatment is paid like an inpatient admission. • **Tobacco Cessation support**: The Plan covers, at no cost for Network providers, at least two tobacco cessation attempts per person per year. A cessation attempt includes coverage for four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and/or individual counseling) (without precertification). All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) are covered at no cost from Network retail pharmacy locations for a 90-day treatment regimen when prescribed by Physician or Health Care Practitioner (without precertification). See also the Drug row in this Schedule. • See the specific exclusions related to Behavioral Health Services, including intellectual disability and learning disability in the Medical Exclusions chapter. • No coverage for programs based on learning theories and motivation, such as Applied Behavioral Analysis (ABA) Therapy.	**EAP Visits:** 100% (no Deductible) **Outpatient Visits and other outpatient services**: 100% after a $25 copay **Inpatient or Residential Treatment Program:** 80% after Deductible is met	**EAP Visits:** 100% (no Deductible) **Outpatient Visits and other outpatient services:** 50% after Deductible is met **Inpatient:** 50% after Deductible is met **Residential Treatment Program:** No coverage	**EAP Visits:** 100% (no Deductible) **Outpatient Visits and other outpatient services:** 100% after a $30 copay **Inpatient or Residential Treatment Program:** 75% after Deductible is met	**EAP Visits:** 100% (no Deductible) **Outpatient Visits and other outpatient services:** 50% after Deductible is met **Inpatient:** 50% after Deductible is met **Residential Treatment Program:** No coverage	**EAP Visits:** 100% (no Deductible) **Outpatient Visits and other outpatient services:** 85% after Deductible is met **Inpatient or Residential Treatment Program:** 85% after Deductible is met	**EAP Visits:** 100% (no Deductible) **Outpatient Visits and other outpatient services:** 60% after Deductible is met **Inpatient:** 60% after Deductible is met **Residential Treatment Program:** No coverage

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Birthing Center	• See the Specialized Health Care Facilities row in this Schedule.						
Blood Transfusions • Blood transfusions and blood products and equipment for its administration.	• Covered only when ordered by a physician.	80% after Deductible is met	50% after Deductible is met	75% after Deductible is met	50% after Deductible is met	85% after Deductible is met	60% after Deductible is met
Chemotherapy • Chemotherapy services and supplies payable when ordered by a Physician.	• For chemotherapy performed in a physician's office, the coinsurance applies to the chemotherapy and supplies while the copay applies to the office visit, when an office visit is billed.	80% after Deductible is met	50% after Deductible is met	75% after Deductible is met	50% after Deductible is met	85% after Deductible is met	60% after Deductible is met
Chiropractic Services	• See Spinal Manipulation row in this Schedule.						

SCHEDULE OF MEDICAL BENEFITS

This Schedule explains what this Plan pays. All benefits are subject to the Deductible except where noted. See also the Medical Exclusions and Definitions chapters for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you. Note: This does not apply to emergency services in an Out-of-Network hospital or Independent Freestanding Emergency Department center, certain non-emergency services by Out-of-Network-network providers at In-Network facilities, or Out-of-Network air ambulance services.**

Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Corrective Appliances **(Prosthetic & Orthotic Devices, Other Than Dental)** • Coverage is provided for rental or purchase of standard models at the option of the Plan. • Rental is payable only up to the allowed purchase price of the corrective appliance. • Benefits are payable for Medically Necessary repair, adjustment and servicing of corrective appliances. • Benefits are payable for Medically Necessary replacement of these devices due to a change in the covered person's physical condition or if the device cannot be satisfactorily repaired. • Colostomy or ostomy and/or urinary catheter (orthotic) supplies.	• See the specific exclusions related to Corrective Appliances in the Medical Exclusions chapter. To help determine what prosthetic or orthotic appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Definitions chapter. • Corrective appliances are covered only when Medically Necessary and ordered by a Physician or Health Care Practitioner. • Prosthetic device includes coverage for a Medically Necessary implantable hearing device, such as a cochlear implant. Coverage is also provided for aural therapy in connection with covered implantable hearing devices. Aural therapy is covered by Speech Therapy benefits. See the Rehabilitation Services row of this Schedule of Medical Benefits for more information. • **Foot orthotics** (orthopedic or corrective shoes and other supportive appliances for the feet) are limited to once in a period of 12 months for adults and once in a period of six months for children under age 19 when replacement is required due to growth. • Orthotic devices used to assist an individual in performing activities of daily living are not payable under this Plan. • External hearing aids are not covered, except implantable hearing devices are covered.	80% after Deductible is met	50% after Deductible is met	75% after Deductible is met	50% after Deductible is met	85% after Deductible is met	60% after Deductible is met
Diabetes Education	• Coverage is payable for a formal diabetes education course/program taught by a Physician or Certified Diabetes Educator. • A diabetes education program is initially payable when a covered person is diagnosed with diabetes. A refresher program is payable up to 5 times per lifetime.	100%, no Deductible	No coverage.	100%, no Deductible	No coverage.	80% after Deductible is met	No coverage.

SCHEDULE OF MEDICAL BENEFITS

This Schedule explains what this Plan pays. All benefits are subject to the Deductible except where noted. See also the Medical Exclusions and Definitions chapters for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you. Note: This does not apply to emergency services in an Out-of-Network hospital or Independent Freestanding Emergency Department center, certain non-emergency services by Out-of-Network-network providers at In-Network facilities, or Out-of-Network air ambulance services.**

Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Dialysis • Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• **It is important that individuals with end stage kidney/renal disease promptly apply for Medicare coverage, regardless of age**. • See also the Coordination of Benefits chapter that discusses what this Plan pays when you are also Medicare eligible.	80% after Deductible is met	50% after Deductible is met	75% after Deductible is met	50% after Deductible is met	85% after Deductible is met	60% after Deductible is met
Dietitian Services • Benefits are payable for Nutritional Counseling to assist individuals with their nutritional health and dietary needs. Services can be used for assistance with food choices when diagnosed with such diseases as obesity, high blood pressure, cardiac disease, diabetes, high cholesterol, allergies, kidney disease, etc. • Services are payable only when performed by a licensed provider practicing within the scope of their license.	• Services of a Registered Dietician or licensed or certified Nutritionist are payable as preventive services, to a maximum of 5 visits per person per year. This visit limit does not apply to nutritional counseling services that are Medically Necessary for the treatment of an individual diagnosed with a mental health or substance abuse condition, such as an eating disorder. • See this website for Health Reform mandated diet counseling services: http://www.uspreventiveservicestaskforce.org	100% no Deductible	50% after Deductible is met	100% no Deductible	50% after Deductible is met	100% no Deductible for diet counseling services mandated by Health Reform Non-mandated services payable at 85% after Deductible is met	60% after Deductible is met

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network

Drugs and Medicines (Outpatient)
• Coverage is provided only for FDA approved pharmaceuticals requiring a prescription and FDA approved for the condition, dose, route, duration and frequency if prescribed by a physician or other health care practitioner authorized by law to prescribe them.
• Insulin, insulin syringes, test strips, prenatal vitamins, & FDA-approved female contraceptives are payable.
• Contact the Prescription Drug Program (whose phone number is listed on the Quick Reference Chart in the front of this document) for the following:
  ◦ The list of Formulary Preferred Drugs.
  ◦ Drugs needing pre-approval by the Prescription Drug Program's clinical staff.
  ◦ Information on which drugs have a quantity limit payable by the Plan.
  ◦ Information on which drugs are part of the step therapy program where you first try a proven, cost-effective medication before moving to a more costly drug option.
• **Specialty Drugs** are available on an outpatient basis when ordered through and managed by the Utilization Management (UM) Company and/or the Prescription Drug Program. Specialty Drugs are high-cost prescription drugs used to treat complex, chronic conditions like multiple sclerosis, rheumatoid arthritis or hepatitis. These drugs need precertification by the clinical staff of the Utilization Management (UM) Company and/or the Prescription Drug Program and are managed because they often require special handling, are date sensitive and are usually available only in a 30-day quantity. NOTE: Not all specialty drugs are covered under the Prescription Drug Program.
• Drugs not yet approved by the FDA are not covered. New FDA-approved drugs will be covered by the Plan unless an amendment states otherwise or the class of drug is excluded.
• See the specific exclusions related to Drugs and Medicines in the Medical Exclusions chapter and the definition of "experimental" in the Definitions chapter.
• **Certain Drugs to Reduce the Risk of Breast Cancer**: no charge at an In-network Retail or Mail Order location for generic tamoxifen or raloxifene prescribed for women who are at increased risk of breast cancer and low risk for adverse medication effects.
	• **No Deductible applies to outpatient drugs for Plan A and Plan B.** Drugs accumulate to the Medical Plan Out-of-Pocket Limit.
	• **Retail prescriptions** are available through pharmacies participating with the Prescription Drug Program whose name is listed on the Quick Reference Chart in the Introduction chapter.
	• The Plan pays for generic drugs, unless specified otherwise by the provider. If no generic drug is available, the Plan will pay for the brand name drug. **If you choose to have your prescription filled with a brand name even though a generic is available, you must pay the difference between the cost of the brand drug and the generic drug**.
	• Brand name drugs obtained through the **Mexico PPO network** will be reimbursed up to the lesser of billed charge or the amount a network retail pharmacy would have charged for the brand drug in the United States. Drugs must be obtained from in-network Mexico PPO pharmacies in order to receive reimbursement from the Plan.
	• **Mail Order prescriptions** are provided only through the Prescription Drug Program whose name is listed on the Quick Reference Chart in the front of this document. **Note**: insulin, diabetic supplies, immunosuppressants and anti-depressants are **not** available via the mail order program, please refer to the retail program.
	• **No coverage** for weight control, cosmetic, or fertility/infertility drugs.
	• FDA approved contraceptives are payable under this Drug benefit (other contraceptives payable under the Family Planning row of this Schedule).
	• Certain **preventive care drugs** mandated by Health Reform, such as tobacco cessation drugs, are payable at no charge as explained in the Medical Expense Benefit chapter under "Coverage of Certain Preventive Care Drugs" on page 30.
	• **Direct Member Reimbursement for use of an Out-of-Network Retail Pharmacy**: If you fill a prescription at an Out-of-Network pharmacy location, you will need to pay for the drug at the time of purchase and later, send your drug receipt to the Prescription Drug Program using the Direct Member Reimbursement (DMR) process as listed on the Quick Reference Chart. DMR forms may be obtained from the Prescription Drug Program. For eligible prescriptions, you will be reimbursed according to the amount that would have been allowed had you used an in-network retail pharmacy minus the appropriate copay/coinsurance.
	• Outpatient prescription drugs are **not** applied to meet the medical plan's Deductible **except** when you are enrolled in the HDHP option. Outpatient prescription drugs are applied to meet the annual Out-of-Pocket Limit.
		Retail Pharmacy:
		(up to a 30-day supply)
		
		Generic:
		$10 copay or cost of the drug if less than $10.00.
		
		Formulary Brand (no generic available):
		$10 copay or 30%, whichever is greater to a maximum of $150 per fill.
		
		Drugs Obtained via the Mexico PPO Network:
		$10 copay or 30%, whichever is greater to a maximum of $150 per fill.
		
		Non-Formulary Brand (generic is available):
		$10 copay or 40% whichever is greater to a maximum of $150 per fill, PLUS, you pay the difference between the cost of the brand versus generic drug.
		
		Specialty Drugs:
		You pay 25% of the cost of the drug to a maximum of $150 per 30-day supply.
		
		Mail Order:
		(up to a 90-day supply)
		Generic: $20 copay
		Formulary Brand: $40 copay
		Non-Formulary Brand: $60 copay
		Note that if the cost of the drug is less than the copay, you pay just the drug cost.
		
		FDA-approved contraceptives for females, certain drugs to reduce the risk of breast cancer and certain preventive care drugs mandated by Health Reform: **No charge for generic drugs** submitted with a physician prescription and no charge for brand drug only if a generic drug is unavailable or medically inappropriate. The attending provider determines medical necessity for FDA-approved female contraceptives.
					FDA-approved contraceptives for females and certain Preventive care drugs mandated by Health Reform: No charge for generic drugs submitted with a physician prescription.
					
					All other drugs: 85% after Deductible is met
						See the Direct Member Reimbursement provisions to the left

SCHEDULE OF MEDICAL BENEFITS

This Schedule explains what this Plan pays. All benefits are subject to the Deductible except where noted. See also the Medical Exclusions and Definitions chapters for important information.

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Durable Medical Equipment (DME) • Coverage is provided for rental or purchase of standard models at the option of the Plan. • Rental is payable only up to the allowed purchase price of the durable medical equipment. • Benefits are payable for Medically Necessary repair and servicing of durable medical equipment, including supplies necessary to operate the DME. • Benefits for replacement of durable medical equipment are payable when replacement is Medically Necessary due to a change in the physical condition of the covered person or if the equipment cannot be satisfactorily repaired. • Benefits are payable for Medically Necessary oxygen, along with the Medically Necessary equipment and supplies required for its administration. • Coverage is provided for diabetic glucose meter and other Medically Necessary diabetes durable medical equipment. • Insulin Pump.	• Durable medical equipment is covered only when its use is Medically Necessary and it is ordered by a Physician or Health Care Practitioner. • **Durable Medical Equipment over $5,000 per item requires precertification.** See the Medical Network and Utilization Management chapter for details. • While breastfeeding, coverage is provided for a standard manual or standard electric breast pump, (including hospital grade breast pumps when Medically Necessary) plus necessary breast pump supplies. Rental, purchase and repair is payable as outlined to the left. Coverage is available at no cost from in-network providers only. Standard cost-sharing applies to use of non-network providers. Reimbursement for a non-network provider is payable up the amount the Plan would have paid had an in-network provider been used. • See the specific exclusions related to durable medical equipment in the Medical Exclusions chapter. • To help determine what durable medical equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions chapter.	Breast pump and supplies: No charge All other DME: 80% after Deductible is met	50% after Deductible is met	Breast pump and supplies: No charge All other DME: 75% after Deductible is met	50% after Deductible is met	Breast pump and supplies: No charge All other DME: 85% after Deductible is met	60% after Deductible is met

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Services, Ambulance Transportation Services, Urgent Care Facility • **Hospital emergency room** (ER) facility for a medical emergency. • **Urgent care facility.** • **Retail Medical Clinic.** If the retail clinic bills the Plan with an urgent care code, the claim is processed same as an urgent care visit. If the claim is billed as a provider office visit, the claim is processed as an office visit. • **Ambulance:** Ground transportation (*e.g.*, ambulance) to nearest appropriate facility as Medically Necessary for treatment of medical emergency or non-emergency ambulance transport for inter-facility transfer. Air/sea transportation only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the health status of the patient for treatment of a medical emergency. When air/sea ambulance transportation is required, it is payable to the nearest acute health care facility qualified to treat the patient's emergency condition. • Ancillary charges (such as lab or x-ray) performed during the ER or Urgent care visit. • Both the emergency room visit facility and professional fees are payable as part of the emergency room visit in this row. • Emergency services are covered: o Without the need for any prior authorization determination, even if the services are provided on an out-of-network basis; o Without regard to whether the health care provider furnishing the emergency services is a network provider or a network emergency facility, as applicable, with respect to the services; o Without imposing any administrative requirement or limitation on out-of-network emergency services that is more restrictive than the requirements or limitations that apply to emergency services received from network providers and network emergency facilities; o Without imposing cost-sharing requirements on out-of-network emergency services that are greater than the requirements that would apply if the services were provided by a network provider or a network emergency facility; o By calculating the cost-sharing for out-of-network emergency services as if the total amount that would have been charged for the services were equal to the recognized amount for the services; and o By counting any cost-sharing payments made by the participant or beneficiary with respect to the emergency services toward any in-network out-of-pocket maximums applied under the Plan (and the in-network out-of-pocket maximum is applied) in the same manner as if the cost-sharing payments were made with respect to emergency services furnished by a network provider or a network emergency facility.	• Emergency room covered only when services are **Emergency Services**. • **Emergency Services** means the following: o An appropriate medical screening exam that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and o Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished). • **Plan A and Plan B: Emergency room (ER) visit** is subject to a copayment per visit after the Deductible is met. The copay will be waived if subsequent immediate hospitalization is required. • For emergency services performed in an out-of-network Emergency Room (ER) visit and air ambulance services from Non-network providers, the payable services accumulate to the in-network Deductible and in-network Out-of-Pocket Limit. • **Plan A and Plan B: Urgent care facility** visit is subject to a copayment per visit (no Deductible applies). The copay will be waived if subsequent immediate hospitalization is required. • Non-emergency medical transportation refers to transport of an individual in a vehicle because the individual cannot safely use public or private transportation due to their Medically Necessary requirement to be positioned in a wheelchair or stretcher, or because they require the use of medical equipment or non-emergency medical monitoring during transport. • There is no requirement to precertify (prior authorize) the use of a hospital-based emergency room visit. Also, the Plan will pay a reasonable amount for hospital-based emergency services performed Out-of-Network, in compliance with health reform regulations. • See the definition of Allowed Charge or contact the medical plan Claims Administrator for more details on what the Plan allows as payment to Out-of-Network emergency service providers.	**Emergency room visit:** 80% after a $150 copay per visit. (Deductible applies to ER visits.) **Urgent care facility visit:** 100% after a $50 copay per visit. (Deductible does not apply to urgent care.) **Emergency Ambulance or Non-emergency transportation:** 80% after In-network Deductible is met	**Emergency room visit:** 80% after a $150 copay per visit. In-network Deductible applies to ER visits. **Urgent care facility visit:** 50% after a $50 copay per visit. (Deductible does not apply to urgent care.) **Emergency Ambulance transportation:** 80% after In-network Deductible is met. **Non-emergency transportation:** 50% after Out-of-Network Deductible is met.	**Emergency room visit:** 75% after a $150 copay per visit. (Deductible applies to ER visits.) **Urgent care facility visit:** 100% after a $50 copay per visit. (Deductible does not apply to urgent care.) **Emergency Ambulance or Non-emergency transportation:** 75% after In-network Deductible is met	**Emergency room visit:** 75% after a $150 copay per visit. In-network Deductible applies to ER visits. **Urgent care facility visit:** 50% after a $50 copay per visit. (Deductible does not apply to urgent care.) **Emergency Ambulance transportation:** 75% after In-network Deductible is met. **Non-emergency transportation:** 50% after Out-of-Network Deductible is met.	**Emergency room visit:** 85% after Deductible is met **Urgent care facility visit:** 85% after Deductible is met **Emergency Ambulance or Non-emergency transportation:** 85% after in-network Deductible is met	**Emergency room visit:** 85% after Deductible is met. In-network Deductible applies to ER visits **Urgent care facility visit:** 60% after Deductible is met **Emergency Ambulance transportation:** 85% after in-network Deductible is met **Non-emergency transportation:** 60% after Out-of-Network Deductible is met

SCHEDULE OF MEDICAL BENEFITS

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you. Note: This does not apply to emergency services in an Out-of-Network hospital or Independent Freestanding Emergency Department center, certain non-emergency services by Out-of-Network-network providers at In-Network facilities, or Out-of-Network air ambulance services.**

Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Endoscopy	• See the Specialized Health Care Facilities row in this Schedule.						
Family Planning Services • Surgical sterilization (*e.g.*, vasectomy, tubal ligation, implants such as Essure). • FDA-approved female contraceptives prescribed by a Physician, including birth control pills/patch (payable under the prescription Drug benefits of this Plan), injectable contraceptives, IUD, diaphragms and implantable birth control devices and services. Injectable contraceptives (e.g., Depo-Provera, Lunelle) are available as follows: • The injectable may be purchased at a retail pharmacy allowing you to return to the physician's office for administration of the injectable; or • You may have the physician administer the injectable from the physician's medication supply, however, the Plan will only consider as the allowable charge, the fee for the injectable that would have been incurred had you purchased the injectable at the retail pharmacy • Certain contraceptives are available through the Prescription Drug Program (see the Drugs row of this Schedule).	• See the specific exclusions related to Family Planning in the Medical Exclusions chapter. • No coverage for fertility and infertility services, including drugs and medicines related to those services. • There is no cost-sharing for FDA-approved female contraceptives and female sterilization services and benefits will be paid at 100% no Deductible, in-network only. Certain contraceptives are available through the Prescription Drug Program (see the Drugs row of this Schedule). • Coverage is provided without cost sharing for items and services integral to the furnishing of contraceptive services, such as anesthesia for a tubal ligation procedure or pregnancy tests needed before the provision of certain forms of contraception, such as an intrauterine device (IUD) regardless of whether the items and services are billed separately. • An exceptions process is available if an individual's health care provider recommends an item or service not covered under the plan's contraceptive coverage policies.	Female Contraceptives and Male or Female sterilization procedures: 100% no Deductible. See also Drugs and Medicines in this chart.	100% for sterilization after Deductible is met Contra-ceptives: 50%, after Deductible met. See also the Physician row for payment of an associated office visit. See also Drugs and Medicines in this chart.	Female Contraceptives and Male or Female sterilization procedures: 100% no Deductible. See also Drugs and Medicines in this chart.	100% for sterilization after Deductible is met Contra-ceptives: 50%, after Deductible met. See also the Physician row for payment of an associated office visit. See also Drugs and Medicines in this chart.	Male sterilization: 85% after Deductible is met Female Contraceptives and Female sterilization procedures: 100% no Deductible. See also Drugs and Medicines in this chart.	60% after Deductible is met. See also Drugs and Medicines in this chart.
Gene Therapy (Human) • A technique designed to introduce human genetic material into human cells to compensate for abnormal genes or to make a beneficial protein, used to treat or prevent disease in humans.	• **Gene therapy services require precertification** (to avoid non-payment) by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. See the Medical Network and Utilization Management chapter for details. • See also the definition of Gene Therapy in the Definitions chapter.	80% after Deductible is met	50% after Deductible is met	75% after Deductible is met	50% after Deductible is met	85% after Deductible is met.	60% after Deductible is met

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network

Genetic Testing and Counseling
 	
The genetic testing payable under this Plan is for:
• state-mandated newborn screening tests for genetic disorders (referred to as surrogate biochemical markers);
• fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Plan Administrator or its designee;
• tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity;
• the genetic testing is recommended by the American College of Obstetrics and Gynecology for pregnant women such as genetic carrier testing for cystic fibrosis;
• genetic testing (e.g., BRCA, stool DNA testing such as Cologuard) and genetic counseling required as a Preventive service, in accordance with ACA/Health Reform regulations (see the Wellness row in this Schedule).
• the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants who have all the following:
  • the testing method is considered scientifically valid for identification of a genetically linked heritable disease; and
  • the covered individual displays clinical features/symptoms, or is at direct risk (family history or 1st or 2nd degree relative) of developing the genetically linked heritable disease/condition in question (pre-symptomatic); and
  • the results of the test will directly impact the clinical decision-making, clinical outcome or treatment being delivered to the covered individual.
• Genetic Counseling is payable when ordered by a Physician, performed by a qualified Genetic Counselor and provided in conjunction with a genetic test that is payable by this Plan. Certain genetic counseling is payable as a Preventive service in accordance with the Affordable Care Act (ACA) regulations.
	• See the definitions of Genetic Counseling, Genetic Testing in the Definitions chapter. Please also see the Exclusions chapter for exclusions relating to Genetic Testing and Counseling.	Health Reform required genetic tests & counseling: 100% no Deductible
		
		All other covered genetic services: 100% after a $25 copay per visit, no Deductible.
			50% after Deductible is met
			
			Cologuard tests: 100% no Deductible
				Health Reform required genetic tests & counseling: 100% no Deductible
				
				All other covered genetic services: 100% after a $30 copay per visit, no Deductible.
					50% after Deductible is met
					
					Cologuard tests: 100% no Deductible
						Health Reform required genetic tests & counseling: 100% no Deductible
						
						All other covered genetic services: 85% after Deductible is met.
							60% after Deductible is met
							
							Cologuard tests: 100% no Deductible

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Home Health Care and Home Infusion Services • Part-time, intermittent **skilled nursing care** services and Medically Necessary supplies to provide home health care or home infusion services, subject to a maximum plan benefit (described to the right). • Home services other than skilled nursing care are not covered. • For home rehabilitation therapy services, see the Rehabilitation (Occupational, Physical, and Speech Therapy) Services row. • Nutritional support may be payable when it is determined by the Plan Administrator or its designee to be Medically Necessary, and is the sole means of adequate nutritional intake and is administered enterally (i.e., by feeding tube) or parenterally (i.e., by intravenous administration) and is not considered a food thickener, baby food, or other regular grocery product that can be mixed in a blender.	• Home Health Care and Home Infusion Therapy services are subject to precertification. See the Medical Network and Utilization Management chapter for details. • See the specific exclusions related to home health care and custodial care (including personal care and childcare) in the Medical Exclusions chapter of this document. • Covered only when ordered by a Physician or Health Care Practitioner. • Maximum plan benefit for skilled nursing care services and supplies to provide home health care and home infusion services is 60 days per person per Plan year. • Home hospice coverage is described below under Specialized Health Care Facilities benefits. Home physical therapy services coverage is described below under the Rehabilitation Services benefits. Prescription drug and medicine coverage is described above under the Drugs and Medicines benefits.	80% after Deductible is met	50% after Deductible is met	75% after Deductible is met	50% after Deductible is met	85% after Deductible is met	60% after Deductible is met
Hospice	• See the Specialized Health Care Facilities row in this Schedule.						

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Laboratory Services (Outpatient) • Technical and professional fees. • For coverage of a diagnostic sleep study/sleep test see the Sleep Study row in this Schedule.	• Covered only when ordered by a Physician or Health Care Practitioner. • **Cardiac doppler echocardiogram requires precertification**. See the Medical Network and Utilization Management chapter for details • Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits. • Lab tests obtained and performed within the physician's office are payable under the office visit copay when an office visit is billed on the same date of service. All other lab services performed Out-of-Network are subject to coinsurance. • Some radiology procedures are covered under the wellness benefits in this Schedule.	100% after a $25 copay per visit, no Deductible	50% after Deductible is met	100% after a $30 copay per visit, no Deductible	50% after Deductible is met	85% after Deductible is met	60% after Deductible is met

SCHEDULE OF MEDICAL BENEFITS

This Schedule explains what this Plan pays. All benefits are subject to the Deductible except where noted. See also the Medical Exclusions and Definitions chapters for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you. Note: This does not apply to emergency services in an Out-of-Network hospital or Independent Freestanding Emergency Department center, certain non-emergency services by Out-of-Network-network providers at In-Network facilities, or Out-of-Network air ambulance services.**

Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity Services • Hospital and birthing center charges and physician fees and midwife fees for Medically Necessary maternity services and newborn care while employee or spouse is confined. • Breastfeeding equipment and supplies are payable as noted on the Durable Medical Equipment row of this Schedule. See also the special rule for coverage of newborn Dependent Children in the Eligibility chapter. • While breastfeeding, the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) at 100%, no Deductible, when provided by an in-network provider acting within the scope of his/her license. In-network providers are listed on the network directory described on the Quick Reference Chart. • Expenses for elective termination of pregnancy (abortion) are not covered unless the attending physician certifies that the health of the woman would be endangered if the fetus were carried to term as necessary to save the life of the woman having the abortion or to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion or where medical complications arise from an abortion. • Amniocentesis or chorionic villus sampling (CVS) for pregnant women only if the procedure is Medically Necessary as determined by the Plan Administrator or its designee. • This Plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section; or requiring a health care practitioner to obtain authorization from the Plan (or its UM company) for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending health care practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).	• For all females, prenatal and postnatal visits and certain other ACA preventive screening services obtained from an in-network provider are payable at no cost to you. Normal plan cost-sharing still applies to all other maternity related services including ultrasounds and delivery fees for the employee or spouse. • When a provider submits a bill to the plan with a global CPT code for the combination of prenatal & postnatal visits and delivery expenses, the Plan's claims administrator will process the claim applying no cost-sharing to 40% of the charges representing the prenatal/postnatal visit expenses, and normal cost-sharing to 60% of the charges representing the delivery expenses. • Charges for a newborn will be considered part of and payable under the mother's delivery admission charges until the mother is discharged. If the newborn cannot be discharged with the mother and needs continued confinement, the newborn's charges from the date of birth will be considered as separate from the mother. See the Eligibility chapter for guidelines on what must occur in order to enroll a newborn under this Plan. • You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. • See the specific exclusions related to Family Planning in the Medical Exclusions chapter. Expenses for pre-planned home births are not payable under this Plan.	Prenatal and postnatal office visits and Lactation Educator: No charge. All other services: 80% after Deductible is met Copays waived if OB/GYN care begins in first trimester of pregnancy.	50% after Deductible is met No waiver of copays if OB/GYN care begins in first trimester of pregnancy.	Prenatal and postnatal office visits and Lactation Educator: No charge. All other services: 75% after Deductible is met Copays waived if OB/GYN care begins in first trimester of pregnancy.	50% after Deductible is met No waiver of copays if OB/GYN care begins in first trimester of pregnancy.	Prenatal and postnatal office visits and Lactation Educator: No charge. All other services: 85% after Deductible is met	60% after Deductible is met

SCHEDULE OF MEDICAL BENEFITS

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you. Note: This does not apply to emergency services in an Out-of-Network hospital or Independent Freestanding Emergency Department center, certain non-emergency services by Out-of-Network-network providers at In-Network facilities, or Out-of-Network air ambulance services.**

Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network

Nondurable Medical Supplies
• Coverage is provided for:
  • Sterile surgical supplies used immediately after surgery.
  • Supplies needed to operate or use covered durable medical equipment or corrective appliances.
  • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services.
  • Dialysis supplies; Colostomy/ostomy supplies.
	• To determine what nondurable medical supplies are covered, see the definition of "Nondurable Medical Supplies" in the Definitions chapter.
	• Insulin syringes and glucose meter test strips for diabetics are covered under the Prescription drug program. See the Drugs row in this Schedule.
		80% after Deductible is met	50% after Deductible is met	75% after Deductible is met	50% after Deductible is met	85% after Deductible is met	60% after Deductible is met

Nutritionist Services	• See the Dietitian Services row in this Schedule.						

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network

Oral and Craniofacial Services
• Accidental Injury to Teeth.
• Oral and/or craniofacial surgery.
• Charges by an oral maxillofacial surgeon for reduction of a facial bone fractures, removal of jaw tumors, treatment of jaw dislocations, treatment of facial and oral wounds or lacerations or infections (cellulitis), and removal of cysts or tumors of the jaws/facial bones. See also the exclusions related to Dental Services in the Medical Exclusions chapter.
• Oral or craniofacial surgery is limited to cutting procedures for removal of tumors, cysts, abscess, acute injury, or as Medically Necessary for the treatment of conditions not related to impacted teeth, root canal, gingivectomy, dental abscess or orthognathic procedures.
	• Treatment of Accidental Injuries to the Teeth: This medical plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Plan Administrator or its designee, all of the following conditions are met:
	  • The accidental injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and
	  • The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and
	  • The dental treatment will return the person's teeth to their pre-injury level of health and function. See also the definition of Injury to Teeth in the Definitions chapter of this document
	• Surgical or non-surgical treatment of Temporomandibular Joint dysfunction/syndrome, including appliances, is excluded. Refer to the dental plan.
	• See the exclusions related to dental services in the Medical Exclusions chapter.
		80% after Deductible is met	50% after Deductible is met	75% after Deductible is met	50% after Deductible is met	85% after Deductible is met	60% after Deductible is met

Outpatient Surgery Facility or Center	• See the Specialized Health Care Facilities row in this Schedule.						
Preadmission Testing • Laboratory tests, x-rays and other Medically Necessary tests performed on an outpatient basis prior to a scheduled hospital admission or outpatient surgery.	• Covered only when ordered by a Physician or Health Care Practitioner. • Not subject to Deductible.	100% no Deductible	100% no Deductible	100% no Deductible	100% no Deductible	85% after the Deductible is met	60% after the Deductible is met
Prescription Drugs	• See the Drugs and Medicines row of this Schedule.						

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Radiology (X-ray), Nuclear Medicine and Radiation Therapy Services (Outpatient) • Technical and professional fees associated with diagnostic and curative services, including radiation therapy.	• Covered only when ordered by a Physician or Health Care Practitioner. • Some radiology procedures are covered under the wellness benefits in this Schedule. • **These diagnostic tests: MRI/MRA, CT, PET scan require precertification**. See the Medical Network and Utilization Management chapter for details.	80% after the Deductible is met	50% after the Deductible is met	75% after the Deductible is met	50% after the Deductible is met	85% after the Deductible is met	60% after the Deductible is met

Reconstructive Services
• Includes expenses for reconstructive surgery, procedures or treatment intended to improve bodily function and or correct a deformity resulting from disease, trauma, infection, congenital anomalies that cause a functional defect or prior covered therapeutic procedure.
• This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:
  • Reconstruction of breast on which the mastectomy was performed.
  • Surgery on the other breast to produce a symmetrical appearance.
  • Prostheses and physical complications of all stages of mastectomy, including lymphedemas.
	• See the specific exclusions related to Cosmetic services and reconstructive surgery in the Medical Exclusions chapter. Most cosmetic and dental (including orthognathic) services are excluded from coverage.	80% after the Deductible is met	50% after the Deductible is met	75% after the Deductible is met	50% after the Deductible is met	85% after the Deductible is met	60% after the Deductible is met

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Rehabilitation Services **(Cardiac and Pulmonary)** • **Cardiac Rehabilitation** is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or MI). • **Pulmonary Rehabilitation** is available to those individuals who are able to actively participate in a pulmonary rehabilitation program that is likely to improve their pulmonary condition, as determined by the Plan Administrator or its designee.	• Cardiac or pulmonary rehabilitation programs must be ordered by a Physician. • **Overall maximum plan benefit** for **cardiac rehabilitation** is limited to services provided during a maximum of 12 weeks per cardiac incident. • **Overall maximum plan benefit** for **pulmonary rehabilitation** is limited to services provided during a maximum of 12 weeks per person during the duration of coverage by the Plan.	80% after the Deductible is met	50% after the Deductible is met	75% after the Deductible is met	50% after the Deductible is met	85% after the Deductible is met	60% after the Deductible is met

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Rehabilitation Services **(Occupational, Physical, and Speech Therapy)** • Short-term **active, progressive** rehabilitation services (occupational, physical, or speech therapy) performed by licensed or duly qualified therapists as ordered by a Physician, including **aquatic therapy** (hydrotherapy, pool therapy) Medically Necessary for musculoskeletal conditions. • Inpatient rehabilitation services in an acute hospital, rehabilitation unit or facility or skilled nursing facility for **short term, active, progressive**, rehabilitation services that cannot be provided in an outpatient or home setting. • Outpatient physical therapy in conjunction with spinal manipulation services is subject to the Plan's limitations for spinal manipulation services. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an inpatient rehabilitation facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• Rehabilitation services are covered only when ordered by a Physician or Health Care Practitioner. • **Inpatient rehabilitation admission is limited to 60 consecutive days per person per injury or illness. Admission to an inpatient rehabilitation facility requires precertification.** See the Medical Network and Utilization Management chapter for details. • Outpatient rehabilitation benefit (any combination of physical, occupational or speech therapy) is payable to 50 visits per person per injury or illness. Wound debridement services performed by a physical therapist do not apply towards this benefit maximum. When unable to participate in outpatient rehabilitation services at an outpatient rehab. office/facility, covered outpatient rehabilitation visits can be provided at home. • **Speech therapy** is covered **if** the services are provided by a licensed or duly qualified speech therapist to restore normal speech or to correct dysphagic or swallowing defects and disorders lost due to illness, injury or surgical procedure. Speech therapy for functional purposes including, but not limited to, stuttering, stammering and conditions of psychoneurotic origin, is excluded from coverage. • Coverage is also provided for **aural therapy** in connection with covered implantable hearing devices. See the Corrective Appliances row of this Schedule of Medical Benefits and Exclusions Chapter for more information. • **Maintenance rehabilitation, habilitation and coma stimulation services are not covered.** See specific exclusions relating to rehabilitation therapies in the Medical Exclusions chapter.	80% after the Deductible is met	No coverage for inpatient rehabilitation facility admission. All other services: 50% after the Deductible is met	75% after the Deductible is met	No coverage for inpatient rehabilitation facility admission. All other services: 50% after the Deductible is met	85% after the Deductible is met	No coverage for inpatient rehabilitation facility admission. All other services: 60% after the Deductible is met

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Second and Third Physician Opinions • Includes up to three (3) opinions per person per diagnosis.	• See the chapter on Medical Network and Utilization Management for details of the second and third opinion program. • Additional Medically Necessary tests are covered under other Plan provisions.	100% when required by the Plan (no Deductible); otherwise 80% after Deductible is met	100% when required by the Plan (no Deductible); otherwise 50% after Deductible is met	100% when required by the Plan (no Deductible); otherwise 75% after Deductible is met	100% when required by the Plan (no Deductible); otherwise 50% after Deductible is met	100% when required by the Plan (no Deductible); otherwise 85% after Deductible is met	100% when required by the Plan (no Deductible); otherwise 60% after Deductible is met
Skilled Nursing Facility	See the Specialized Health Care Facilities row in this Schedule						
Sleep Study • Diagnostic sleep study/sleep test using a full-channel nocturnal polysomnography (NPSG) (Type I device) performed in a healthcare facility. • Sleep studies using devices that do not provide a measurement of apnea-hypopnea index (AHI) and oxygen saturation are not payable by this Plan.	• Covered only when ordered by a Physician or Health Care Practitioner. • **Sleep studies require precertification**. See the Medical Network and Utilization Management chapter for details.	80% after the Deductible is met	No coverage.	75% after the Deductible is met	No coverage.	85% after the Deductible is met	No coverage

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Specialized Health Care Facilities • **Ambulatory/outpatient surgical facility**. • Under certain circumstances the medical plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by a Dental Plan if the utilization management firm determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the associated dental professional fee services provided while at a hospital or outpatient surgery facility. • **Hospice** (inpatient hospice and home hospice) for terminally ill individuals. • **Skilled Nursing Facility (SNF).** • **Subacute care facility**, also called Long Term Acute Care (LTAC) facility. • **Endoscopy Facility (Outpatient):** Endoscopy is a procedure to evaluate the interior surfaces of an organ by inserting a device such -as an endoscope into the body, including but not limited to the lungs, intestines, bladder, sinus, etc. • **Birthing center.** • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a Specialized Health Care Facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• **Admission to a specialized health care facility is subject to precertification**. See the chapter on Medical Network and Utilization Management for details. • Specialized health care facility services must be ordered by a Physician. To determine if a facility is a "specialized health care facility," see the Definitions chapter. • Bereavement counseling that is not part of the hospice program is covered under the behavioral health benefits of the Plan. • Skilled nursing facility is limited to 60 days per year. • Subacute care/LTAC facility is limited to 60 days per injury or illness. • **Endoscopy Facility:** For certain colonoscopy coverage starting at age 45 there is no cost-sharing, see the row titled Wellness Programs: Adult Health Maintenance for information. • **Birthing Center:** This Plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section; or requiring a health care practitioner to obtain authorization from the Plan (or its UM company) for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending health care practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).	**Facility Fees and Home Hospice:** 80% after Deductible is met	No coverage for skilled nursing facility or inpatient hospice. **All other Facility Fees and Home Hospice:** 50% after Deductible is met	**Facility Fees and Home Hospice:** 75% after Deductible is met	No coverage for skilled nursing facility or inpatient hospice. **All other Facility Fees and Home Hospice:** 50% after Deductible is met	**Facility Fees and Home Hospice:** 85% after Deductible is met	No coverage for skilled nursing facility or inpatient hospice. **All other Facility Fees and Home Hospice:** 60% after Deductible is met

SCHEDULE OF MEDICAL BENEFITS

This Schedule explains what this Plan pays. All benefits are subject to the Deductible except where noted. See also the Medical Exclusions and Definitions chapters for important information.

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Spinal Manipulation Services • Spinal manipulation services, including ancillary and related services (*e.g.*, visit, x-rays, physical therapy) from a physician or chiropractor, subject to an annual maximum plan benefit shown in the Explanations and Limitations column.	• Covered services are for **back-related care only, for adults 18 years or older.** • **Annual maximum plan benefit for all spinal manipulation services is 16 visits per person per year.**	100% after a $25 copay per visit, (no Deductible)	Same as in-network	100% after a $50 copay per visit, (no Deductible)	Same as in-network	85% after Deductible is met	60% after Deductible is met
Subacute Facility	• See the Specialized Health Care Facilities row in this Schedule.						
Transplantation (Organ and Tissue) • Coverage is provided only for eligible services directly related to transplantation of the following human organs or tissue: bone marrow, cornea, heart, intestine, kidney, liver, lung(s), pancreas, skin, or stem cells harvested from peripheral blood, including, facility and professional services, FDA approved drugs, Medically Necessary equipment and supplies. • Organ or tissue procurement/acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor. • Eligible donor expenses, not payable by their own health plan, will be payable without application of this Plan's Deductibles, copays or coinsurance, except under the HDHP where the Deductible must first be met before donor expenses are payable at 100% coinsurance.	• See the specific exclusions related to Experimental and investigational services and Transplantation in the Medical Exclusions chapter. • **Transplantation services are subject to precertification.** See the chapter on Medical Network and Utilization Management for details. • Benefits are payable only if services are provided in a hospital or specialized health care facility approved by the Plan Administrator or its designee. • For plan participants who serve as a donor, donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan.	80% after Deductible is met	No coverage	75% after Deductible is met	No coverage	85% after Deductible is met	No coverage

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network

Weight Management Benefit
 	
• Coverage is available for one surgical treatment of morbid obesity (bariatric surgery) per lifetime, including, but not limited to gastrointestinal bypass surgery and gastric restrictive surgery such as Lap-band® and any complications of bariatric surgery thereof to participants who are determined by the Plan Administrator or its designee to be morbidly obese (as defined in this Plan).
• Morbidly Obese is defined in the Definitions chapter of this document.
• As a **preventive counseling benefit** in compliance with Health Reform, the Plan covers the following services. For adults:
  • with a body mass index (BMI) of 30 kg/m2 or higher, OR,
  • who are overweight (defined as a BMI of 25 to 29.9 kg/m2) or obese (defined as a BMI of 30 kg/m2 or higher) AND have additional cardiovascular disease (CVD) risk factors,
the Plan covers Physician prescribed **intensive behavioral counseling interventions**. Intensive behavioral counseling interventions means the Plan will consider as Medically Necessary preventive services, up to a combined limit of 26 individual or group visits per 12-month period. No charge for in-network provider.
For obese children ages 6 years and older, the Plan covers Physician prescribed **intensive behavioral counseling** interventions to promote improvement in weight status, at the visit frequency as directed by the child's pediatrician. No charge for in-network provider. Normal cost-sharing for intensive behavioral counseling from non-network providers.
	• Bariatric surgery is covered only when ordered and performed by a Physician.
	• **Bariatric (weight management) surgery requires precertification**. See the chapter on Medical Network and Utilization Management for details.
	• Weight reduction drugs and surgical procedures to remove excessive skin resulting from weight loss are not considered payable by this Plan.
	• The Plan covers office visits and Medically Necessary diagnostic services ordered as part of the pre/post-operative management of a patient undergoing evaluation for or actual bariatric surgery for morbid obesity. Office visits are payable in accordance with the Physician services row of this Schedule. Diagnostic services are payable in accordance with the lab and radiology services rows of this Schedule.
		Bariatric Surgery: 80% after Deductible is met
		
		Preventive Counseling Benefit: 100% no Deductible
			Bariatric Surgery: No coverage
			
			Preventive Counseling Benefit: 50% after Deductible met
				Bariatric Surgery: 75% after Deductible is met
				
				Preventive Counseling Benefit: 100% no Deductible
					Bariatric Surgery: No coverage
					
					Preventive Counseling Benefit: 50% after Deductible met
						Bariatric Surgery: 85% after Deductible is met
						
						Preventive Counseling Benefit: 100% no Deductible
							Bariatric Surgery: No coverage
							
							Preventive Counseling Benefit: 60% after Deductible met

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Wellness Programs: Well Child Examinations and Immunizations • The wellness/preventive services payable by this plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC). You can visit these websites below for information on Wellness/Preventive Benefits (including immunizations) payable by the Medical Plan in accordance with Health Reform regulations: • https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at • http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ • http://www.hrsa.gov/womensguidelines/ • http://www.cdc.gov/vaccines/schedules/index.html?s_cid=cs_001 • For children ages 6 years and older with obesity, the Plan covers Physician prescribed **intensive behavioral counseling** interventions to promote improvement in weight status at the visit frequency recommended by the child's in-network pediatrician. • If there is no network a provider who can provide the Health Reform required wellness service, then the plan will cover the service when performed by an out-of-network provider without cost-sharing. • Coverage is provided in primary care clinician visits for fluoride varnish applied to the primary teeth of children through age 5 years. • Where the information in this document conflicts with newly released Affordable Care Act regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required.	• When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g., coinsurance and Deductible) for the diagnostic or therapeutic services but not for the preventive services. • When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g., coinsurance and Deductible) will apply to the diagnostic or therapeutic services provided. • Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). • The Plan will use reasonable medical management techniques for consideration of payable preventive services such as age, location for service and test frequency. • Services not covered under the wellness benefit may be covered under another portion of the medical plan. • If you obtain a covered immunization (including a COVID-19 immunization) at a retail pharmacy or other retail facility location, you will need to pay for the service and later send your bill (with proof of payment) to the medical plan claims administrator for reimbursement. You will be reimbursed for the immunization as an in-network claim. • See also the Weight Management row for coverage of preventive counseling for weight management. • Preventive services are payable without regard to gender assigned at birth, or current gender status.	100%, no Deductible	50% after Deductible is met.	100%, no Deductible	50% after Deductible is met.	100%, no Deductible	60% after Deductible is met.

SCHEDULE OF MEDICAL BENEFITS

This Schedule explains what this Plan pays. All benefits are subject to the Deductible except where noted. See also the Medical Exclusions and Definitions chapters for important information.

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you. Note: This does not apply to emergency services in an Out-of-Network hospital or Independent Freestanding Emergency Department center, certain non-emergency services by Out-of-Network-network providers at In-Network facilities, or Out-of-Network air ambulance services.**

Benefit Description	Explanations and Limitations	Plan A		Plan B		High Deductible Health Plan HDHP with HSA	
		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Wellness Programs: **Adult Health Maintenance** • The wellness/preventive services payable by this plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC). • You can visit these websites below for information on Wellness/Preventive Benefits (including immunizations) payable by the Medical Plan in accordance with Health Reform regulations: • https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: • http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ • http://www.hrsa.gov/womensguidelines/ • http://www.cdc.gov/vaccines/schedules/index.html?s_cid=cs_001 • Women are permitted to receive routine gynecology (GYN) health exams in addition to the routine preventive health exams. • Men are permitted to receive an office visit for a prostate exam once per calendar year in addition to the routine preventive health exams. • Coverage is provided for one **colonoscopy** every 10 years for individuals ages 45 and up, regardless of diagnosis. Anesthesia associated with a preventive colonoscopy is payable at no charge from in-network providers. • Stool DNA tests, including Cologuard tests, are payable at no charge from in-network providers once per calendar year per adult plan participant. • Preventive services are payable without regard to gender assigned at birth, or current gender status. • If there is no network a provider who can provide the Health Reform required wellness service, then the plan will cover the service when performed by an out-of-network provider without cost-sharing. • Where the information in this document conflicts with newly released Affordable Care Act regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required.	• In addition to the wellness services listed on the website to left, the Plan will pay for these wellness services once per calendar year per adult plan participant: wellness/physical exam, annual prostatic specific antigen (PSA) lab test for n age 50 and older, and screening mammogram for women (35 and older). Breast tomosynthesis (3D digital mammogra payable as a preventive service and as a diagnostic servic when ordered by a Physician as an alternative to a 2D mammogram or in addition to a 2D mammogram. • Shingles immunization payable starting at age 50. • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the preventive services. • When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. • Preventive services are considered for payment when billed under the appropriate preventive service codes (except an office visit for a prostate exam), and benefit adjudication depends on accurate claim coding by the providers. • The Plan will use reasonable medical management techniques for consideration of payable preventive services such as age, location for service and test frequency. • Services not covered under the wellness benefit may be covered under another part of the medical plan. • If you obtain a covered immunization (including a COVID-19 immunization) at a retail pharmacy or other retail facility location, you will need to pay for the service and later send your bill (with proof of payment) to the medical plan claims administrator for reimbursement. You will be reimbursed for the immunization as an in-network claim. • See also the Weight Management row for coverage of preventive counseling for weight management.	100%, no Deductible	50% after Deductible is met. Cologuard tests: 100% no Deductible	100%, no Deductible	50% after Deductible is met. Cologuard tests: 100% no Deductible	100%, no Deductible	60% after Deductible is met. Cologuard tests: 100% no Deductible

MEDICAL NETWORK AND UTILIZATION MANAGEMENT

MEDICAL NETWORK: PREFERRED PROVIDER ORGANIZATION (PPO)

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

IMPORTANT NOTE

Because providers are added to and dropped from the PPO network periodically throughout the year it is best if you ask your health care provider IF they are still participating with the PPO or contact the network each time BEFORE you seek services.

- **IN-NETWORK SERVICES:**

  In-network Preferred health care providers have agreements with the Plan's PPO which means they provide health care services and supplies for a favorable discounted negotiated fee for plan participants.

  When a plan participant uses the services of an In-Network Preferred health care provider, the participant's financial responsibility is less. After you meet your Deductible, you will pay just a copay or a lower coinsurance than if you received those Medically Necessary services or supplies from a health care provider who is not a Preferred PPO provider.

  The Preferred PPO provider has agreed to accept the Plan's payment plus any applicable coinsurance or copayment that you are responsible for paying as payment in full. Please refer to the Schedule of Medical Benefits for specific financial information by type of service.

  Note that with respect to claims involving any third party payer, including auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the contract between the Health Care Providers and the Network may not require them to adhere to the discounted amount the Plan pays for covered services, and the providers may charge their usual non-discounted fees.

Show your ID card to the health care provider every time you use services so they know that you are enrolled under this Plan and where to send their bills.

- **OUT-OF-NETWORK SERVICES:**

  Out-of-network health care providers are either Participating network providers or have no agreements with the Plan (are non-network) and are generally free to set their own charges for the services or supplies they provide.

  The Plan will reimburse the plan participant for the Allowed Amount (Allowed Amount is defined in the Definitions chapter) for Medically Necessary services or supplies which are payable by the plan, subject to the Plan's Deductibles, coinsurance, copayments, limitations and exclusions.

  Plan participants must submit proof of claim before any such reimbursement will be made.

  NOTE: Non-network health care providers may bill the plan participant for any balance due in addition to the amount payable by the Plan, commonly referred to as "balance billing." Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or Deductibles) that exceed the Plan's payment for a covered service. **You can avoid balance billing by using In-Network providers.** See also the Special Reimbursement Provision on the next page.

DIRECTORIES OF PREFERRED PPO PROVIDERS

Physicians and health care providers who participate as Preferred Providers in the Plan's PPO are added and deleted during the year. At any time, you can find out if a health care provider is a Preferred Network member of the PPO by using the website or calling the PPO Network phone number listed on the Quick Reference Chart.

A directory of local health care providers who are Preferred members of the Plan's PPO is available free of charge. Visit the website of the PPO Network or the YABC website, as listed on the Quick Reference Chart in the front of this document.

IMPORTANT NOTE

Remember, because providers are added to and dropped from the PPO network periodically throughout the year **it is best if you ask your health care provider IF they are still participating with the PPO or contact the network each time BEFORE you seek services.**

For a list of In-Network providers, see the website of the Network located on the Quick Reference Chart in the front of this document.

INCORRECT PPO PROVIDER INFORMATION

A list of PPO Providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plans or an organization contracting on its behalf.

If you obtain and rely upon incorrect information provided by the Plans about whether a provider is a PPO Provider from the Plans or its administrators, the Plans will apply the PPO Cost-Sharing Amount to your claim, even if the provider was a Non-PPO Provider.

SPECIAL REIMBURSEMENT PROVISIONS

The following chart explains the Plan's special reimbursement for services when Out-of-Network providers are used. The Plan Administrator or its designee determines if and when the following special reimbursement circumstances apply to a claim. Medical records may be requested in order to assist with a determination on the need for special reimbursement provisions.

SPECIAL REIMBURSEMENT PROVISIONS This chart explains the Plan's special reimbursement provisions if the services of an Out-of-Network Provider are used. The Plan Administrator or its designee determines if/when the following reimbursement applies to a claim.	**WHAT THE PLAN PAYS** (toward eligible claims submitted by an Out-of-Network provider)
• Child over 19 resides temporarily outside the service area while attending college. • Child resides outside the service area under a QMCSO. • The individual had care for emergency services (as defined in this Plan) at a non-network hospital or Independent Freestanding Emergency Department center, certain non-emergency services by non-network providers at network facilities, or non-network air ambulance services outside the In-Network service area. • The individual was treated/confined in an In-Network facility but an Out-of-Network provider performed certain Medically Necessary covered services without meeting the notice and consent exception described below under "Cost-Sharing Amount Requirements for Emergency and Non-Emergency Services at Network Facilities by Out-of-Network Providers. • Services (such as lab or x-rays) received from an Out-of-Network provider in connection with a visit to an In-Network provider, if the choice of the Out-of-Network provider who performed ancillary services was outside the patient's control and without meeting the notice and consent exception described below under "Cost-Sharing Amount Requirements for Emergency and Non-Emergency Services at Network Facilities by Out-of-Network Providers. For example, the In-Network provider accidentally sends the patient's lab work to an Out-of-Network lab for processing. • The individual obtained and relied upon incorrect information about whether a provider was a network provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to the claim, even if the provider was Out-of-Network. • According to the PPO Network, there is no In-Network provider qualified by area of professional specialty or practice available to provide Medically Necessary eligible health care services.	As if the care was provided In-Network including Deductible, coinsurance, copays and Out-of-Pocket limit and the allowance for bills will be reimbursed according to the Allowed Amount for non-network providers. See the definition of Allowed Amount in the Definitions chapter of this Plan.
• Use of an Out-of-Network provider when an In-Network provider was available to be used.	As if the care was provided Out-of-Network including Deductible, coinsurance, copays and Out-of-Pocket limit.

NO AUTHORIZATION REQUIRED

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the medical plan network who specializes in obstetrics or gynecology.

The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Medical Plan network whose website is listed on the Quick Reference Chart in the front of this document.

UTILIZATION MANAGEMENT (UM) PROGRAM

Purpose Of the Utilization Management (UM) Program:

Your Plan is designed to provide you and your eligible family members with financial protection from significant health care expenses. The development of new medical technology and procedures and the ever-increasing cost of providing health care may make it difficult for a participating employer of the YABC Consortium to afford the cost of maintaining your Plan.

To enable your Plan to provide coverage in a cost-effective way, your Plan has adopted a UM program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the participating employer of the YABC Consortium is better able to afford to maintain the Plan and all its benefits.

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

Management of the Utilization Management Program:

The Plan's Utilization Management Program is administered by an independent professional Utilization Management Company operating under a contract with the Plan (hereafter referred to as the UM Company). The name, address and telephone number of the UM Company appears in the Quick Reference Chart in the front of this document.

The health care professionals in the UM Company focus their review on the necessity and appropriateness of Hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical or surgical services.

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

Elements of the Utilization Management Program:

The Plan's UM program consists of:

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

Restrictions and Limitations of the Utilization Management Program (Very Important Information)

1. The fact that your physician recommends surgery, hospitalization, confinement in a specialized health care facility, or that your physician or other health care provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be an eligible expense or be considered Medically Necessary for determining coverage under the medical plan.
2. The Utilization Management program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of plan benefits. The UM organization's certification that a service is Medically Necessary doesn't mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.
3. All treatment decisions rest with you and your physician (or other health care provider). You should follow whatever course of treatment you and your physician (or other health care provider) believe to be the most appropriate, even if the UM organization does not certify a proposed surgery or other proposed medical treatment as Medically Necessary; or as an eligible expense. However, the benefits payable by the plan may be affected by the determination of the UM organization. The Plan will not pay regular plan benefits for a hospitalization or confinement in a specialized health care facility because the UM organization does not certify a proposed confinement.
4. With respect to the administration of this Plan, the employer, the Plan and the UM organization are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the UM organization as Medically Necessary, or for the results if the patient chooses not to receive health care services that have not been certified by the UM organization as Medically Necessary.
5. Precertification of a service does not guarantee that the Plan will pay benefits for that service because, other factors, such as ineligibility for coverage on the actual date of service, may be a factor in non-payment of a service.

PRECERTIFICATION REVIEW

How Precertification Review Works

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

WHAT SERVICES MUST BE PRECERTIFIED BY THE UTILIZATION MANAGEMENT COMPANY (Precertified Means Approved Before They are Provided)
• All elective hospital admissions. Note: for pregnant women, precertification is required only for hospital stays or birthing center stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section.
• All elective admissions to a skilled nursing facility, subacute care facility, endoscopy facility, or hospice.
• Residential treatment program.
• All elective surgery to be performed in a hospital or ambulatory (outpatient) surgical facility.
• All admissions to any hospital or specialized health care facility for inpatient rehabilitation therapy.
• All home health care and all home infusion services.
• An upcoming transplant as soon as the participant is identified as a potential transplant candidate.
• Bariatric (weight management) surgery.
• Durable medical equipment over $5,000 per item.
• These imaging tests: MRI, CT, PET scan.
• Sleep studies.
• Cardiac Doppler Echocardiogram.
• Any technique that uses genes to treat or prevent disease (**gene therapy**) including but not limited to Kymriah, Yescarta, Luxturna, etc.
• Administration of a **class of drugs called "survival motor neuron-2 (SMN2)-directed antisense oligonucleotides,"** which includes drugs such as Spinraza (nusinersen).

- Specialty infusion/injectable medications which are covered under the Medical Benefits
- For individuals who will participate in a clinical trial, precertification is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial

NOTE: Certain medications require precertification by contacting the Prescription Drug Program, whose contact information is listed on the Quick Reference Chart in the front of this document.

All prescription drugs and specialty medications requiring precertification must be coordinated through the UM company or Prescription Drug Program. See the Schedule of Medical Benefits and Quick Reference chart for more information.

What Services <u>May Be</u> Precertified (Approved Before They Are Provided)

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

How To Request Precertification (Pre-service review)

It is <u>your responsibility</u> to assure that precertification occurs when it is required by this Plan. Any penalty for failure to precertify is on you, not the health care provider.

You or your physician must call the UM organization at the telephone number shown on the Quick Reference Chart in the Introduction chapter of this document

1. Calls for elective services should be made at least **seven (7) days** before the expected date of service.
2. The caller should be prepared to provide **all of the following information**: the employer's name, the employee's name, the patient's name, address, and phone number and social security number; Physician's name and phone number or address; the name of any Hospital, specialized health care facility or any other Health Care provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.
3. When calling to precertify, **if the preservice review process was not properly followed** the caller will be notified as soon as possible but not later than 5 calendar days after you request.
4. If additional information is needed, the UM organization will advise the caller. The UM organization will review the information provided, and will let you, your physician and the hospital, specialized health care facility, any other health care provider, and the claims administrator know whether or not the proposed health care services have been certified as Medically Necessary.

   The UM organization will usually respond to your treating physician or other health care provider **by telephone within three (3) working days after it receives the request and any required medical records and/or information**, and its determination will then be confirmed in writing.
5. If your admission or service is determined not to be Medically Necessary, you and your physician will be given recommendations for alternative treatment. You may also pursue an appeal. See the Claim Filing and Appeals Information chapter regarding appealing a UM determination

Appeal of A Denial of Precertification

See the Claim Filing and Appeals Information chapter for details on appealing a preservice review determination.

CONCURRENT (CONTINUED STAY) REVIEW

How Concurrent (Continued Stay) Review Works

1. When you are receiving medical services in a hospital or specialized health care facility, the UM organization may contact your physician or other health care providers to **assure that continuation of medical services is Medically Necessary and help coordinate your medical care with the benefits available under the Plan**. See also the section titled "Restrictions and Limitations of the Utilization Management Program" in this chapter.
2. Concurrent review may include such services as coordinating home health care or durable medical equipment needs, assisting with discharge plans, determining the need for continued medical services, and/or advising your physician or other health care providers of the various options and alternatives available under this Plan.
3. If at any point your stay or services are found to NOT be Medically Necessary and that care could be safely and effectively delivered in another environment, such as through home health or in another type of health care facility,

you and your physician will be notified. This does not mean that you must leave the hospital or stop receiving services, but if you choose to stay or continue services, all expenses incurred after the notification will be your responsibility. If it is determined that your hospital stay or services were not Medically Necessary, no benefits will be paid on any related hospital, medical or surgical expense. See also the section of this chapter on UM Appeals.

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

Appeal of a Denial of a Concurrent Review

See the Claim Filing and Appeals Information chapter for details on appealing a concurrent review determination.

EMERGENCY HOSPITALIZATION

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

PREGNANCIES

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

SECOND AND THIRD OPINIONS

How The Second And Third Opinion Process Works

1. At any time during the review process, you may be asked by the UM organization to obtain a second opinion about a proposed health care service to help determine if the health care service is Medically Necessary, or if an alternative effective approach to the individual patient's health care management exists. A second opinion may be requested when it appears that there may be a question regarding the effectiveness or reliability of a proposed service or the proposed service involves a high risk in relation to the anticipated benefit; or there appear to be conflicting diagnoses, vague indications, or possible inadequate clinical management.
2. If a Second Opinion is required, **you** will need to arrange an examination by a physician who is certified by the American Board of Medical Specialists in the field related to the proposed service, is independent of the physician who proposed the service, and will not be eligible to perform the service.
3. The Second Opinion physician may review past medical records along with clinical findings from his or her own examination of the patient and will report his or her findings to the UM organization. If the second opinion recommendation differs from the treating physician's recommendation, you may be required to obtain a Third Opinion from another physician who will be selected in the same manner as the Second Opinion physician.

   The results of the Third Opinion will be reviewed by the UM organization, and the recommendation of the majority of the physicians (the attending physician and the second and third opinion physicians) will prevail.

   If, as a result of the second and/or third opinion, it is determined that the procedure recommended by the treating physician is not Medically Necessary, **no benefits will be payable if you choose to undergo the procedure**. See also the section titled "Restrictions and Limitations of the Utilization Management Program" in this chapter.

Patient-Requested Second and Third Opinions

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

Appeal of a Second or Third Opinion that Disagrees with a Recommended Procedure

If the second or third opinion disagrees with the procedure recommended by the treating physician, and the disagreement cannot be resolved by discussion between the treating and reviewing physicians, you and/or your

physician may submit a written appeal of the decision, accompanied by any additional information to support the need for the proposed health care service. The appeal, with supporting information, should be sent to the UM organization at the office or to the fax number shown in the Quick Reference Chart in the Introduction chapter of this document.

The UM organization will respond **in writing within 30 days after it receives the request and any required medical records and/or information**.

Cost of the Second and Third Opinions

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

RETROSPECTIVE (POST-SERVICE) REVIEW

All claims for medical services or supplies that have not been reviewed under the Plan's precertification, concurrent (continued stay) review, or second and third opinion programs may be subject to retrospective review, at the option of the claims administrator, to determine if they are Medically Necessary.

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

CASE MANAGEMENT

How Case Management Works

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

Working With the Case Manager

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

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

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

FAILURE TO FOLLOW REQUIRED UTILIZATION MANAGEMENT PROCEDURES

(Very Important Information)

If you don't follow the precertification review, concurrent (continued stay) review, or case management procedures, or if you fail to obtain a required Second or Third opinion before incurring medical expenses, or if you undergo a medical procedure that has not been determined to be Medically Necessary under the Second or Third Opinion Program, the Claims Administrator will request that the UM organization perform a retrospective review to determine if the services were Medically Necessary.

1. If the UM organization determines that the services **were not Medically Necessary**, no plan benefits will be payable for those services.
2. If the UM organization determines that the services **were Medically Necessary**, the benefits payable by the Plan (for all services received that were subject to the Utilization Management review procedures and requirements set forth in this chapter that you did not follow) **will be reduced by an additional 10% coinsurance**.

This additional coinsurance will **not** be applied to meet your Out-of-Pocket Limit. However, if the services were for an emergency hospitalization and the services were determined to be Medically Necessary, the precertification penalty will be waived if the certification is obtained within 12 months of the date of service.

The difference between the amount you would be responsible for paying based on the benefits that would be payable if the review procedure had been followed and the actual benefits payable because the review procedure was not followed will not count toward the Plan's Deductible or annual Out-of-Pocket Limit.

See also the Claim Filing and Appeals Information chapter for details on appealing an adverse benefit determination.

MEDICAL EXCLUSIONS

The following is a list of medical services and supplies or expenses **not covered by the medical plan**. The exclusions applicable to the dental plan appear in a separate chapter of this document. The Plan Administrator and other plan fiduciaries and individuals to whom responsibility for the administration of the medical plan has been delegated will have discretionary authority to determine the applicability of these exclusions and the other terms of the plan and to determine eligibility and entitlement to plan benefits in accordance with the terms of the plan. General Exclusions are listed first followed by specific medically related plan exclusion.

GENERAL EXCLUSIONS (applicable to all medical service and supplies)

1. **Autopsy:** Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.
2. **Adoptive Cell Therapy:** A type of cellular immunotherapy in which immune cells are extracted, altered, and then given to a patient to help the body fight diseases, such as cancer. Standardly taken from the patient's own blood or tumor tissue, grown in large numbers in the laboratory, and then given back to the patient to help the immune system fight the cancer. Also known as adoptive cell transfer, cellular adoptive immunotherapy, and T-cell transfer therapy
3. **Complications:** Expenses for complications of any non-covered service/procedure/treatment.
4. **Costs of Reports, Bills, etc.:** Expenses for preparing medical reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, e-mailings charges, prescriptions refill charges, disabled plates/automotive forms, interest charges, late fees, mileage costs, provider administration fees, concierge/retainer agreement/membership fees and/or photocopying fees.
5. **Educational Services:** Even if they are required because of injury, illness or disability of a Covered Individual, the following expenses are not payable by the Plan: educational services, supplies or equipment, including, but not limited to, computers, software, printers, books, tutoring, visual aids, auditory aides, speech aids/synthesizers, auxiliary aids such as communication boards, listening systems, device/programs for behavioral training including intensive intervention programs for behavioral change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated cost in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices.
6. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any plan benefit limitation, or annual maximum plan benefits, as described in the Medical Expense Benefits chapter and Schedule of Medical Plan Benefits in this document.
7. **Expenses Exceeding the Allowed Amount:** Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Allowed Amount as defined in the Definitions chapter of this document.
8. **Expenses for Which a Third Party is Responsible:** Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party, as applicable, or expenses for which another party is required to pay (e.g., no fault, personal injury protection, etc.). Expenses (past, present or future) for which another party is required to pay (e.g., no fault, personal injury protection, etc.) are not covered. See the provisions relating to Third Party Liability in the Coordination of Benefits (COB) chapter of this document for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
9. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the medical plan or after the date the patient's coverage ends, except under those conditions described in the COBRA chapter.
10. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be experimental and/or investigational as defined in the Definitions chapter of this document.
11. **Failure to Comply with Medically Appropriate Treatment:** Expenses incurred by any Covered Individual as a result of failure to comply with medically appropriate treatment, as determined by the Plan Administrator or its designee.

12. **Illegal Act:** Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of commission, or attempted commission by the Covered Individual, of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual, unless such injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor. The Plan Administrator's discretionary determination that this exclusion applies shall not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.
13. **Leaving a Hospital Contrary to Medical Advice:** Hospital or other Health Care Facility expenses if you leave the facility against the medical advice of the attending Physician within 72 hours after admission.
14. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Individual, including, without limitation, construction or modification of ramps, elevators, hand rails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtrations/purification, swimming pools, emergency alert systems, etc.
15. **Neuropsychological Testing:** Tests used to evaluate patients who have experienced a traumatic brain injury, brain damage, or organic neurological problems (e.g., dementia). May also be used to evaluate the progress of a patient who has undergone treatment or rehabilitation for a neurological injury or illness.
16. **Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual, unless those travel expenses are related to a plan approved transplant as outlined under Transplantation in the Schedule of Medical Benefits.
17. **Physical Examinations, Tests for Employment, School, etc.:** Expenses for physical examinations, functional capacity/job analysis examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, vocation, workers' compensation, retirement/disability status or pension, or by any third party.
18. **Private Room in a Hospital or Health Care Facility:** The use of a private room in a Hospital or other Health Care Facility, unless the facility has only private room accommodations or unless the use of a private room is certified as Medically Necessary by the Plan Administrator or its designee.
19. **Stand-By Physicians or Health Care Practitioners:** Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Practitioner was available to do so on a stand-by basis.
20. **Travel and Related Expenses**: Expenses for and related to travel or transportation (including lodging, meals and related expenses).
21. **Services Covered by Workers' Compensation:** Expenses for the treatment of conditions covered by workers' compensation or occupational disease law.
22. **Services for Patient Convenience:** Expenses for patient convenience, comfort, hygiene or beautification, including, but not limited to, care of family members while the Covered Individual is confined to a hospital or other specialized health care facility or to bed at home, guest meals, television, DVD/Compact disc (CD) and other similar devices, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.
23. **Services Not Medically Necessary:** Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in the Definitions chapter of this document.
24. **Services Not Prescribed by a Physician:** Expenses for services rendered or supplies provided that are not recommended or prescribed by a physician, except for covered services provided by a behavioral health practitioner, midwife or nurse midwife, chiropractor or podiatrist.
25. **Services Performed by Medical Students or Interns:** Expenses for the services of a medical student or intern.
26. **Services Provided by Employer:** Expenses for services rendered through a medical/health department, clinic or similar facility provided or maintained by the YABC Consortium, or if benefits are otherwise provided under this plan or any other plan that the YABC Consortium contributes to or otherwise sponsors, such as HMOs.

27. **Military service-related injury/illness:** If an eligible individual under this Plan receives services in a U.S. Department of Veteran Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan.
28. **Services Provided Outside the United States:** Expenses for medical services or supplies rendered or provided outside the United States, **except** for covered treatment in Mexico provided through the Mexico PPO network International Medical Solutions (IMS), or for a medical emergency as defined in the Definitions chapter of this document.
29. **Services Provided Without Cost to Recipient:** Expenses for services rendered or supplies provided for which a covered person is not required to pay or which are obtained without cost or there would be no charge if the person receiving the treatment were not covered under this Plan.
30. **Travel Contrary to Medical Advice:** Expenses incurred by any Covered Individual during travel if a physician or other health care provider has specifically advised against such travel because of the health condition of the Covered Individual.
31. **Telephone Calls**: Any and all telephone calls between a physician or other health care provider and any other health care provider, UM organization, or any representative of the Plan for any purpose whatsoever, including, without limitation: communication with any representative of the Plan or it's UM organization for any purpose related to the care or treatment of a Covered Individual, consultation with any Health Care Provider regarding medical management or care of a patient; coordinating medical management of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient's care; providing counseling to anxious or distraught patients or family members, except for telemedicine services for Behavioral Health Services and services provided by the contracted telemedicine provider listed in the Quick Reference Chart of this document.
32. **War:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, except as required by law.
33. **Operation of a Vehicle Under Influence of Alcohol or Drugs:** As determined by the Plan Administrator or its designee, expenses were incurred by any covered individual for injuries caused in a motor vehicle accident if the covered individual was operating the vehicle while intoxicated (had a blood alcohol level that exceeded the legal limit of the jurisdiction in which the accident occurred or no breathalyzer exam was performed or the person refused to submit to a requested breathalyzer or blood test) or was under the influence of illegal drugs; unless the injuries arise as a result of a physical or mental health condition. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal, or failure to prosecute) in connection with the motor vehicle accident.
34. Expenses for and related to **Service animals**, including an animal that has been individually trained to do work or perform tasks for the benefit of an individual with a disability, such as seeing eye dogs, or other disability-assistance dogs/birds/miniature horses and the like, seizure detection animals, diabetes/low blood sugar detection animals, service monkeys, etc. The Plan also excludes service animal supplies, transportation and veterinary expenses.
35. Expenses for **non-routine services and supplies associated with a clinical trial**, such as: (1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis. For individuals who will participate in a clinical trial, precertification is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.
36. **Untimely Filed Claims**: Expenses for services or supplies that would otherwise be covered by the Plan will not be covered or payable by the Plan if a claim for payment of such services is not submitted to the Claims Administrator within 12 months from the date that the service is rendered or the supply provided.
37. Expenses for **hypnosis,** hypnotherapy, and biofeedback.
38. Expenses for **programs based on learning theories and motivation,** such as Applied Behavioral Analysis (ABA) Therapy (as defined in the Definitions chapter of this document) and related services.
39. Expenses for services related to:

a) dyslexia, learning disorders, educational delays, including test and related expenses to determine the presence of or degree of a person's dyslexia or learning/reading disorder;
b) developmental disabilities;
c) vocational disabilities;
d) court ordered Behavioral Health Care services (except when Medically Necessary and the ordered services are a covered benefit), or custody counseling;
e) family planning/pregnancy, adoption, transsexual reassignment/sex counseling;
f) attention deficit disorders (ADD) with or without hyperactivity, except office visits to a Physician for medication management of the diagnosis of ADD with or without hyperactivity. Medications for this diagnosis are payable under the Drug benefit of the plan;
g) expenses for a non-hospital, wilderness therapy program, outdoor behavioral health program, boot camp-type program, boarding school, military school, foster home/care, group home, half-way/quarter-way house, or sober living/transitional living environment. Note: marital/family counseling is payable and is also available through the EAP services discussed under Behavioral Health in the Schedule of Medical Benefits.
h) Expenses for **home visits** by a provider to a patient's home ("house calls") for covered services when not part of the Home Health Care benefit.

40. **EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES:**

a) Allergy/Alternative/Complementary Health Care Services Exclusions

1. Expenses for acupuncture and/or acupressure.
2. Expenses for chelation therapy: except as may be Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.
3. Expenses for faith or religious healing or spiritual healing or prayer.
4. Expenses for naturopathic, naprapathic and/or homeopathic supplies, substances or products.
5. Expenses for experimental/investigational allergy treatments including but not limited to sublingual (under the tongue) drops/oral antigen, rhinophototherapy, repository emulsion therapy (a form of therapy where certain materials are placed inside the body to improve allergies).

b) Assistant Surgeon Fees

1. Assistant surgeon expenses are only payable when it is determined by the Plan Administrator or its designee that the services of an assistant surgeon were Medically Necessary.

c) Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions

1. Expenses for any **items that are not Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment** as each of those terms is defined in the Definitions chapter of this document, including but not limited to air purifiers, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, mattresses, water beds, and air conditioners.
2. Expenses for replacement of **lost, missing, stolen, duplicate, or personalized Corrective Appliances**, including Orthotic Devices and/or Prosthetic Appliances, or Durable Medical Equipment.
3. Expenses for **occupational therapy adaptive supplies and devices** used to assist a person in performing activities of daily living including self-help devices such as feeding utensils, reaching tools, devices to assist in dressing and undressing, shower bench, raised toilet seat, etc.
4. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they **exceed the cost of standard models** of such appliances or equipment.

d) Cosmetic Services Exclusions

1. Surgery or medical treatment to improve or preserve physical appearance, but not physical function as distinguished from Medically Necessary surgery or treatment to correct defects resulting from trauma, infection or other diseases, or the consequences of treatment of trauma, infection or other diseases, or to correct a congenital disease or anomaly of a covered Dependent Child that causes a functional defect.

   Cosmetic surgery or treatment, as determined by the Plan Administrator or its designee, includes but is not limited to removal of tattoos, breast augmentation or other medical or surgical treatment intended to restore or improve physical appearance, elimination of redundant skin of the abdomen, surgery to improve self-esteem or treat psychological symptoms or psychosocial complaints related to one's appearance, treatment of varicose veins, cosmetic skin products such as Restylane, Renova or other medical or surgical treatment intended to restore or improve physical appearance.

2. However, the medical plan **does** cover Medically Necessary reconstructive surgery or treatment if it is required to correct damage caused by accidental traumatic injury such as Reconstructive surgery when it follows surgery covered by the plan that results from trauma, infection or other disease; and Reconstructive surgery to correct the effects of congenital disease or a gross developmental anomaly of a covered Dependent Child that causes a functional defect and breast reconstruction as required by the Women's Health and Cancer Rights Act.
3. Covered individuals should use the plan's precertification procedure to determine if a proposed surgery will be considered cosmetic surgery or reconstructive.

e) Custodial Care Exclusions

1. Expenses for custodial care as defined in the Definitions section of this document, regardless of where they are provided, including, without limitation adult day care, child day care, services of a homemaker, or personal care, sitter/companion service, except when custodial care is provided as part of a covered Hospice program.
2. Services required to be performed by Physicians, Nurses or other Skilled Health Care providers are **not** considered to be provided for Custodial Care services and are covered if they are determined by the Plan Administrator or its designee to be Medically Necessary. However, any services that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are **not covered**, even if they are Medically Necessary.
3. Expenses related to a nursing home (that is not a skilled nursing facility), an assisted living arrangement or a memory care/dementia care facility.

f) Dental Services Exclusions

1. Expenses for dental prosthetics or dental services or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, illness or injury affecting another part of the body, including but not limited to dental prosthetics, endodontics such as root canal, dental restorations, and dental services for the care, filling, removal or replacement of teeth, or the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to teeth.
2. Expenses for the diagnosis, treatment or prevention of Temporomandibular Joint (TMJ) Dysfunction or Syndrome, as that condition is defined in the Definitions chapter of this document.
3. Expenses for Orthognathic services/surgery for treatment of aesthetic malposition of the bones of the jaw such as with Prognathism, Retrognathism, Temporomandibular Joint dysfunction/syndrome or other cosmetic reasons.
4. Expenses for dental services such as removal of teeth including wisdom teeth, gingivectomy, procedures in preparation for future dental work or dental implant, (such as sinus lift, soft tissue graft, bone graft/replacement), root canal (endodontic) therapy, except those services listed as payable under the Oral and Craniofacial Services row in the Schedule of Medical Benefits.
5. Expenses for dental services may be covered under the medical plan if they are incurred for the repair or replacement of Accidental Injury to Teeth or restoration of the jaw if damaged by an external object in an accident. For the purposes of this coverage by the Plan, an accident does not include any injury caused by biting or chewing. See Oral and Craniofacial Services in the Schedule of Medical Benefits to determine if those services are covered.
6. Expenses covered under the dental plan, and all expenses excluded under the dental plan unless coverage is specifically provided under the medical plan.

g) Drugs, Medicines And Nutrition Exclusions

1. Pharmaceuticals requiring a prescription that have not been approved by the U.S. Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed (i.e. are used "off-label"); except for drugs to treat cancer or are Experimental and/or Investigational as defined in the Definitions chapter of this document.
2. Non-prescription (meaning non-legend-over-the-counter) drugs or medicines, **except for** insulin, insulin syringes and diabetic supplies and certain over the counter (OTC) medication prescribed by a Physician or Health Care Practitioner, to be covered without cost-sharing in accordance with Health Reform regulations.
3. Drugs requiring a prescription by state law, but not by federal law, are not covered.

4. Foods and nutritional/dietary supplements including, but not limited to, home meals, formulas, foods, diets, vitamins, (except prenatal) herbs and minerals, (whether they can be purchased over-the-counter or require a prescription) except foods, and nutritional supplements provided during a stay in a health care facility covered by this Plan and prescribed in compliance with Health Reform regulations.

   Note: Nutritional support may be payable when it is determined by the Plan Administrator or its designee to be Medically Necessary, and is the sole means of adequate nutritional intake and is administered enterally (i.e., by feeding tube) or parenterally (i.e., by intravenous administration) and is not considered a food thickener, baby food, or other regular grocery product that can be mixed in a blender.
5. Medical Foods.
6. Naturopathic or homeopathic supplies, substances or products.
7. Drugs, medicines or devices for:
   a) fertility and/or infertility;
   b) hair removal or hair growth products (*e.g.,* Propecia, Rogaine, Minoxidil, Vaniqa);
   c) syringes (**except for** insulin syringes and diabetic supplies such as lancets, test strips, test tape, supplies for blood glucose testing devices, alcohol swabs,);
   d) cosmetic drugs products such as Restylane and Renova and Botox;
   e) weight management drugs prescribed solely for weight loss.
8. Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal or state law.
9. Take-home drugs or medicines provided by a Hospital, emergency room, Ambulatory Surgical Facility/Center, or other Health Care Facility. Note the Plan does permit payment of covered take-home drugs when provided by International Medical Solutions (IMS Network).

f) Durable Medical Equipment Exclusions

See the Exclusions related to Corrective Appliances and Durable Medical Equipment.

g) Family Planning (Fertility and Reproductive Care) Services Exclusions

1. Expenses for the diagnosis and treatment of **infertility** and complications thereof, including, but not limited to, services, drugs and procedures or devices to achieve fertility; in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen or other fees, cryostorage of egg/sperm, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures, adoption, and reversal of sterilization procedures.
2. Expenses for **medical or surgical treatment of sexual dysfunction** or inadequacy, regardless of cause, and any complications thereof, except that medications and laboratory services for diagnosis of sexual dysfunction are payable.
3. Expenses for **medical or surgical treatment related to transsexual** (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.
4. Expenses related to **condoms.** FDA-approved contraceptives for females are payable by the Plan as noted under Family Planning and Drugs and Medicines in the Schedule of Medical Benefit.
5. Expenses for **pre-planned home delivery**.
6. Expenses for **elective termination of pregnancy** (abortion), unless the attending physician certifies that the health of the woman would be endangered if the fetus were carried to term as is necessary to save the life of the woman having the abortion or to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion or where medical complications arise from an abortion.
7. Expenses for **childbirth education,** and **Lamaze classes**.
8. **Circumcision:** Expenses for circumcision of a male more than 10 weeks old unless it is determined to be Medically Necessary.
9. Expenses related to **cryostorage of umbilical cord blood or other tissue or organs.**

h) Foot Care Exclusion

1. Expenses for routine foot care, (including but not limited to trimming of toenails, removal or reduction of corns and callouses, removal of thick/cracked skin on the heels, foot massage, preventive care assessments of pulses, skin condition and sensation) or hand care including manicure and skin conditioning, unless the Plan Administrator or its designee determines such care to be Medically Necessary.

i) Genetic Testing and Counseling Exclusions

1. **Genetic Testing**: The following expenses for genetic tests, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics are not covered, including:
   a) **Pre-parental genetic testing (also called carrier testing)** intended to determine if an individual is at risk of passing on a particular genetic mutation, such as a family member who is unaffected but at risk for producing affected children.
   b) Expenses for **Pre-implantation Genetic Diagnosis (PGD)** where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal in connection with in vitro fertilization.
   c) **Home genetic testing kits/services and paternity testing** are not covered.
   d) Genetic testing determined by the Plan Administrator or its designee to be **not Medically Necessary, experimental or investigational**.
   e) **Genetic testing and non-Covered Individuals:** No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the Medically Necessary treatment of a Covered Individual.

   Plan Participants should use the Plan's Claims Administrator to determine if proposed Genetic Testing is covered or excluded.
2. **Genetic Counseling**: Expenses for genetic counseling, except when associated with a covered genetic test, and these three conditions are met: a) is ordered by a Physician, and b) performed by a qualified genetic counselor (or other qualified health care provider) and c) performed with regard to a genetic test that is payable by this Plan.

j) Hair Exclusions

1. Expenses for and related to hair removal or hair transplantation and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Vaniqa, Rogaine or other prescription drugs or medicines used to promote the growth of hair, or for expenses for and related to hair replacement including but not limited to, devices, wigs, toupees and/or hairpieces or hair analysis.

k) Hearing Care Exclusion

1. Expenses for and related to the purchase, servicing, fitting and/or repair of external hearing aid devices **except** implantable hearing devices such as cochlear implants are covered.

l) Home Health Care Exclusions

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

m) Nursing Care Exclusion

1. Expenses for services of private duty nurses except where the Plan Administrator or its designee determines that the private duty nursing care is Medically Necessary as defined in the Definitions chapter of this document.

n) Rehabilitation Therapies (Inpatient or Outpatient) Exclusions

1. Expenses for educational, job training and/or vocational rehabilitation.
2. Expenses for massage therapy, rolfing (deep muscle manipulation and massage) and craniosacral therapy (noninvasive rhythmic manipulation of the craniosacral areas) and related services.
3. Expenses incurred at an inpatient rehabilitation facility for any inpatient Rehabilitation Therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or

its designee, is otherwise incapable of participating in a purposeful manner with the therapy services and/or remember what is taught, including, but not limited to coma stimulation programs and services.

4. Expenses for Maintenance Rehabilitation (as defined under Rehabilitation in the Definitions chapter of this document).
5. Expenses for speech therapy for functional purposes including, but not limited to, speech impediment, stuttering, lisping, tongue thrusting stammering and conditions of psychoneurotic origin or for childhood developmental speech delays and disorders (unless such speech delay is a direct result of an injury, surgery or resulting from a covered treatment).
6. Expenses for Habilitation services (to help individuals attain certain functions that they never have acquired) except speech therapy for certain conditions as noted in Item 5 above. Coverage is also provided for **aural therapy** in connection with covered implantable hearing devices. See the Corrective Appliances and Rehabilitation Services rows of the Schedule of Medical Benefits for more information.
7. Expenses for prolotherapy (injection of sclerosing solutions into joints, muscles, or ligaments).

o) Spinal Manipulation Exclusions

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

p) Transplantation (Organ and Tissue) Exclusions

1. Expenses for human organ and/or tissue transplants not listed in the Schedule of Medical Benefits or that are experimental and/or investigational, and all complications thereof.
2. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except heart halves.
3. For plan participants who serve as a donor, donor expenses are not payable unless the person who receives the donated organ/tissue is the person covered by this Plan.
4. Expenses for insertion and maintenance of an artificial heart or other organ or related device including complications thereof, except heart valves, kidney dialysis, and a ventricular assist device (VAD) (that is a mechanical pump used to assist a damaged or weakened heart in pumping blood) **only when** used as a bridge to a heart transplant or for support of blood circulation post-cardiotomy (following open-heart surgery, or for destination therapy (permanent mechanical cardiac support only if there is approval from the FDA for that purpose, and the device is used according to the FDA-approved labeling instructions).

q) Vision Care Exclusions

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

r) Weight Management And Physical Fitness Exclusions

1. Expenses for medical treatment of obesity, including, but not limited to weight loss programs, dietary instructions, and any complications thereof, except as required by the Affordable Care Act (ACA) law. See the Definitions chapter for a definition of Morbid Obesity. See also the Weight Management row in the Schedule of Medical Benefits for coverage of bariatric surgery.
2. Expenses for medical or surgical treatment of severe underweight, including, but not limited to high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with Medically Necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by physicians to determine normal body weight.
3. Expenses for health clubs, exercise programs, gymnasium memberships, exercise equipment, other facility for physical fitness programs, fitness instructors, work hardening and/or weight training services, ergonomic chairs/desks, exercise/activity/health monitoring/tracking devices, or software applications including smartwatches/jewelry and wireless or wearable sensors/trackers.

DENTAL EXPENSE BENEFITS

Dental plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. A separate election or opt out is required for dental plan benefits and dental plan premiums are adjusted for individuals that opt in or out of coverage.

ELIGIBLE DENTAL EXPENSES

Services may be received from any licensed dentist or dental hygienist; and this Plan will reimburse as noted in the Schedule of Dental Benefits. The itemized bill reflecting the provider's fees must be submitted to the Claims Administrator for reimbursement. You will be reimbursed according to the Allowed Amount up to the amount allowed by the Plan.

You are covered for dental expenses you incur for most, but not all, dental services and supplies that are provided by a dental care provider and are determined by the Plan Administrator or its designee to be **"Medically Necessary**" but only to the extent that:

- the Plan Administrator or its designee determines that the services are the most cost-effective ones that meet acceptable standards of dental practice and would produce a satisfactory result; and
- services are not experimental or investigational; and
- services or supplies are not excluded from coverage (as provided in the Dental Plan Exclusions chapter of this document); and
- services or supplies are not in excess of a Maximum Plan Benefit as shown in this Dental Expense Benefits chapter; and
- charges for them are not in excess of the Allowed Amount. See also the Definitions chapter for the definitions of "Medically Necessary" and Allowed Amount.

This section of the document explains which expenses for dental services and supplies are covered (that is, are eligible dental expenses) and which are not. Generally, the Plan will not reimburse you for all eligible dental expenses. Usually, you will have to satisfy some Deductible and pay some coinsurance toward the amounts you incur that are eligible dental expenses.

NON ELIGIBLE DENTAL EXPENSES

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

OVERVIEW OF DENTAL DEDUCTIBLE, PLAN MAXIMUMS, AND COINSURANCE			
Annual Dental Plan Deductible	**Annual Dental Plan Maximum**	**General Overall (Lifetime) Maximum Plan Benefit**	**Coinsurance**
What you must **pay each plan year before** the Dental Plan pays benefits.	The most the Dental Plan will pay for covered dental expenses in one year.	The most this Dental Plan will pay for all covered dental expenses for one person.	How you and the Dental Plan will split the cost of covered dental expenses.
Individual: $50 Family: $100	$1,500 per person per year. This maximum does not apply to children under age 18.	$1,500 for orthodontia $350 for non-surgical Temporomandibular Joint services	Preventive: 100% Basic: 80% Major: 50% Orthodontia: 50% (All services are subject to the Deductible except preventive.)

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

DEDUCTIBLES

Each plan year, you are responsible for paying all your eligible dental expenses until you satisfy the annual Deductible. Then the Plan begins to pay benefits. There are two types of Deductibles: Individual and Family.

- The individual Deductible is the maximum amount one covered person has to pay each plan year before Plan benefits begin. **The Plan's individual Deductible is $50.**
- The family Deductible is the maximum amount that a family of two or more has to pay each plan year before Plan benefits begin. **The Plan's family Deductible is $100.**
- **NOTE:** Eligible dental expenses incurred for preventive services are **not** subject to the Deductible.

COINSURANCE

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

- **NOTE:** Eligible dental expenses incurred for preventive services are not subject to coinsurance.

OVERALL MAXIMUM PLAN BENEFITS

- **Annual Dental Plan Maximum Benefit:** The Plan's annual maximum plan benefits payable per plan year on account of dental services, except for Temporomandibular Joint or orthodontia services, for any individual covered under this Plan is **$1,500**. This maximum does not apply to children under age 18.
- **Orthodontia Services**: The overall lifetime maximum plan benefits payable for dental expenses incurred on account of orthodontia services for any individual covered under this Plan and any previous dental expense plan or program provided to that individual by your employer is **$1,500**.
- **Temporomandibular Joint Syndrome/Disorder (TMJ) Services**: The overall lifetime maximum plan benefits payable for expenses incurred on account of non-surgical TMJ for any individual covered under this Plan and any previous dental expenses plan or program provided to that individual by your employer is **$350.**

EXTENSION OF DENTAL COVERAGE

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

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

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

PAYMENT OF DENTAL BENEFITS

Dental services and supplies are **considered to have been incurred on the date the services are performed or supplies are furnished**. Completion of dental services is required for payment by this Plan. The Plan will consider partial payment of benefits using acceptable American Dental Association (ADA) coding as determined on a case-by-case basis.

1. **Fixed Partial Dentures, Bridgework, Crowns, Inlays and Onlays:** All services related to installation of Fixed Partial Dentures, Bridgework, Crowns, Inlays and Onlays are considered to have been incurred on the date the tooth (or teeth) is (or are) prepared for the installation.
2. **Removable Partial or Complete Dentures:** All services related to the preparation of Removable Partial or Complete Dentures are considered to have been incurred on the date the impression for the Dentures is taken.
3. **Root Canal Treatment (Endodontics):** All services related to Root Canal treatment (Endodontics) are considered to have been incurred on the date the tooth is opened for the treatment.
4. **Orthodontia:** Services related to Orthodontia are provided over a period of many months, and are usually subject to a fixed charge for the entire program of treatment, usually payable in monthly installments. All services related to Orthodontia are considered to have been incurred on a month-to-month basis, and the Plan will pay benefits for

services performed each month as long as eligibility for dental benefits is maintained, active treatment is continued and the benefit maximum has not been reached.

ALTERNATIVE PROCEDURES

Often there are several ways to treat a particular dental problem that will produce a satisfactory result. The Plan will pay benefits based on the procedure that meets the **least expensive professionally acceptable** standards of dental practice as determined by the Plan Administrator or its designee.

You may choose a more costly procedure. However, if you do, you will be responsible for paying the difference between the charges for the more costly procedure and the benefits paid by the Plan.

All treatment decisions rest with you and your Dentist. The pretreatment estimate procedure described below will help you know what benefits the Plan will pay. You will then be able to determine the difference (if any) that you may have to pay yourself.

PRETREATMENT ESTIMATES

Whenever you expect that your dental expenses for a course of treatment will be more than $500, you may use the pretreatment estimate procedure. This procedure lets you know how much you will have to pay before you begin treatment.

To obtain a pretreatment estimate, you and your Dentist should complete the regular dental claim form, available from and to be sent to the Claims Administrator, indicating the type of work to be performed along with pertinent x-rays and the estimated cost (valid for a 120-day period). Once it is received, the Claims Administrator will review the form and then send you and your Dentist (within 30 days) a statement showing what the Plan will pay. Your Dentist may call the Claims Administrator whose number is listed on the Quick Reference Chart in the front of this document, for a prompt determination of the benefits payable for a particular dental procedure.

PRESCRIPTION DRUGS NEEDED FOR DENTAL PURPOSE

Necessary prescription drugs needed for a dental purpose, such as antibiotics or pain medications, should be obtained using the Prescription Drug Benefit of the Medical Plan.

SCHEDULE OF DENTAL BENEFITS

A chart outlining a description of the Plan’s Dental Benefits and the explanations of them appears on the following pages.

SCHEDULE OF DENTAL BENEFITS This chart shows what the Dental Plan pays. The Dental Plan Deductible applies to all benefits except where noted. See also the Dental Plan Exclusions and Definitions chapters of this document.			
Benefit Description	**Explanations**	**Deductible**	**Plan Pays**
Preventive Services • Oral examination. • Prophylaxis (cleaning of the teeth). • Examination in connection with emergency palliative treatment. • Examination for consultation purposes. • Bite-wing x-rays. • Full mouth x-rays. • Topical application of sodium or stannous fluoride. • Periodontal prophylaxis. • Space maintainers.	• Preventive services are **subject to the annual and overall maximum dental plan benefits.** • Oral examination limited to twice in a 12-month period. • Prophylaxis, scaling, cleaning and polishing limited to twice in a 12-month period. • Bite-wing x-rays limited to once in a period of 12 consecutive months. • Full mouth x-rays limited to once in a period of 24 consecutive months. • Fluoride limited to family members under the age of 19 and limited to not more than twice in a 12-month period. • Periodontal prophylaxis limited to once every 3 months not to exceed 4 times in a 12-month period. • Space maintainers for the premature loss of posterior primary teeth, limited to children under the age of 14.	No	100%

SCHEDULE OF DENTAL BENEFITS This chart shows what the Dental Plan pays. The Dental Plan Deductible applies to all benefits except where noted. See also the Dental Plan Exclusions and Definitions chapters of this document.			
Benefit Description	**Explanations**	**Deductible**	**Plan Pays**
Basic Services • Medically necessary oral examination. • Dental x-rays as required for diagnosis of a specific dental condition. • Application of sealants on bicuspid and posterior teeth (molars). • Injection of necessary antibiotic drugs by the attending dentist. • Amalgam (silver) silicate, acrylic, synthetic porcelain and composite filling restoration for decayed or broken teeth. • Periodontal scaling and root planning (SCRP) periodontal Occlusal. • Treatment of periodontal and other diseases of the gums and supporting structures of the mouth (gingiva and/or alveolar bone). • Tooth extractions. • Space maintainers. • Gingivectomy. • Laboratory services for biopsy or cultures necessary for treatment of a specific dental condition. • Adjusting, relining or re-basing of removable dentures or bridgework. • Occlusal adjustment, only in connection with periosurgery. • Oral surgery, including tooth extractions and surgical procedures. • Endodontic treatment, including root canal therapy. • Administration of local, general anesthesia and/or intravenous sedation in connection with oral surgery and covered dental services. • Non-surgical treatment of temporomandibular joint syndrome/disorder (TMJ). • Laboratory services, including cultures necessary for diagnosis and/or treatment of a specific dental condition. • Drugs and medicines that are FDA-approved pharmaceuticals requiring a prescription and FDA approved for the condition, dose, route, duration and frequency that were prescribed by a dentist.	• Basic services are **subject to annual and overall maximum dental plan benefits.** • Application of sealants limited to permanent bicuspids and molars, once in a period of 36 consecutive months, for children under the age of 19. • Periodontal scaling and root planing is payable once per quadrant per 24-month period and the pocket depth must be 5mm or more to qualify for this procedure. • Oral surgery is limited to removal of impacted teeth or as necessary for: • teeth covered partially or totally by bone; • root canal treatment; or • gingivectomy. • Non-surgical treatment of Temporomandibular Joint limited to $350 per person per lifetime. • Administration of local anesthesia is payable as it is considered part of the payable dental service and is not paid separately.	Yes	80%

SCHEDULE OF DENTAL BENEFITS This chart shows what the Dental Plan pays. The Dental Plan Deductible applies to all benefits except where noted. See also the Dental Plan Exclusions and Definitions chapters of this document.			
Benefit Description	**Explanations**	**Deductible**	**Plan Pays**

Major Services
• Installation of fixed bridgework, dentures and cast inlays.
• Onlays and crowns, including porcelain.
• Repair or re-cementing of crowns, inlays or onlays.
• Adjusting, relining or re-basing of removable dentures.
• Replacement of an existing partial or full removable denture or fixed bridgework; addition of teeth to an existing partial or removable denture; bridgework to replace teeth that were extracted if evidence, satisfactory to the Plan Administrator or its designee, is presented that the conditions shown to the right have been satisfied.
• Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace natural teeth that were lost or extracted. Expenses on account of adjustments to fixed bridgework are covered only for the 6-month period following initial installation.
• Precision or semi-precision attachments for prosthetic devices.
• Gold restorations.
	• Major services are **subject to annual and overall maximum dental plan benefits.**
	• Installation of fixed bridgework must be completed within 12 months of the extraction.
	• When porcelain is used for onlays or crowns on posterior teeth, plan benefits are limited to the amount payable for metal onlays or crowns.
	• For replacement of an existing partial or full removable denture:
	  • The replacement or addition of teeth is necessary to replace one or more teeth extracted after the existing denture or bridgework was installed and the addition of teeth is completed within 12 months of the extraction.
	  • The existing denture or bridgework cannot be made serviceable and was installed at least 5 years prior to the replacement date, and the patient was covered by the dental plan for at least 2 years.
	  • The existing denture is an immediate temporary denture replacing one or more natural teeth extracted. Replacement by a permanent denture is required. The replacement must take place within 12 months from the placement of the temporary denture.
	  • The replacement is due to accidental injury requiring oral surgery and the replacement takes place within 15 months of the accident.
		Yes	50%

Orthodontia Services
• Necessary services related to an active course of orthodontia treatment include diagnosis, evaluation and pre-care.
• The initial installation of orthodontic appliances for an active course of orthodontia treatment.
• Adjustment of active orthodontia appliances.
• This orthodontia benefit is for nonsurgical services provided to correct malocclusion (alignment of the teeth and or jaws) that significantly interferes with their function.
• Expenses related to orthodontia will be covered only when one or more of the conditions shown to the right have been satisfied.
	• Orthodontia services **are subject to an overall maximum orthodontia plan benefit.**
	• Payment for orthodontia benefits will **not continue** if treatment ceases **for any reason**.
	• Repair or replacement of orthodontia appliances are **not covered**.
	• **Conditions required for coverage of orthodontia:**
	  • The existence of an extreme buccolingual version of the teeth, either unilateral or bilateral. (The teeth are pushed out toward the cheek or in toward the tongue on one or both sides.)
	  • A protrusion of the upper teeth of more than 3 millimeters.
	  • A protrusion or retrusive relation of the maxillary or mandibular arch.
		Yes	50%,
			to the lifetime orthodontia maximum.

DENTAL PLAN EXCLUSIONS

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

GENERAL EXCLUSIONS

1. **Costs of Reports, Bills, etc.:** Expenses for preparing dental reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken appointments, telephone calls and/or photocopying fees.
2. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any plan benefit limitation, annual maximum plan benefits, or overall maximum plan benefits as described in the Dental Expense Benefits chapter of this document.
3. **Expenses Exceeding the Allowed Amount:** Any portion of the expenses for covered dental services or supplies that are determined by the Plan Administrator or its designee to exceed the Allowed Amount as defined in the Definitions chapter of this document.
4. **Expenses for Orthodontia That Started Before Coverage Began:** Expenses for any dental services relating to any active course of orthodontia treatment that began before the effective date of coverage under this Plan, even if those services are provided after the effective date of coverage under this Plan.
5. **Expenses for Which a Third Party Is Responsible:** Expenses for dental services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party, as applicable. See the provisions relating to Third Party Liability in the Coordination of Benefits (COB) chapter of this document for an explanation of the circumstances under which the plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
6. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the dental plan or after the date the patient's coverage ends.
7. **Expenses Related to Services Rendered After Termination of Coverage:** Expenses for the initial installation of dentures or bridgework replacing a tooth or a group of teeth that was started while the individual was covered under this Plan but were finally installed or delivered more than 31 days after termination of coverage.
8. **Experimental and/or Investigational Services:** Expenses for any dental services and supplies that are determined by the Plan Administrator or its designee to be experimental and/or investigational as defined in the Definitions chapter of this document.
9. **Illegal Act:** Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of commission, or attempted commission by the Covered Individual, of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual. The Plan Administrator's discretionary determination that this exclusion applies shall not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.
10. **Travel and Related Expenses:** Expenses for and related to travel or transportation (including lodging, meals and related expenses), unless those expenses have been preapproved by the Plan Administrator or its designee.
11. **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law. This applies even if you or your covered Dependent were not covered by workers' compensation insurance, or if the Covered Individual's rights under workers' compensation or occupational disease or similar law has been waived or qualified.
12. **Services Not Medically Necessary:** Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in the Definitions chapter of this document.

13. **Services Not Performed by a Dentist or Dental Hygienist:** Expenses for dental services not performed by a dentist (except for services of a dental hygienist that are supervised and billed by a dentist and are for cleaning or scaling of teeth or for fluoride treatments).
14. **Military Service-Related Injury/Illness**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan.
15. **Services Provided by Relatives:** Expenses for dental services provided by any dentist or other dental care practitioner who is the parent, Spouse, sibling (by birth or marriage such as a brother-in-law), aunt/uncle or child of the patient or covered employee.
16. **Services Provided Outside the United States:** Expenses for dental services or supplies rendered or provided outside the United States, except for treatment in Mexico or for a dental emergency as defined in the Definitions chapter of this document.
17. **Services Provided Without Cost to Recipient:** Expenses for dental services or supplies for which a covered person is not required to pay or which are obtained without cost or there would be no charge if the person receiving the treatment were not covered under this Plan.
18. **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion or invasion, except as required by law.

SPECIFIC DENTAL CARE EXCLUSIONS

1. **Analgesia, Sedation, Hypnosis, etc.:** Expenses for analgesia, sedation, hypnosis and/or related services provided for apprehension or anxiety.
2. **Cosmetic Services:** Expenses for dental surgery or dental treatment for cosmetic purposes, as determined by the Plan Administrator or its designee, including but not limited to veneers and facings. However, the following will be covered if they otherwise qualify as covered dental expenses and **are not covered** under your medical expense coverage:
    a. Reconstructive dental surgery when that service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part.
    b. Surgery or treatment to correct deformities caused by sickness.
    c. Surgery or treatment to correct birth defects outside the normal range of human variation.
    d. Reconstructive dental surgery because of congenital disease or anomaly of a covered Dependent Child that has resulted in a functional disorder.
3. **Drugs and Medicines**: Expenses for prescription drugs and medications that are covered under your medical expense coverage, and for any other dental services or supplies if benefits are otherwise provided under the Plan's medical expense coverage; or under any other plan/program that your employer contributes to or otherwise sponsors; through a medical or dental department, clinic or similar facility provided or maintained by the organization.
4. **Duplicate or Replacement Bridges, Dentures or Appliances:** Expenses for any duplicate or replacement of any lost, missing or stolen bridge, denture or orthodontic appliance other than replacements described in the Major Services section of the Schedule of Dental Benefits.
5. **Duplication of Dental Services:** If a person covered by this plan transfers from the care of one dentist to the care of another dentist during the course of any treatment, or if more than one dentist renders services for the same dental procedure, the Plan will not be liable for more than the amount that it would have been liable had but one dentist rendered all the services during each course of treatment, nor will the Plan be liable for duplication of services.
6. **Education Services and Home Use Supplies:** Expenses for dental education such as for plaque control, oral hygiene or diet or home use supplies, including, but not limited to, toothpaste, toothbrush, water-pick, fluoride, mouthwash, dental floss, etc.
7. **Gnathologic Recordings for Jaw Movement and Position:** Expenses for gnathologic recordings for jaw movement and position.

8. **Hospital Expenses Related to Dental Care:** Expenses for hospitalization related to Dental Surgery or care except as may be payable under the Medical Plan as noted in the Schedule of Medical Benefits.
9. **Implantology:** Expenses for implantology (artificial root structure placed into the jaw to support bridgework or dentures).
10. **Mouth Guards:** Expenses for athletic mouth guards and associated devices.
11. **Myofunctional Therapy:** Expenses for myofunctional therapy.
12. **Periodontal Splinting:** Expenses for periodontal splinting.
13. **Personalized Bridges, Dentures, Retainers or Appliances:** Expenses for personalization or characterization of any dental prosthesis, including but not limited to any bridge, denture, retainer or appliance.
14. **Sealants:** Expenses for sealants (materials other than fluorides painted on the grooves of the teeth to prevent decay), except as payable under the Schedule of Dental Benefits.
15. **Services or Appliances Subject to Orthodontia Benefit:** Expenses for any dental services or appliances including, but not limited to items to increase vertical dimension, restore occlusion, stabilize tooth structure lost by wear or bruxism and harmful habits, except as provided under the orthodontia services benefit outlined in the Schedule of Dental Benefits.
16. **Space Maintainers, Study Models, etc.:** Expenses for anterior space maintainers, study models, molds and/or casts, except as payable under the Schedule of Dental Benefits.
17. **Treatment of Jaw or Temporomandibular Joints:** Expenses for surgical treatment, by any means, of jaw joint problems including temporomandibular joint disorder or syndrome (except non-surgical Temporomandibular Joint treatment as payable under the Schedule of Dental Benefits) and any other craniomandibular disorders or other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues relating to that joint.
18. **Gold Restorations**, unless the tooth cannot be restored with other types of restorative materials.
19. Services that are an integral component of a covered treatment.
20. **Fees charged for infection control procedures** and for compliance with Occupational Safety and Health Administration (OSHA) requirements.
21. **Expenses related to complications of a non-covered service**.

VISION EXPENSE BENEFITS

This section outlines the **fully insured Vision Plan** coverage; however, where the text in this chapter deviates from the certificate of coverage and summary of benefits produced by the vision plan insurance company, the insurance company documents will prevail. Contact the Vision Plan insurance company (whose name is listed on the Quick Reference chart in the front of this document) for a copy of vision plan insurance benefit information.

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

Vision plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. A separate election or opt out is required for these insured vision plan benefits and vision plan premiums are adjusted for individuals that opt in or out of coverage.

NETWORK PROVIDERS

The Vision Plan is a network of preferred vision providers (licensed ophthalmologist, optometrist or dispensing optician) who have a contract to provide discounted fees to you for services covered under this Vision Plan. By using the services of an In-Network provider, both you and the Plan pay less (see the Network column of the Schedule of Vision Benefits).

A current list of network service providers is available free of charge when you call the Vision Plan whose name, address and telephone number are noted on the Quick Reference Chart in the Introduction chapter of this document. To receive services, simply call a network vision provider and identify yourself as a member of the Vision plan.

NON-NETWORK PROVIDERS

Services may be received from any licensed optometrist, ophthalmologist and/or dispensing optician; however, this plan will pay at the non-network benefit level as noted in the Schedule of Vision Benefits. The itemized bill reflecting the non-network provider's fees must be submitted to the Vision Plan Administrator for reimbursement. You will be reimbursed according to the Allowed Amount or the schedule below, whichever is less.

Non-network provider services may cost you more than if those same services were obtained from an In-Network provider. Non-Network Providers may bill the Plan participant for any balance that may be due in addition to the amount payable by the Plan, also called balance billing. <u>You can avoid balance billing by using In-Network providers</u>. (See the definitions of Allowed Amount and Balance Billing in the Definitions chapter of this document).

NOTE: Vision claims must be submitted to the Vision Plan Administrator <u>within 12 months of the date of service</u> or payment cannot be considered.

DEFINITION OF TERMS USED IN THIS VISION PLAN

- A **vision exam** includes a professional eye examination and an eye refraction. The exam typically includes:
  - an assessment of your health history particularly as it is relevant to your vision,
  - external exam of the eyes for pathological abnormalities of the eyes including but not limited to the pupil, lens and lashes/eyelids,
  - internal exam including but not limited to an assessment of the lens and retina along with tononometry (measurement of the fluid pressure in the eye to help detect signs of glaucoma), visual field testing (checks peripheral visual capabilities), biomicroscopy (retina examination) and inspection of the retina with an ophthalmoscope, visual acuity (the ability to see clearly at all distances) and refraction (testing the eyes' ability to focus light rays on the retina from a distance and close-up).
- **Contact Lens Exam** means a special examination of the eye and the surface of the eye (the cornea) for the purpose of helping you receive a proper fitting contact lens. This exam can include a measurement of the curvature of the eye, assessment of the moisture/tear content of the eye, evaluation of the alignment of the lens on the surface of the eye, etc.
- **Dispensing Optician** means a person qualified to manufacture and dispense eyeglasses and/or contact lenses.
- **Optometrist** is a person licensed to practice optometry.
- **Ophthalmologist** is a physician (MD or DO) licensed to practice ophthalmology, including eye surgery and prescription of drugs.
- **Fundus Photography** is a photo of the inside of the eye showing the optic nerve and retinal vessels.

SCHEDULE OF VISION BENEFITS			
Covered Vision Benefits	**Explanation** See also the Vision Exclusions.	**Plan Pays**	
		Network Provider (Doctor)	**Non-Network Provider**
Vision Exam and analysis of visual function.	• Covered once every 12 months.	100% after a $10 copay	Up to $45 per exam
Eyeglasses (frames and lenses)	• A single vision, lined bifocal, lined trifocal lenses or lenticular lenses every 12 months if needed; **and/or** • A frame not to exceed the frame allowance, every 24 months, if needed. • This program provides a wide selection of quality frames. Because of the cosmetic nature of frames and rapidly changing styles, this Plan has a limit (determined by the Vision Plan Administrator) on the reimbursement for frames. Covered persons who select frames that exceed the frame allowance will pay the additional cost.	100% after a $15 copay for lenses and/or frames. Frame of your choice is covered/allowed up to $130 (up to $150 for featured frames), plus 20% discount off any Out-of-Pocket costs for frames. $70 Walmart/Sam's Club/Costco frame allowance Standard progressives, scratch coating and polycarbonate lenses are covered with the copay.	Single vision (pair)*= Up to $30 Lined bifocal lenses (pair)*= Up to $50 Lined trifocal lenses (pair)*= Up to $65 Lenticular lenses (pair)* = Up to $100 Frame = Up to $70. *Plan benefits for lenses are per complete set not per lens. Scratch coating and polycarbonate lenses are not payable.
Contact Lenses	• Once every 12 months in lieu of all other lens and frame benefits. • Elective Contact Lenses: When you choose contacts instead of glasses your $130 allowance applies to the cost of your contacts and there is a $60 copay for the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts.	Contacts that are Medically Necessary (as determined by the Vision Plan Administrator) because no less expensive professionally acceptable alternative is available: Covered in full Elective Contact Lenses: 100%, the Plan pays up to $130.	Contacts required for vision correction (Medically Necessary as determined by the Vision Plan Administrator): Up to $210 Elective Contact Lenses: Up to $105.
Low Vision Benefit	• The low vision benefit is available to covered persons who have severe visual problems that are not correctable with regular lenses and is subject to prior approval by the Vision Plan Administrator. Maximum benefit available is $1,000 (excluding copayment) every two years. • Supplemental Testing: includes complete low vision analysis/diagnosis which includes a comprehensive examination of visual functions including the prescription of corrective eyewear or vision aids where indicated. • Supplemental Care Aids: subsequent low vision aids as visually necessary or appropriate.	Supplemental Testing: Covered in full Supplemental Care Aids: You pay 25% of cost	Supplemental testing: up to $125 Supplemental Care Aids: You pay 25% of cost Reimbursement will be determined by the Vision Plan Administrator. There is no assurance that the reimbursement will be within 25% of the cost.
Primary Eyecare for Diabetics	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details."	100% after a $20 copay (copay applies to exam services)	No coverage.

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

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

VISION PLAN EXCLUSIONS

The Vision Plan is designed to cover visual needs rather than cosmetic materials. When a covered person selects any of the following extras, the Vision Plan will pay the basic cost of the allowed vision service/supply and the covered person will pay the additional cost for the extras such as:

1. Oversized lenses (61mm or greater, except with prior authorization).
2. Progressive multi-focal lenses.
3. Blended lenses and Laminated lenses.
4. Contact lenses, except as otherwise stated in the Schedule of Vision Benefits.
5. Photochromic lenses; Tinted lenses, except pink #1 and #2.
6. Optional cosmetic processes.
7. Antireflective coating; Color coating and Mirror coating.
8. Cosmetic lenses; and UV (Ultraviolet) protected lenses.
9. Certain limitations on low vision care.
10. A frame that costs more than the Plan's allowance as noted in the Schedule of Vision Benefits.
11. Orthoptics or vision training, and any associated supplemental testing.
12. Plano (non-prescription) lenses (less than a $\pm$ diopter power) or two pair of glasses in lieu of bifocals.
13. Replacement of lenses and frames furnished under this program, which are lost or broken, will not be replaced except at the normal intervals when services are otherwise available as described in the Schedule of Vision Benefits.
14. Medical or surgical treatment of the eyes.
15. Corrective vision treatment of an experimental nature.
16. Costs for services and/or materials above the Plan Benefit allowances.
17. Services and/or material not indicated on the Schedule of Vision Benefits.
18. Insulin or any medication or supplies of any type.

FILING A VISION CLAIM/APPEALING A DENIED CLAIM

When you use the services of an In-Network vision provider, you should pay the provider for your appropriate copays along with any services you purchased that are not covered by the Vision Plan. The provider will submit the claim to the Vision Plan.

If you use the services of a non-network vision provider, you will need to pay the provider for all services and then, at a later date but within twelve (12) months of the date of service, submit the bill to the Vision Plan whose name and address are listed on the Quick Reference Chart in the front of this document. You will be reimbursed up to the amount allowed under the Vision Plan as noted in the Schedule of Vision Benefits. Vision claims submitted beyond twelve months of the date of service may not be considered for reimbursement.

To appeal a denied vision plan claim, contact the Vision Plan (contact information is on the Quick Reference Chart).

CLAIM FILING AND APPEALS INFORMATION

This chapter describes the procedures for filing claims for certain benefits under this Plan and for appealing adverse benefit determinations in connection with those claims. Claims covered by these procedures include those claims filed under the Medical Plan including the Prescription Drug Program and the Dental Plan. Refer to the Vision Plan Insurance Company for information on Vision Plan claims and appeals.

The Plan takes steps to assure that **Plan provisions are applied consistently** with respect to you and other similarly situated Plan participants. The claims procedures outlined in this chapter are designed to **afford you a full, fair and fast review of the claim to which it applies**. This chapter also discusses the process the Plan undertakes on **certain appealed claims, to consult with a Health Care Professional** with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary, is experimental or investigational).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

A Qualified Medical Child Support Order (QMCSO) may require the Plan to pay Plan benefits on account of eligible expenses incurred by Dependent Child(ren) covered by the Plan either to the provider who rendered the services or to the custodial parent of the Dependent Child(ren). If coverage of the Dependent Child(ren) is actually provided by the Plan, and if the Plan Administrator or its designee determines that it has received a QMCSO, it will pay Plan benefits on account of expenses incurred by Dependent Child(ren) to the extent otherwise covered by the Plan as required by that QMCSO. For additional information regarding QMCSOs, see the Eligibility chapter of this document.

WHEN YOU MUST REPAY PLAN BENEFITS

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

1. some or all of the health care expenses were not payable by you or your covered Dependent; or
2. you or your covered Dependent received money to pay some or all of those health care expenses from a source other than the Plan; or
3. you or your covered Dependent achieve any recovery whatsoever, through a legal action or settlement in connection with any sickness or injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the health care expenses for which Plan benefits were paid (See also the Subrogation section of the COB chapter);or
4. the Plan erroneously paid benefits to which you were not entitled under the terms and provisions of the Plan; or
5. the Plan erroneously paid benefits because of false information entered on your enrollment form (or as applicable, online enrollment application), claim form or required documentation;

then, the Plan will be entitled to:

a. recover overpayments from the entity to which the overpayment was made or from the plan participant directly;
b. a refund from you or your Health Care Provider for the difference between the amount paid by the Plan for those expenses and the amount of Plan benefits that should have been paid by the Plan for those expenses based on the actual facts;
c. offset future benefits (that would otherwise be payable on behalf of you or your dependents) if necessary in order to recover such expenses; and/or
d. its attorney's fees, costs and expenses incurred in recovering monies that were wrongfully paid.

TIME LIMIT FOR FILING CLAIMS

All medical, prescription drug, and dental claims must be submitted to the plan within 12 months after the expenses were incurred. No plan benefits will be paid for any claim not submitted within this period.

Vision Claims: If you use the services of a non-network vision provider, you will need to pay the provider for all services and then, at a later date but **within 12 months** of the date of service, submit the bill to the Vision Plan whose name and address are listed on the Quick Reference Chart in the front of this document.

Vision claims submitted beyond twelve months of the date of service may not be considered for reimbursement.

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after the stated timeframe.

WHEN YOU MUST GET PLAN APPROVAL IN ADVANCE OF OBTAINING HEALTH CARE

Some Plan benefits are payable without a financial penalty only if the Plan approves payment **before** you receive the services. These benefits are referred to as pre-service claims (also known as preauthorization or precertification). See the definition of pre-service claims in this chapter. You are not required to obtain approval in advance for emergency care including care provided in a hospital Emergency Room, or hospital admission for delivery of a baby.

COORDINATION OF BENEFITS (COB) PROVISION

This Plan contains a Coordination of Benefits (COB) provision to prevent double payment for covered expenses. This provision works by coordinating the benefits under this Plan with other similar plans under which a person is covered so that the total benefits available will not exceed one hundred percent of allowable expenses. You may be asked to submit information about any additional coverage you have available to you so that this Plan knows whether and how much it should pay toward your eligible services. Without your cooperation in forwarding information on additional coverage to this Plan, the Plan may deny claims until the requested information is obtained. See the Coordination of Benefits chapter for more information.

KEY DEFINITIONS (listed alphabetically)

Adverse Benefit Determination: For the purpose of the initial and appeal claims processes, an adverse benefit determination is defined as:

- a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in this Plan or a determination that a benefit is not a covered benefit; and
- a reduction in a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate; or
- a rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions.

Appropriate Claims Administrator: means the companies/organizations and types of claims outlined in the chart below. (See the Quick Reference Chart in this document for the contact information for these Appropriate Claims Administrators)

Appropriate Claims Administrator	Types of Claims Processed
Medical and Behavioral Health Claims Administrator	Medical and Behavioral Health post-service claims.
Utilization Management Company	Urgent, Concurrent and Pre-service claims
Prescription Drug Program	Pre-service claims for outpatient prescription drugs Post-service claims for out-of-network retail drugs
Dental Claims Administrator	Dental post-service claims.
Vision Plan Insurance Company	Pre-service and post-service vision claims

Claim: For purposes of benefits covered by these procedures, a claim is a request for a Plan benefit made by an individual (commonly called the "claimant" but hereafter referred to as "you") or that individual's authorized representative (as defined later in this chapter) in accordance with the Plan's claims procedures, described in this chapter.

There are **four types of claims** covered by the procedures in this chapter: **Pre-service, Urgent, Concurrent, and Post-service**, described later in this chapter. The type of claim is determined as of the time the claim or review of denial of the claim is being processed.

A claim must include the following elements to trigger the Plan's claims processing procedures:

a. be **written or electronically** submitted (oral communication is acceptable only for urgent care claims);
b. be **received by the Appropriate Claims Administrator** as that term is defined in this chapter;
c. **name a specific individual including their social security number or Medicare HICN number**;
d. **name a specific medical condition or symptom**;
e. **name a specific treatment, service or product** for which approval or payment is requested;

f. **made in accordance with the Plan's benefit claims filing procedures** described in this chapter; and
g. **includes all information required by the Plan and its Appropriate Claims Administrator, such as the existence of additional health coverage that would assist the Plan in coordinating benefits**.

A claim is NOT:

a. a request made by **someone other than** the individual or his/her authorized representative;
b. a request made by a **person who will not identify him/herself** (anonymous);
c. a **casual inquiry about benefits** such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
d. a request for **prior approval of Plan benefits where prior approval is not required** by the Plan;
e. an **eligibility inquiry that does not request Plan benefits**. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
f. a **request for services and claims for a work-related injury/illness**, unless the Workers' Compensation program has provided a written confirmation that the injury/illness is not compensable as a work-related claim;
g. a **submission of a prescription** with a subsequent adverse benefit determination at the point of sale at a retail pharmacy or from a mail order service;
h. a **request for an eye exam, lenses, frames or contact lenses** with a subsequent adverse benefit determination at the point of sale from the Plan's contracted in-network PPO vision providers.

Concurrent Care Claim: A concurrent care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short. The services that will receive concurrent care review are listed in the Utilization Management chapter in this document.

Days: For the purpose of the claim and appeal procedures outlined in this chapter, "days" refers to calendar days, not business days.

Health Care Professional: Means a Physician or other Health Care Professional licensed, accredited or certified to perform specified health services consistent with State law.

Independent Review Organization or IRO means an entity that conducts independent external reviews of adverse benefit determinations in accordance with the Plan's external review provisions and current federal external review regulations.

Post-Service Claim: A post-service claim is a claim for benefits under the Plan that is not a pre-service claim. Post-service claims are claims that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim and an electronic bill, submitted for payment after services have been provided, are examples of post-service claims. A claim regarding rescission of coverage will be treated as a post-service claim.

Pre-Service Claim: A pre-service claim is a request for benefits under this group health Plan where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care. The services that require precertification (also called prior authorization) are listed in the Utilization Management chapter and the Drug row of the Schedule of Medical Benefits in this document.

The Plan Administrator may determine, in its sole discretion, to pay benefits for the services needing precertification (that were obtained without prior approval) if you were unable to obtain prior approval because circumstances existed that made obtaining such prior approval impossible, or application of the pre-service (precertification) procedure could have seriously jeopardized the patient's life or health.

Rescission: Means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required premiums or contributions. The plan is permitted to rescind your coverage if you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of this Plan (see also the section on "When The Plan Can End Your Coverage For Cause" described in the Eligibility chapter).

Tolled: Means stopped or suspended, particularly as it refers to time periods during the claims process.

Urgent Care Claim: An urgent care claim is a claim (request) for medical care or treatment in which applying the time periods for precertification, as determined by your Health Care Professional:

- could seriously jeopardize the life or health of the individual or the individual's ability to regain maximum function, or
- in the opinion of a physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, or is a claim involving urgent care.

The services that require precertification (also called prior authorization) are listed in the Utilization Management chapter and the Drug row of the Schedule of Medical Benefits in this document.

REVIEW OF ISSUES THAT ARE NOT A CLAIM AS DEFINED IN THIS CHAPTER

A Plan participant may request review of an issue (that is not a claim as defined in this chapter) by writing to the YABC Plan Administrator whose contact information is listed on the Quick Reference Chart in this document. The request will be reviewed and the participant will be advised of the decision within 60 days of the receipt of the request.

AUTHORIZED REPRESENTATIVE

This Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an adverse benefit determination under this Plan (because of your death, disability or other reason acceptable to the Plan). An authorized representative under this Plan also includes a Health Care Professional. Under this Plan you do not need to designate in writing that the in-network Health Care Professional is your authorized representative if that in-network Health Care Professional is part of the claim appeal.

The Plan requires a written statement from an individual that he/she has designated an authorized representative (except for a health care professional who does not require a written statement in order to appeal a claim for a plan participant) along with the representative's name, address and phone number. To designate an authorized representative, you must submit a completed authorized representative form (available from the Appropriate Claims Administrator.

Where an individual is unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g.*, notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the individual's legal spouse, parent, grandparent or child over the age of 18).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative and not the individual. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. A participant may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Appropriate Claims Administrator.

In the case of an urgent care claim, if an in-network Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), such in-network Health Care Professional will be considered by this Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form. Under this Plan non-network providers cannot automatically be designated to be an Authorized Representative, the plan participant must make a written designation if they desire a non-network provider to be their authorized representative for a claim appeal; however this designation does not extend to permit the non-network provider to file legal action on behalf of the participant or their claim appeal.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

HOW TO FILE A POST-SERVICE CLAIM FOR BENEFITS UNDER THIS PLAN

A claim for post-service benefits is a request for Plan benefits (that is not a pre-service claim) made by you or your authorized representative, in accordance with the Plan's claims procedures, described in this chapter. See also the "Key Definitions" subheading of this chapter for a definition of a "claim" and the information on what is and is not considered a claim.

1. Plan benefits for post-service claims are considered for payment upon receipt of a **written** (or electronic where appropriate) proof of claim, commonly called a bill. A completed claim usually contains the necessary proof of claim but sometimes additional information or records may be required. The Appropriate Claims Administrator will not accept a balance due statement, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim.

2. Generally, Plan benefits for a Hospital or Health Care Facility will be paid directly to the facility. Plan benefits for surgery will usually be paid directly to the surgeon and anesthesiologist providing the services. This is because the Plan's financial responsibility for eligible benefits is generally automatically assigned to the provider of the service unless the claim is marked that the bills have been paid by the covered person. For eligible claims, the Plan pays their portion of the billed services and you, the covered person, are responsible to pay your portion of the claim to the provider.

3. If health care services are provided through the Preferred Provider Organization (PPO), the PPO Health Care Facility/Provider will usually submit the written proof of claim directly to the PPO Network for repricing or to the Appropriate Claims Administrator.

4. If you pay for non-PPO health care services at the time services are provided, you may later submit the bill to the Appropriate Claims Administrator. At the time you submit your claim you must furnish evidence acceptable to the Appropriate Claims Administrator that you or your covered dependent paid some or all of those charges. If non-PPO Plan benefits will be paid to you, they will be paid up to the amount allowed by the Plan for those expenses.

5. **Claim Forms:** Occasionally a health care provider will send a claim directly to you. In this case you should contact the Appropriate Claims Administrator (defined in this chapter) to find out if they require you to complete a claim form. If a claim form is required it may be obtained from the Appropriate Claims Administrator whose contact information is listed on the Quick Reference Chart in this document.
   - Complete the employee part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
   - The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your Physician or Health Care Practitioner or Dentist can complete the Health Care Provider part of the claim form, or you can attach the bill for professional services if it contains **all** of the following information:
     - A description of the services or supplies provided.
     - Details of the charges for those services or supplies, including CPT/CDT codes.
     - Diagnosis including ICD codes.
     - Date(s) the services or supplies were provided.
     - Patient's name, social security or ID number, address and date of birth.
     - Insured's name, social security or ID number, address and date of birth, if different from the patient.
     - Provider's name, address, phone number, professional degree or license, and federal tax identification number.
   - Please review your bills to be sure they are appropriate and correct. **Report any discrepancies in billing to the Appropriate Claims Administrator.** This can reduce costs to you and the Plan.
   - Complete a **separate claim form** for each person for whom Plan benefits are being requested.
   - If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your Deductible, if a plan maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, how to appeal a claim, etc.
   - Mail the claim form and a copy of the provider's actual claim to the Appropriate Claims Administrator.
   - If at the time you submit your claim, you furnish evidence acceptable to the Plan that you or your covered dependent paid some or all of those charges, Plan benefits for covered services may be able to be paid to you up to the amount allowed by the Plan for those services.

6. In all instances, when Deductibles, coinsurance or copayments apply, you are responsible for paying your share of the charges.

7. The Appropriate Claims Administrator will review your post-service claim no later than 30 calendar days from the date the claim is received. You will be notified if you did not properly follow the post-service claims process.
   - This 30-day period may be extended one time for up to 15 additional calendar days if the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond its control, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 30 day period using a written Notice of Extension.

- The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. You will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
- If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.
- The Appropriate Claims Administrator will then make a claim determination no later than 15 calendar days from the earlier of the date the Plan receives the additional information or the date displayed in the Notice of Extension on which the Plan will make a decision if no additional information is received.
- **Proof of Dependent Status:** (See also the following two sections of the Eligibility chapter of this document: Proof of Dependent Status section and Failure to Provide Proof of Dependent Status under the Initial Enrollment section).
  - When processing claims submitted on behalf of a **Newborn Dependent Child** the Appropriate Claims Administrator must receive confirmation of the child's eligibility for coverage (*e.g.*, copy of certified birth certificate for newborn).
  - When processing claims submitted on behalf of a **Dependent Child who is 26 years or older** the Appropriate Claims Administrator must receive confirmation of the child's eligibility (e.g., disabled adult child verification).
  - If claims are submitted on behalf of a **Dependent for whom the Plan has not yet received proof of dependent status**, the Appropriate Claims Administrator must receive the proof of eligibility, or confirmation from the Plan Administrator of the child's eligibility for coverage, before the claim can be considered for payment.
  - When processing claims submitted on behalf of a **new Spouse**, the Appropriate Claims Administrator must receive confirmation of the Spouse's eligibility (e.g., copy of marriage certificate).
  - When processing **claims related to an accident** the Appropriate Claims Administrator may need information about the details of the accident in order to consider the claim for payment.

The Plan will provide you, automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

8. **If the post-service claim is approved,** you will be notified in writing (or electronically, as applicable) on a form commonly referred to as an Explanation of Benefits or EOB. The provider of service (or you when applicable) will be paid according to Plan benefits.

9. **If the post-service claim is denied** in whole or in part, a notice of this initial denial will be provided to you in writing (or electronically, as applicable in addition to the Explanation of Benefits or EOB form. This notice of initial denial will:
   - identify the claim involved (e.g., date of service, health care provider, claim amount if applicable, diagnosis and treatment codes and meanings of the codes);
   - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
   - give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;

- contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
- provide an explanation of the Plan's internal appeal procedure and external review processes (when external review is relevant) along with time limits and information regarding how to initiate an appeal;
- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
- disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

10. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
    - SPANISH (Español): Para obtener asistencia en Español, llame al 1-602-231-8896 or 1-866-365-9198.
    - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-602-231-8896 or 1-866-365-9198.
    - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-602-231-8896 or 1-866-365-9198.
    - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-602-231-8896 or 1-866-365-9198.
11. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished **within 30 days** of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.
12. **If you disagree with a denial of a post-service claim**, you or your authorized representative may ask for a post-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A POST-SERVICE CLAIM

This Plan maintains a 2-level appeals process. Appeals must be submitted in writing to the Appropriate Claims Administrator for the first level of appeal review and to the Plan Administrator who is the YABC Board of Trustees for the second level appeal review, both of whom have their contact information listed on the Quick Reference Chart in this document. You will be provided with:

- upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

  Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

  If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process

that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan (the Board of Trustees or its designee) who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the appropriate named fiduciary (the Board of Trustees or its designee) will:
  - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

1. Under this Plan's 2-level appeal process, the Plan routes the first level of review to the Appropriate Claims Administrator who will make the first level determination on the post-service appeal no later than 30 calendar days from receipt of the appeal.
   - There is **no extension permitted** in the first or second level of the appeal review process.
   - You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.
   - If still dissatisfied with the initial appeal level determination you will have 180 calendar days under this Plan from receipt of the first level review determination to request a second level appeal review by writing to the YABC Board of Trustees whose contact information is listed on the Quick Reference Chart in this document.
   - The YABC Board of Trustees then will make a second level determination no later than 30 calendar days from receipt of the second level appeal.
2. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person other than the person that originally denied the claim and who is not subordinate to the person who originally denied the claim.
3. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit, the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
4. You will receive a notice of the appeal determination. If that determination is adverse, it will include at each level of the appeal review, the following:
   - information that is sufficient to identify the claim involved (e.g., date of service, health care provider, claim amount if applicable);
   - the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level of appeal or external review;
   - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - an explanation of the Plan's 2nd level appeal and the external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;

- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
- the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."
- disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.

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- TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-602-231-8896 or 1-866-365-9198.
- CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-602-231-8896 or 1-866-365-9198.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-602-231-8896 or 1-866-365-9198.

5. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished **within 30 days** of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

6. This concludes the post-service appeal process under this Plan.

HOW TO FILE AN URGENT CARE CLAIM FOR BENEFITS UNDER THIS PLAN

If your claim involves urgent care (as defined earlier in this chapter and as determined by your attending Health Care Professional), you may file the claim or the Plan will honor a Health Care Professional as your authorized representative in accordance with the Plan's urgent care claims procedures described below.

1. Urgent care claims (as defined previously in this chapter) may be requested by you orally or by writing to the Appropriate Claims Administrator whose contact information is listed on the Quick Reference Chart in this document.

2. In the case of an urgent care claim, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), the Health Care Professional will be considered by this Plan to be the authorized representative bypassing the need for completion of the Plan's written authorized representative form.

3. The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

   Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

   If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

4. You will be notified of the Plan's benefit determination as soon as possible but **no later than 72 hours** after receipt of an urgent care claim by the Appropriate Claims Administrator. You will be notified if you fail to follow the urgent care claim procedures or fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan.

5. **If you fail to provide sufficient information to decide an urgent care claim**, you will be notified as soon as possible, but no later than 24 hours after receipt of the urgent care claim by the Appropriate Claims Administrator, of the specific information necessary to complete the urgent care claim and you will be allowed not less than 48 hours to provide the information. You will then be notified of the Plan's benefit determination on the urgent care claim as soon as possible but no later than 48 hours after the earlier of the receipt of the needed information **or** the end of the period of time allowed to you in which to provide the information.

6. **If the urgent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.

7. **If the urgent care claim is denied** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice provided no later than 3 calendar days after the oral notice. The notice of initial urgent care claim denial will:
   - identify the claim involved (e.g., date of service, health care provider, claim amount if applicable);
   - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
   - give the specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;
   - contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - provide an explanation of the Plan's internal appeal procedure and external review process along with time limits and information regarding how to initiate an appeal, including a description of the expedited appeal review process and external review process for urgent care claims;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request, and
   - disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes;

8. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.
   - SPANISH (Español): Para obtener asistencia en Español, llame al 1-602-231-8896 or 1-866-365-9198.
   - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-602-231-8896 or 1-866-365-9198.
   - CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-602-231-8896 or 1-866-365-9198.
   - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-602-231-8896 or 1-866-365-9198.

9. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished **within 30 days** of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

10. **If you disagree with a denial of an urgent care claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF AN URGENT CARE CLAIM

1. You may request an appeal review of an urgent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator, whose contact information is listed on the Quick Reference Chart in this document.

2. You will be provided with:
   - upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   - automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
   - Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
   - If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.
   - a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan (the Board of Trustees or its designee) who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
   - in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Plan will:
     - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
     - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.
3. The Plan will make a determination on the appeal (without the opportunity for an extension) as soon as possible but no later than 72 hours after receipt of the appeal.
4. The notice of appeal review of an urgent care claim will be provided orally with written confirmation (or electronic, as appropriate). You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - information that is sufficient to identify the claim involved (e.g., date of service, health care provider, claim amount if applicable);
   - a statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level appeal or external review;
   - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - an explanation of the Plan's 2nd level appeal and the external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;

- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
- the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."
- disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-602-231-8896 or 1-866-365-9198.
- TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-602-231-8896 or 1-866-365-9198.
- CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-602-231-8896 or 1-866-365-9198.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-602-231-8896 or 1-866-365-9198.

5. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished **within 30 days** of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

6. This concludes the urgent care claim appeal process under this Plan.

HOW TO FILE A CONCURRENT CLAIM FOR BENEFITS UNDER THIS PLAN

If your claim involves concurrent care (as that term is defined earlier in this chapter), you may file the claim by writing (orally for an expedited review) to the Appropriate Claims Administrator whose contact information is listed on the Quick Reference Chart in this document.

1. If a decision is made to reduce or terminate an approved course of treatment, you will be provided notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

2. The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

   Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

   If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

3. Concurrent claims that are an urgent care claim will be processed according to the initial review and appeals procedures and timeframes noted under the Urgent care claim section of this chapter.

4. Concurrent claims that are not an urgent care claim will be processed according to the initial review and appeals procedures and timeframes applicable to the claims as noted under the Pre-service or Post-service claim sections of this chapter.

5. **If the concurrent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.

6. **If the concurrent care claim is denied,** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice. The notice of initial concurrent denial will:
   - identify the claim involved (e.g., date of service, health care provider, claim amount if applicable);
   - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
   - give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;
   - contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - provide an explanation of the Plan's internal appeal procedure and external review processes along with time limits and information regarding how to initiate an appeal;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.
   - disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-602-231-8896 or 1-866-365-9198.
- TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-602-231-8896 or 1-866-365-9198.
- CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-602-231-8896 or 1-866-365-9198.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-602-231-8896 or 1-866-365-9198.

7. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished **within 30 days** of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

8. **If you disagree with a denial of a concurrent claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A CONCURRENT CARE CLAIM

1. You may request an appeal review of a concurrent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator, whose contact information is listed on the Quick Reference Chart in this document.

2. You will be provided with:
   - upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   - automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided

as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan (the Board of Trustees or its designee) who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the appropriate named fiduciary (the Board of Trustees or its designee) will:
  - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

3. A determination will be made on the appeal (without the opportunity for extension) as soon as possible before the benefit is reduced or treatment is terminated.

4. The notice of appeal review for the concurrent claim may be provided orally (for urgent care claims), with written (or electronic, as appropriate) notice. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - information sufficient to identify the claim involved (e.g., date of service, health care provider, claim amount if applicable);
   - the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for a 2nd level appeal or external review;
   - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - an explanation of the Plan's 2nd level appeal and the external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-602-231-8896 or 1-866-365-9198.
- TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-602-231-8896 or 1-866-365-9198.
- CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-602-231-8896 or 1-866-365-9198.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-602-231-8896 or 1-866-365-9198.

5. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished **within 30 days** of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.
6. This concludes the concurrent claim appeal process under this Plan.

HOW TO FILE A PRE-SERVICE CLAIM FOR BENEFITS UNDER THIS PLAN

1. A claim for pre-service (as defined in this chapter) must be made by a claimant or the claimant's authorized representative (as described in this chapter) in accordance with this Plan's claims procedures outlined in this chapter.
2. A pre-service claim (claim which requires precertification) must be submitted (orally or in writing) in a timely fashion (as discussed in the Utilization Management chapter of this document and the Drug row of the Schedule of Medical Benefits) to the Appropriate Claims Administrator (as defined in this chapter).
3. The pre-service claim will be reviewed no later than 15 calendar days from the date the pre-service claim is received by the Appropriate Claims Administrator. If you do not follow the pre-service claim filing process, you will be notified as soon as possible or within 5 calendar days from your request.
4. The 15 calendar day review period may be extended one time for up to 15 additional calendar days if it is determined that an extension is necessary due to matters beyond the control of the Appropriate Claims Administrator, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 15-day period by using a written Notice of Extension.
5. If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.
6. The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.
7. In either case noted above, you will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
8. A claim determination will be made no later than 15 calendar days from the earlier of the date the additional information is received or the date displayed in the Notice of Extension on which a decision will be made if no additional information is received.
9. The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
   Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
   If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.
10. **If the pre-service claim is approved** you will be notified orally and in writing (or electronic, as applicable).
11. **If the pre-service claim is denied in whole or in part**, a notice of this initial denial will be provided to you orally and in writing (or electronic, as applicable). This notice of initial denial will:
    - identify the claim involved (e.g., date of service, health care provider, claim amount if applicable);
    - state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;

- give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
- reference the specific Plan provision(s) on which the determination is based;
- contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
- provide an explanation of the Plan's internal appeal procedure and external review processes along with time limits and information regarding how to initiate an appeal;
- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request; and
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.
- disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-602-231-8896 or 1-866-365-9198.
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- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-602-231-8896 or 1-866-365-9198.

12. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished **within 30 days** of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

13. **If you disagree with a denial of a pre-service claim,** you or your authorized representative may ask for a pre-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A PRE-SERVICE CLAIM

This Plan maintains a 2-level appeals process. Appeals must be submitted in writing to the Appropriate Claims Administrator for the first level of appeal review and to the YABC Board of Trustees in care of the Plan Administrator for the second level appeal review, both of whom have their contact information listed on the Quick Reference Chart in this document. You will be provided with:

- upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

  Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit

Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan (the Board of Trustees or its designee) who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the appropriate named fiduciary (the Board of Trustees or its designee) will:
  - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

1. Under this Plan's 2-level appeal process, the Plan routes the first level of review to the Appropriate Claim Administrator who will make the first level determination on the pre-service appeal no later than 15 calendar days from receipt of the appeal.
2. There is **no extension permitted** to the Plan in the first or second level of the appeal review process. You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.
3. If still dissatisfied with the initial appeal level determination you will have 180 calendar days under this Plan from receipt of the first level review determination to request a second level appeal review by writing to the YABC Board of Trustees in care of the Plan Administrator whose contact information is listed on the Quick Reference Chart in this document.
4. A second level determination will be made no later than 15 calendar days from receipt of the second level appeal.
5. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.
6. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
7. You will receive a notice of the appeal determination. If that determination is adverse, it will include, at each level of the appeal review, the following:
   - information sufficient to identify the claim involved (e.g., date of service, health care provider, claim amount if applicable);
   - the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
   - the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
   - an explanation of the Plan's 2nd level appeal and the external review process, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;

- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
- the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."
- disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.

- SPANISH (Español): Para obtener asistencia en Español, llame al 1-602-231-8896 or 1-866-365-9198.
- TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-602-231-8896 or 1-866-365-9198.
- CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-602-231-8896 or 1-866-365-9198.
- NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-602-231-8896 or 1-866-365-9198.

8. Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished **within 30 days** of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.
9. This concludes the pre-service appeal process under this Plan.

OUTLINE OF THE TIMEFRAMES FOR THE CLAIM FILING AND CLAIM APPEAL PROCESS

Overview of Claims and Appeals Timeframes				
	Urgent	**Concurrent**	**Pre-service**	**Post-service**
Plan must make **Initial Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days	30 days
Extension permitted during initial benefit determination?	No[1]	No	15 days	15 days
Appeal Review must be submitted to the Plan within:	180 days	180 days	180 days	180 days
Plan must make **Appeal Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days for each level	30 days for each level
Second Appeal Review must be submitted to the Plan within:	NA	NA	180 days of receipt of the first level appeal determination	180 days of receipt of the first level appeal determination
Extension permitted during appeal review?	No	No	No	No

[1]: no formal extension for urgent care claims but regulation does allow that if a claimant files insufficient information the claimant will be allowed up to 48 hours to provide the information.

EXTERNAL REVIEW OF CLAIMS

This External Review process is intended to comply with the Affordable Care Act (ACA) external review requirements as set forth in Interim Final Regulations implementing the ACA and in Technical Release 2010-01. For purposes of this section, references to "you" or "your" include you, your covered dependent(s), and you and your covered dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s).

You may seek further external review, by an Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim is denied and it fits within the following parameters:

- The denial involves medical judgment, including but not limited to, those based on the Plan's requirements for

medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, an adverse determination related to coverage of routine costs in a clinical trial, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and/or

- The denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time.
- The denial involves a claim subject to the protections of the No Surprises Act (an Out-of-Network Emergency Facility, certain services of an Out-of-Network Provider at an In-Network Facility, or an Out-of-Network Air Ambulance Service).

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan or if the claim is for dental plan or vision plan services. There is no cost to you to request an external review. The Plan assumes responsibility for fees associated with External Review outlined in this document. The Plan requires its contracted IROs to maintain written records for at least three years.

Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on appeal. The Plan assumes responsibility for fees associated with External Reviews outlined in this document.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

EXTERNAL REVIEW OF STANDARD (NON-URGENT) CLAIMS:

Your request for external review of a standard (not urgent) claim must be made, in writing, **within four (4) months of the date that you receive notice** of an Initial Claim Benefit Determination or adverse Appeal Claim Benefit Determination. For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

Because the Plan's internal review and appeals process, generally, must be exhausted before external review is available, in the normal course, external review of standard claims will only be available for Appeal Claim Benefit Determinations.

An external review request on a standard claim should be made to the following applicable **Plan designee**:

- The Medical Plan Claims Administrator, with respect to a denied claim not involving retail or mail order prescription drug expenses or behavioral health expenses;
- The Prescription Drug Program provider, with respect to a denied claim involving retail or mail order prescription drug expenses;
- The Utilization Management Program provider, with respect to a denied Pre-service or concurrent review determination not involving prescription drug expenses or behavioral health expenses;

Contact information for the Medical Plan Claims Administrator, the Prescription Drug Program provider, and the Utilization Management Program is in the Quick Reference Chart in the front of this document.

A. **Preliminary Review of Standard Claims**.

1. Within five (5) business days of the Plan's or appropriate Plan designee's receipt of your request for an external review of a standard claim, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether:
   (a) You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
   (b) The Adverse Determination satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan or to a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation of coverage;
   (c) You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and

(d) You have provided all of the information and forms required to process an external review.

2. Within one (1) business day of completing its preliminary review, the Plan or appropriate Plan designee will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

   (a) If your request is complete and eligible for external review; or

   (b) If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

   (c) If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request and allow you to perfect (complete) the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

B. **Review of Standard Claims by an Independent Review Organization (IRO)**.

1. If the request is complete and eligible for an external review, the Plan or appropriate Plan designee will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

   (a) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days).

   (b) Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

   (c) If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. **Reconsideration** by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

   (d) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

   In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

   (e) The assigned IRO will provide written notice of its final external review decision to you and the Plan or appropriate Plan designee **within 45 days** after the IRO receives the request for the external review.

      1) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

      2) If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim.

(f) The assigned IRO's decision notice will contain:

1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);
2) The date that the IRO received the request to conduct the external review and the date of the IRO decision;
3) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;
4) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
5) A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);
6) A statement that judicial review may be available to you; and
7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

EXTERNAL REVIEW OF EXPEDITED URGENT CARE CLAIMS:

A. You may request an expedited external review if:

a) you receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

b) you receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Your request for an expedited external review of a non-standard claim should be made to the following applicable **Plan designee**:

- The Utilization Management Program provider, with respect to a denied Urgent, Pre-service or Concurrent review determination not involving retail or mail order prescription drug expenses or behavioral health expenses;
- The Prescription Drug Program provider, with respect to a denied claim involving retail or mail order prescription drug expenses;

Contact information for the Utilization Management Program provider, and the Prescription Drug Program provider, is identified in the Quick Reference Chart in the front of this document.

B. **Preliminary Review for an Expedited Claim**.

Immediately upon receipt of the request for expedited external review, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The Plan or appropriate Plan designee will immediately notify you (e.g., telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

C. **Review of Expedited Claim by an Independent Review Organization (IRO)**.

Following the preliminary review that a request is eligible for expedited external review, the Plan or appropriate Plan designee will assign an IRO (following the process described under Standard Review above). The Plan or appropriate Plan designee will expeditiously (e.g., meaning via telephone, fax, courier, overnight

delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of their final expedited external review decision, in accordance with the requirements, set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than **seventy-two (72) hours** after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

(a) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

(b) If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim.

OVERVIEW OF THE TIMEFRAMES DURING THE FEDERAL EXTERNAL REVIEW PROCESS:

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
Claimant requests an external review (*generally after internal claim appeals procedures have been exhausted*)	Within 4 months after receipt of an Adverse Claim Benefit Determination (benefits denial notice)	After receipt of an Adverse Claim Benefit Determination (benefits denial notice)
Plan or appropriate Plan designee performs preliminary review	Within 5 business days following the Plan's or appropriate Plan designee's receipt of an external review request	Immediately
Plan's or appropriate Plan designee's notice to claimant regarding the results of the preliminary review	Within 1 business day after Plan's or appropriate Plan designee's completion of the preliminary review	Immediately
When appropriate, claimant's timeframe for perfecting an incomplete external review request	Remainder of the 4-month filing period or if later, 48 hours following receipt of the notice that the external review is incomplete	Expeditiously
Plan or appropriate Plan designee assigns case to IRO	**In a timely manner**	**Expeditiously**
Notice by IRO to claimant that case has been accepted for review along with the timeframe for submission of any additional information	In a timely manner	Expeditiously
Time period for the Plan or appropriate Plan designee to provide the IRO documents and information the Plan considered in making its benefit determination	Within 5 business days of assigning the IRO to the case	Expeditiously
Claimant's submission of additional information to the IRO	Within 10 business days following the claimant's receipt of a notice from the IRO that additional information is needed (IRO may accept information after 10 business days)	Expeditiously
IRO forwards to the Plan any additional information submitted by the claimant	Within 1 business day of the IRO's receipt of the information	Expeditiously
If (on account of the new information) the Plan reverses its denial and provides coverage, a Notice is provided to claimant and IRO	Within 1 business day of the Plan's decision	Expeditiously

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
External Review decision by IRO to claimant and Plan	Within 45 calendar days of the IRO's receipt of the request for external review	As expeditiously as the claimant's medical condition or circumstances require but in no event more than 72 hours after the IRO's receipt of the request for expedited external review. (If notice is not in writing, within 48 hours of the date of providing such non-written notice, IRO must provide written notice to claimant and Plan.)
Upon Notice from the IRO that it has reversed the Plan's adverse benefit determination	Plan must immediately provide coverage or payment for the claim	Plan must immediately provide coverage or payment for the claim

DEEMED EXHAUSTION OF THE PLAN'S INTERNAL CLAIMS AND APPEALS PROCEDURES

If the Plan fails to strictly adhere to its internal claims and appeals requirements, the Plan participant is deemed to have exhausted the Plan's internal claims and appeals process and can initiate a request for a voluntary external review (when external review is applicable) or can proceed with legal action.

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal review procedures described in this document) **for every issue deemed relevant by the claimant**, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. In addition, you are not required to exhaust external review before seeking judicial remedy. No lawsuit may be started more than three years after the end of the year in which services were provided.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. The Plan Administrator also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

ELIMINATION OF CONFLICT OF INTEREST

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

FACILITY OF PAYMENT

If the YABC Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the Health Care Professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, YABC Board of Trustees, Plan Administrator, Appropriate Claims Administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

COORDINATION OF BENEFITS (COB): DUPLICATE COVERAGE

How Duplicate Coverage Occurs

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

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

1) Another group or individual health care plan;
2) Medicare;
3) Other government program, such as Medicaid, Tricare, or a program of the U.S. Department of Veterans Affairs, or any coverage either provided by a federal, state or local government or agency, or any coverage required by federal, state or local law, including, but not limited to, any motor vehicle no-fault coverage for medical expenses or loss of earnings that is required by law;
4) Workers' compensation;
5) Coverage resulting from a judgment at law or settlement;
6) Any responsible third party, its insurer, or any other source on behalf of that party;
7) Any first party insurance (e.g., medical, personal injury, no-fault, underinsured motorist or uninsured motorist coverage);
8) Any policy from any insurance company or guarantor of a third party;
9) Any other source (e.g., crime victim restitution, medical, disability, school insurance).

The Plan's benefit coverage is excess to other responsible parties' coverage sources such as coverage from a judgment, settlement, or any responsible party.

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

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

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

When And How Coordination Of Benefits (COB) Applies

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

Which Plan Pays First: Order of Benefit Determination Rules

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

Group plans determine the sequence in which they pay benefits or which plan pays first by applying a uniform order of benefit determination rules in a specific sequence. This plan uses the order of benefit determination rules established by

the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules always pays its benefits first.**

When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first rule does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. The rules are:

Rule 1: Non-Dependent or Dependent

a. The plan that covers a person other than a dependent, for example as an employee, Retiree, member or subscriber is the primary plan that pays first; and the plan that covers the same person as a dependent is the secondary plan that pays second.

b. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

   (1) secondary to the plan covering the person as a dependent; and

   (2) primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee);

   then the order of benefits is reversed, so that the plan covering the person as a dependent pays first and the plan covering the person other than as a dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

a. The plan that covers the parent whose birthday falls earlier in the calendar year pays first and the plan that covers the parent whose birthday falls later in the calendar year pays second, if:

   (1) the parents are married;

   (2) the parents are not separated (whether or not they ever have been married); or

   (3) a court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child.

b. If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first and the plan that has covered the other parent for the shorter period of time pays second.

c. The word "birthday" refers to the month and day in a calendar year not the year in which the person was born.

d. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current Spouse does, the plan of the Spouse of the parent with financial responsibility pays first. However, this provision does **not** apply during any plan year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

   If the specific terms of a court decree state that both parents are responsible for the Dependent Child's health care expenses or health care coverage, a plan that covers a parent whose birthdate falls earlier in the calendar year pays first and the plan that covers the parent whose birthdate falls later in the calendar year pays second.

e. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their Spouses (if any) is:

   (1) The plan of the custodial parent pays first;

   (2) The plan of the Spouse of the custodial parent pays second; and

   (3) The plan of the non-custodial parent pays third; and

   (4) The plan of the Spouse of the non-custodial parent pays last.

f. For a Dependent Child who has coverage under either or both parents' plans and also has his/her own coverage as a dependent under a Spouse's plan, the order of benefits shall be determined, as described in Rule 5 (the longer/shorter length of coverage) and if the length of coverage is the same, then the birthday rule (Rule 2) applies between the Dependent Child's parents coverage and the dependent's spouse's coverage. For example, if a married Dependent Child on this Plan is also covered as a dependent on the group plan of their spouse, this Plan looks to Rule 5 first and if the two plans have the same length of coverage, then the Plan looks to whose birthday is earlier in the year: the employee-parent covering the dependent or the employee-spouse covering the Dependent Child.

Rule 3: Active/Laid-Off or Retired Employee

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

Rule 4: Continuation Coverage

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

Rule 5: Longer/Shorter Length of Coverage

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

Rule 6: When No Rule Determines the Primary Plan

If none of the previous rules determines which plan pays first, each plan will pay an equal share of the expenses incurred by the covered individual.

HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY

When this plan pays second, it will pay the same benefits that it would have paid had it paid first, **less** whatever payments were actually made by the plan (or plans) that paid first. In no case will this Plan pay more in benefits for each claim as it is submitted than it would have paid had it been the Plan that paid first. This has the effect of maintaining this Plan's Deductibles, coinsurance and exclusions. As a result, when this Plan pays second, you may not receive the equivalent of 100% of the total cost of the covered health care services.

1. "Allowable expense" means a health care service or expense, including Deductibles, coinsurance or copayments, which is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

   a. The difference between the cost of a semi-private room in a hospital or specialized health care facility and a private room, unless the patient's stay in a private hospital room is Medically Necessary.

   b. If the coordinating plans determine benefits on the basis of the Allowed Amount, any amount in excess of the highest Allowed Amount is not an allowable expense.

   c. If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

d. If one coordinating plan determines benefits on the basis of the Allowed Amount and the other coordinating plan provides benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the allowable expense for all plans.

e. When benefits are reduced by a primary plan because a covered person did not comply with the primary plan's provisions, such as the provisions related to UM in this plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this plan when it pays second.

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

ADMINISTRATION OF COB

1. To administer COB, the plan reserves the right to:
   a. exchange information with other plans involved in paying claims;
   b. require that you or your health care provider furnish any necessary information;
   c. reimburse any plan that made payments this plan should have made; or
   d. recover any overpayment from your hospital, physician, dentist, other health care provider, other insurance company, you or your dependent.
2. If this plan should have paid benefits that were paid by any other plan, this plan may pay the party that made the other payments in the amount this plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this plan, and this plan will be fully discharged from any liability it may have to the extent of such payment.
3. To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the medical and dental expenses that were incurred. However, any person who claims benefits under this plan must give it all the information the plan needs to apply COB.
4. If this plan is secondary, this plan will pay secondary medical benefits only when the coordinating primary plan pays medical benefits, and it will pay secondary dental benefits only when the primary plan pays dental benefits. This plan will not pay secondary medical benefits when the coordinating primary plan pays dental benefits, nor will this plan pay secondary dental benefits when the coordinating primary plan pays medical benefits.
5. If this plan is secondary, and if the coordinating primary plan provides benefits in the form of services, this plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan.
6. If this plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained Out-of-Network, benefits for services covered by this plan will be payable by this plan only to the extent they would have been payable if this plan were the primary plan.
7. If this plan is secondary; if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this plan; and if this plan advances an amount equal to the benefits it would have paid had it been the primary plan, this plan will be subrogated to all rights the plan participant may have against the other plan, and the plan participant will execute any documents required or requested by this plan to pursue any claims against the other plan for reimbursement of the amount advanced by this plan.

MEDICARE AND OTHER GOVERNMENT PROGRAMS

Entitlement to Medicare

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

Medicare Beneficiary May Retain or Cancel Coverage Under This Plan

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

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

Coverage Under Medicare and This Plan When You Are Totally Disabled

If you become totally disabled and entitled to Medicare because of your disability, you will no longer be considered to remain actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this plan pays second. Generally, if an eligible dependent under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, this Plan pays first for that dependent and Medicare pays second. This Medicare secondary payer rule applies to employers with 100 or more employees.

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

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

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

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

Summary Chart on COB with Medicare

If you are covered by Medicare and also have other group health plan coverage, the coordination of benefits (COB) rules are set by the Centers for Medicare & Medicaid Services (CMS). These COB rules are outlined below:

Summary of the Coordination of Benefits between Medicare and the Group Health Plan			
If you:	**Situation**	**Pays First**	**Pays Second**
Are covered by both Medicare and Medicaid	Entitled to Medicare and Medicaid	Medicare	Medicaid, but only after other coverage such as a group health plan has paid
Are age 65 and older and covered by a group health plan because you are working or are covered by a group health plan of a working Spouse of any age	The employer has less than 20 employees	Medicare	Group health plan
	The employer has 20 or more employees	Group health plan	Medicare
Have an employer group health plan after you retire and are age 65 or older	Entitled to Medicare	Medicare	Group health plan (*e.g.,* a retiree plan coverage)
Are disabled and covered by a large group health plan from your work or from a family member who is working	The employer has less than 100 employees	Medicare	Group health plan
	You are entitled to Medicare or the Employer has 100 or more employees	Group health plan	Medicare
Have End-Stage Renal Disease (ESRD is permanent kidney failure requiring dialysis or a kidney transplant) and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group health plan	Medicare
	After 30 months of eligibility or entitlement to Medicare	Medicare	Group health plan
Are covered under worker's compensation because of a job-related injury or illness	Entitled to Medicare	Workers' compensation for worker's compensation-related claims	Usually does not apply however Medicare may make a conditional payment.
Have black lung disease and are covered under the Federal Black Lung Benefits Program	Entitled to Medicare and the Federal Black Lung Benefits Program	Federal Black Lung Benefits Program for black lung-related claims	Medicare
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or Liability insurance, for the accident-related claims	Medicare
Are a veteran and have Veterans' benefits	Entitled to Medicare and Veterans' benefits	Medicare pays for Medicare-covered services. Veterans' Affairs pays for VA-authorized services. Generally, Medicare and VA cannot pay for the same service.	Usually does not apply

Summary of the Coordination of Benefits between Medicare and the Group Health Plan			
If you:	**Situation**	**Pays First**	**Pays Second**
Are covered under TRICARE	Entitled to Medicare and TRICARE	Medicare pays for Medicare-covered services. TRICARE pays for services from a military hospital or any other federal provider.	TRICARE may pay second
Are age 65 or over OR, are disabled and covered by both Medicare and COBRA	Entitled to Medicare	Medicare	COBRA
Have End-Stage Renal Disease (ESRD) and COBRA	First 30 months of eligibility or entitlement to Medicare	COBRA	Medicare
	After 30 months	Medicare	COBRA
See also : http://www.medicare.gov/Publications/Pubs/pdf/02179.pdf or 1-800-Medicare for more information			

HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY TO MEDICARE

When The Plan Participant Is Covered By This Plan And Also By Medicare Parts A and B: This Plan pays the same benefits provided for active employees less the amounts paid by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the Allowed Amount of the Health Care Provider.

When The Plan Participant Is Covered By This Plan And Also By A Medicare Advantage (Formerly Called Medicare + Choice Or Part C) Without Prescription Drug Benefits:

1. This Plan provides benefits that supplement the benefits you receive from Medicare Part A and B coverage. If a plan participant is covered by this Plan and also by a Medicare Advantage program and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services In-Network when the Medicare Advantage program requires it, this plan will reimburse all applicable copayments and will pay the same benefits provided for active employees less any amounts paid by the Medicare Advantage program.
2. **However, if the plan participant doesn't comply with the rules of the Medicare Advantage program, including without limitation, approved referral, preauthorization, or case management requirements, this plan will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the plan participant receives.**

When The Plan Participant Is Eligible For But Not Covered By Medicare:

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

When The Plan Participant Is Covered By This Plan And Also Enters Into A Medicare Private Contract:

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

When Covered by this Plan and the Individual also has signed an Advance Beneficiary Notice (ABN): Under the law a health care provider who believes that Medicare may not pay for a particular proposed service is to issue an Advance Beneficiary Notice (ABN) to a Medicare beneficiary (meaning an individual who is determined by the Social Security Administration to be eligible for and has actually enrolled in Medicare benefits). If the Plan receives a claim coded to explain that the Medicare beneficiary has signed an ABN, **this Plan will NOT pay any benefits** for any health care services and/or supplies the Medicare beneficiary receives pursuant to the ABN if Medicare will not pay such expenses.

When Covered By This Plan And Also By A Medicare Part D Plan Such As A Prescription Drug Plan:

If you have dual coverage under both this Plan and Medicare Part D, the following explains how this Plan and Medicare will coordinate that dual coverage:

a. For Medicare-eligible Active Employees and non-Medicare eligible Retirees (early Retirees) and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage is secondary.

b. For Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage is primary and this group health plan pays secondary. Note that dual coverage may affect your Out-of-Pocket Limit under your Medicare prescription drug plan.

For more information on Medicare Part D refer to www.medicare.gov or contact your Human Resource/Payroll department.

MEDICAID

If an individual is covered by both this Plan and Medicaid or a State Children's Health Insurance Program (CHIP), this Plan pays first and Medicaid or the State Children's Health Insurance Program (CHIP) pays second.

TRICARE

If a Dependent is covered by both this plan and Tricare, this plan pays first and Tricare pays second. For an employee called to active duty for more than 30 days, Tricare is primary and this plan is secondary for active members of the armed services only. If an eligible individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, benefits are not payable by the Plan.

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

If you receive services in a U.S. Department of Veterans Affairs hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If you receive services in a U.S. Department of Veterans Affairs hospital or other military medical facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are not in excess of the Allowed Amount.

Motor Vehicle No-Fault Coverage Required By Law

If an eligible individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second. The Plan's benefit coverage is excess to any vehicle insurance (including medical payments coverage/MPC, personal injury protection/PIP, and/or no-fault).

Other Coverage Provided By State Or Federal Law

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

Indian Health Services (IHS)

If an individual is covered by both this Plan and Indian Health Services, this Plan pays first and Indian Health Services pays second.

WORKERS' COMPENSATION

This plan does **not** provide benefits if the medical or dental expenses are covered by workers' compensation or occupational disease law. If the organization contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law.

However, before such payment will be made, you and/or your covered dependent must execute a subrogation and reimbursement agreement acceptable to the Plan Administrator or its designee. However, the failure of the individual to sign such an agreement will not constitute a waiver by the Plan, the Board of Trustees or the Claims Administrator of their rights to recover any payments that the Plan has advanced.

SUBROGATION, REIMBURSEMENT, AND THIRD-PARTY RECOVERY PROVISION

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").
2. Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.
3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.
4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.
2. If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.
3. The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. If the Plan Participant(s) fails to file a claim or pursue damages against:
   a) the responsible party, its insurer, or any other source on behalf of that party;
   b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   c) any policy of insurance from any insurance company or guarantor of a third party;

d) worker's compensation or other liability insurance company; or,

e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance

1. If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:
   a) the responsible party, its insurer, or any other source on behalf of that party;
   b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   c) any policy of insurance from any insurance company or guarantor of a third party;
   d) worker's compensation or other liability insurance company or
   e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

Separation of Funds

1. Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

1. In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
   a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
   b) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
   c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
   d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
   e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
   f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.
2. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).
3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

Offset

1. Failure by the Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

Minor Status

1. In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

1. The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

1. In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

COBRA CONTINUATION OF COVERAGE
WHEN YOUR MEDICAL AND DENTAL COVERAGE ENDS

Extension And Continuation Of Coverage In General

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

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

Extension Of Dental Coverage

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

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

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

CONTINUATION OF COVERAGE (COBRA)

Entitlement to COBRA Continuation Coverage

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

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

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov.

Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

IMPORTANT:

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

COBRA Administrator

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

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

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. A Qualified Beneficiary may elect COBRA even if that person is already enrolled in Medicare. A parent or legal guardian may elect COBRA for a minor child.

A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other Covered Individuals including Special Enrollment.

1. "**Qualified Beneficiary:**" Under the law, a Qualified Beneficiary is any Employee or Retiree or the Spouse or Dependent Child of an employee or Retiree who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption, or placement for adoption with the covered employee or Retiree during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

   A child of the covered employee or Retiree who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee's or Retiree's period of employment, is entitled the same rights under COBRA as an eligible Dependent Child.

   A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is **not** a Qualified Beneficiary. This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

2. **"Qualifying Event:"** Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the Covered Individual LOSES health care coverage under this Plan**. If a Covered Individual has a qualifying event but does not lose their health care coverage under this Plan, (*e.g.,* employee continues working even though entitled to Medicare) then COBRA is not available.

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

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries[1]		
	Employee	Spouse	Dependent Child(ren)
Employee terminated (for other than gross misconduct), including retirement.	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for health care coverage or eligible but not at the same required premiums).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months

1: When a covered employee's Qualifying Event (e.g. termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the employee's covered Spouse and Dependent Children who are Qualified Beneficiaries (but not the employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date of the loss of Plan coverage. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months (making a total of 29 months) under certain circumstances (described in another section of this chapter on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this chapter.

Medicare Entitlement

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

Can I enroll in Medicare instead of COBRA Continuation Coverage after my Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

The month after your employment ends; or
The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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

In order to have the chance to elect COBRA Continuation Coverage after loss of coverage due to a divorce, legal separation, or a child ceasing to be a "Dependent Child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that Qualifying Event occurs.**

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

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

Officials of the employee's own employer should notify the COBRA Administrator within 30 days of these events: an employee's death, termination of employment (including retirement), reduction in hours making the employee ineligible for coverage, or entitlement to Medicare (if entitlement causes the employee to be ineligible for coverage). However, **you or your family should also promptly notify the COBRA Administrator in writing** if any such event

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Notices Related to COBRA Continuation Coverage

When:

a. **your employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to health care coverage under the Plan, you died, have become entitled to Medicare, or

b. **you notify the COBRA Administrator** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

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

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

COBRA in Anticipation of a Divorce

If an employee eliminates coverage for his/her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a qualifying event even though the ex-spouse is not covered under the Plan on the date of the divorce. The COBRA regulations provide that if a covered employee eliminates or reduces a spouse's coverage **in anticipation of their divorce** or legal separation, then upon the Plan receiving a notice of the official divorce or legal separation, the Plan will offer COBRA to the ex-spouse as of the date of divorce or legal separation (even though the ex-spouse is not covered under the Plan at the time the divorce or legal separation is finalized).

The **ex-spouse must notify the Plan Administrator within 60 days from the date the divorce** or legal separation is final to trigger this Plan to take action on this situation (even if the divorce or legal separation decree or other court order requires the employee pay for the ex-spouse's health coverage). In accordance with approval by the Plan Administrator, the duration of COBRA is for a 36-month period measured from the date the divorce or legal separation is finalized.

The COBRA Continuation Coverage That Will Be Provided

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

When COBRA Continuation Coverage of your participation in the **health care flexible spending account (Health FSA)** is available, it will be on the same terms outlined above for group health coverage, but since the person who elects COBRA will no longer be employed by their employer, it will not be possible to make contributions to the health care flexible spending account on a before-tax basis.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

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

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

NOTE: You may not receive an invoice (bill) for the initial COBRA premium payment or for the monthly COBRA premium payments. You are responsible for making timely payments for COBRA continuation coverage to the COBRA Administrator listed on the Quick Reference Chart.

IMPORTANT

There may not be invoices or payment reminders provided to you for COBRA premium payments. You are responsible for making sure that timely COBRA premium payments are made to the COBRA Administrator.

Grace Periods

Initial COBRA Payment: The initial payment for the COBRA Continuation Coverage is due to the COBRA Administrator **45 days** after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect.

Subsequent COBRA Payments: After the initial COBRA payment, **subsequent payments are due** on the first day of each month, but there will be a **30-day grace period** to make those payments. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

For Monthly Payments, What If The Full COBRA Premium Payment Is Not Made When Due?

If the COBRA Administrator receives a COBRA premium payment that is not for the full amount due, the COBRA Administrator will determine if the COBRA premium payment is short by an amount that is significant or not. A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall exceeds the lesser of $50 or 10% of the required COBRA premium payment.

If there is a significant shortfall then COBRA continuation coverage will end.

If there is not a significant shortfall, the COBRA Administrator will notify the Qualified Beneficiary of the deficiency amount and allow a reasonable period of 30 days to pay the shortfall. If the shortfall is paid in the 30-day time period then COBRA continuation coverage will continue for the month in which the shortfall occurred.

If the shortfall is not paid in the 30-day time period then, under this Plan, COBRA continuation coverage will end on the last date for which full COBRA premiums have been received (which may result in a mid-month termination of COBRA coverage).

IMPORTANT REMINDERS

- ✓ **You are responsible for making sure that timely COBRA premium payments are made to the COBRA Administrator in full and on time.**
- ✓ **If you fail to make a periodic COBRA premium payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.**

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

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

HIPAA Special Enrollment and COBRA

- **Addition of Newly Acquired Dependents**

  If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage, you have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that child for COBRA Continuation Coverage if you do so within 31 days after the birth, adoption, or placement for adoption. The newborn/adopted child will be entitled to the full duration of COBRA.

  If you marry while you are enrolled for COBRA, your spouse is not a Qualified Beneficiary, but the spouse can be added for the remainder of the duration of your existing COBRA coverage.

Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the COBRA Administrator to add a dependent.

- **Loss of Other Group Health Plan Coverage**

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

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

  Loss of coverage also includes a Dependent who loses coverage through Medicaid or a State Children's Health Insurance Program (CHIP). Enrollment in COBRA must be requested within 60 days after the Medicaid or CHIP coverage ends.

To request enrollment in COBRA for an eligible Dependent under Special Enrollment, the Qualified Beneficiary must, request enrollment within 31 days (60 days for CHIP) after the date on which the Dependent first becomes eligible for Special Enrollment, by contacting the COBRA Administrator and completing and submitting an enrollment form.

Adding a Dependent may cause an increase in the amount you pay for COBRA Continuation Coverage.

Notice of Unavailability of COBRA Coverage

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

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

A Spouse and Dependent Child who already have COBRA coverage, and then experience a second qualifying event, may be entitled to extend their COBRA from 18 or 29 months, to a total of 36 months, of COBRA coverage. Second qualifying events may include the death of the covered employee, divorce, or legal separation from the covered employee, the covered employee becoming entitled* to Medicare benefits (under Part A, Part B or both), or a Dependent Child ceasing to be eligible for coverage as a dependent under the group health plan.

*NOTE: Entitlement means the individual is eligible for and enrolled in Medicare. **Medicare entitlement is not a Qualifying Event under this Plan** and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for Spouses and Dependent Children who are Qualified Beneficiaries. Legal separation is not a Qualifying Event under this Plan and as a result, legal separation following a termination of coverage or reduction in hours will not extend COBRA to 36 months for a Spouse and Dependent Child who are Qualified Beneficiaries.

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

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

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up

to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

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

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

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

1. This extension is available only if:

   - the Social Security Administration determines that the individual's disability began no later than 60 days after the termination of employment or reduction in hours; and

     the disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.

   Notifying the Plan: you or another family member need to follow this procedure (to notify the Plan) by sending a written notification to the COBRA Administrator of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage.

   - The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the COBRA Administrator before the end of the 18-month COBRA Continuation period.

2. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage will be 50% higher than the cost for that coverage during the 18-month period.

3. The COBRA Administrator must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

REMINDER: You must notify the Plan within 60 days after receiving a disability determination letter from the Social Security Administration. Failure to notify the Plan in a timely fashion may jeopardize your rights to extended COBRA coverage.

Early Termination of COBRA Continuation Coverage

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

1. The first day of the time period for which the amount due for the COBRA Continuation Coverage is **not paid in full and on time**;
2. The date on which the employee's employer no longer provides group health coverage to any of its employees;
3. The date, after the date of the COBRA election, on which the covered person first becomes entitled to Medicare;
4. The date, after the date of the COBRA election, on which the covered person first becomes covered under another group health plan. **IMPORTANT:** The qualified beneficiary must notify this Plan as soon as possible once they become aware that they will become covered under another group health plan, by contacting the COBRA Administrator.
5. The date the Plan has determined that the covered person must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan);
6. During an extension of the maximum coverage period to 29 months due to the disability of the covered person, the disabled person is determined by the Social Security Administration to no longer be disabled.

Notice of Early Termination of COBRA Continuation Coverage

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

The notice will be provided as soon as practicable after the COBRA Administrator determines that COBRA coverage will terminate early.

Once COBRA coverage terminates early it cannot be reinstated.

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

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

COBRA Questions or To Give Notice of Changes in Your Circumstances

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

Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you must notify the COBRA Administrator as soon as possible but no later than:

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

FMLA and COBRA

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

APPEALING AN ADVERSE DETERMINATION RELATED TO COBRA

If an individual receives an adverse determination (denial) related to a request for eligibility for COBRA (such as with a Notice of Unavailability of COBRA), a request for extension of COBRA for a disability, a request for extension of COBRA for a second qualifying event, or a notice of early termination of COBRA, the individual is permitted to appeal to the Plan.

To request an appeal, follow this process:

a) Send a written request for an appeal to the COBRA Administrator within 60 days of the date you received the adverse determination letter.
b) Explain why you disagree with the adverse determination.
c) Provide any additional information you want considered during the appeal process.
d) Include the most current name and address of each individual affected by the adverse determination.
e) The COBRA Administrator will respond in writing to this appeal within 60 days of the Plan's receipt of the request for appeal. The appeal response will be sent to the address provided by the individual. This concludes the COBRA appeal process.

OTHER INFORMATION

Plan Amendments Or Termination

Yuma Area Benefit Consortium (YABC) reserves the right to amend or terminate this plan or any part of it at any time, without advance notice to participants. Amendments may be made in writing to a trustee of the Yuma Area Benefit Consortium and it will be reviewed by the trustees. If approved by the trustees, it will become effective on such date as may be specified in the document amending the plan. The plan or any coverage under it may be terminated by the trustees of the Yuma Area Benefit Consortium.

Statement Of The Consortium's Rights

The Yuma Area Benefit Consortium (YABC) makes no representation that employment with participating employers represents lifetime security or a guarantee of continued employment. Further, your eligibility or rights to benefits under this plan should not be interpreted as a guarantee of employment. An individual's employment may be terminated because of:

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

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

No Liability For Practice Of Medicine

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

Non-Assignment

Coverage and your rights under this Plan may not be assigned. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; however, a Plan Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered. A direction to pay a provider is not an assignment of any right under this Plan, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, and is not an assignment of any legal or equitable right to institute any court proceeding.

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

Effective April 14, 2003 a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like the Yuma Area Benefit Consortium (hereafter referred as the Plan) maintain the privacy of personally identifiable health information (called **Protected Health Information or PHI**).

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

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

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

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the plan sponsor for the purpose of reviewing a benefit claim or for other reasons related to the administration of the Plan.

A. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

- **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.
- **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:
    a. Determination of eligibility, coverage, cost sharing amounts (e.g., cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;
    b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing;
    c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization review, including precertification, concurrent review and/or retrospective review.
- **Health Care Operations** includes, but is not limited to:
    a. business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;
    b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions,
    c. Underwriting, (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,
    d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
    e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

B. **When an Authorization Form is Needed:** Generally the Plan will require that you sign a valid authorization form (available from a Privacy Officer shown in the Quick Reference Chart) in order for the Plan to use or disclosure your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

C. The Plan will disclose PHI to the plan sponsor only upon receipt of a certification from the plan sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the plan sponsor agrees to:

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law,
2. Ensure that any agents, including their subcontractors, to whom the plan sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.
3. Not use or disclose the information for employment-related actions and decisions,
4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices).
5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
6. Make PHI available to the individual in accordance with the access requirements of HIPAA,
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
8. Make available the information required to provide an accounting of PHI disclosures,
9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA, and
10. If feasible, return or destroy all PHI received from the Plan that the plan sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.
11. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

D. In order to ensure that adequate separation between the Plan and the plan sponsor is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

1. The Plan Administrator,
2. Benefits administration staff designated by the Plan Administrator.
3. Business Associates under contract to the Plan including but not limited to those entities listed in the Quick Reference Chart who are responsible for such items as medical and dental claims administrators, preferred provider organization networks, and COBRA administration.

E. The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions that the plan sponsor performs for the Plan. If these persons do not comply with this obligation, the plan sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officers whose addresses and phone numbers are listed on the Quick Reference Chart in the front of this document.

F. Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

G. **Hybrid Entity**: For purposes of complying with the HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions. The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the self-funded medical plan options, including retail and mail order prescription drug benefits, self-funded dental plan options, certain executive medical benefit programs, COBRA administration and Health Flexible Spending Account (FSA) administration.

Right Of Plan To Require A Physical Examination

The Plan reserves the right to have the person, who is totally disabled or who has submitted a claim for benefits and is undergoing treatment under the care of a physician, to be examined by a physician selected by the Plan Administrator or its designee at any time during the period that benefits are extended under this Plan. The cost of such an examination will be paid by the Plan.

Information You Or Your Dependents Must Furnish To The Plan (Very Important Information)

In addition to information you must furnish in support of any claim for plan benefits under this plan, you or your covered dependents must furnish, information you or they may have that may affect eligibility for coverage under the Plan.

Failure to give this Plan a timely notice (as noted below) may cause your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage, or may cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability, or may cause claims to not be able to be considered for payment until eligibility issues have been resolved, or may result in a participant's liability to the Plan if any benefits are paid to an ineligible person.

Submit such information in writing to the Plan Administrator at the address shown in the Quick Reference Chart in the front of this document. The information needed and timeframes for submitting such information are outlined below. See also the COBRA chapter for special timeframes applicable to those benefits:

Type of Information Needed	Date Information is to be Submitted to the Plan
• Change of name or address or the existence of other health care coverage for any covered person.	As soon as possible but not later than 60 days after the change or addition of other coverage.
• Marriage, divorce, legal separation, addition of a new Dependent, death of any covered person.	Within 30 days but not later than 60 days.
• Covered Dependent (Spouse or child) becomes disabled or is no longer disabled.	Within 30 days of the date the person becomes disabled or is no longer disabled.
• Covered child ceases to be a Dependent as defined by this Plan (*e.g.,* over the limiting age of the Plan, etc.)	As soon as possible but not later than 60 days after the date the child is no longer considered a Dependent.
• An individual meets the termination provisions of this Plan.	Within 30 days of the date of the termination event.
• Employee receives a determination of disability from the Social Security Administration (SSA) or is no longer disabled according to SSA. • Medicare enrollment or disenrollment.	See the COBRA chapter for timeframe.

Headings Do Not Modify Plan Provisions

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

DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the plan. See also the Claim Filing and Appeals Information chapter for definitions relevant to claim filing and appeals.

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

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

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

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

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

Affordable Care Act (ACA): a comprehensive federal health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, Health Reform, or "Obamacare"). The law has 2 parts: the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (the Reconciliation Act). The Affordable Care Act (ACA) includes requirements for coverage of certain health care services that impact medical plans.

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

Allowed Amount/Allowable Charge: For Emergency Services, non-Emergency Services provided by an Out-of-Network Provider at an In-Network facility, and Air Ambulance services, the Allowed Charge is the Recognized Amount. For all other services, this means the amount this Plan allows as payment for eligible Medically Necessary services or supplies. The allowed amount is determined by the Plan Administrator or its designee to be the **lowest** of:

1. **With respect to a network provider** (PPO or Participating network Health Care or Dental Care provider/facility), the fee set forth in the agreement between the PPO or Participating network Health Care or Dental Care Provider/facility and the PPO network or the Plan; **or**
2. **With respect to a non-network provider**, allowed amount means the following:
   a. **High-cost drugs exceeding $1,000 per dose** dispensed by a facility during an inpatient stay or by an outpatient facility during an outpatient service are payable up to 125% of the Average Wholesale Price (AWP) based on the most current edition of the Red Book (drug pricing manual) plus a dispensing fee allowance of 25%. This allowance for high-cost drugs shall also apply to drugs administered on an outpatient basis by a Physician or Health Care Practitioner, such as in an outpatient facility, clinic or office setting.
   b. **High-cost surgical implants, medical devices and prosthetics exceeding $5,000 per item** as dispensed by a facility during an inpatient stay or in an outpatient setting (including but not limited to pacemakers, hardware such as screws and rods, artificial joints and stents) are payable up to 125% of manufacturer's invoice plus an acquisition and administration allowance of up to 25%. This allowance for surgical implants, devices, and prosthetics also applies to these items dispensed on an outpatient basis by a Physician or Health Care Practitioner, such as in an outpatient facility, clinic, or office setting.
   c. **Allowable charges by a hospital facility for inpatient or outpatient services, or by a freestanding outpatient facility or clinic** are payable to a maximum of 200% of the Medicare Allowable amount.
   d. **With respect to Non-Network Emergency Room services**, the plan allowance is the **greater** of:

- the negotiated amount for in-network providers (the median amount if more than 1 amount to in-network providers), or
- 100% of the plan's usual payment (Allowed Charge) formula (reduced for cost-sharing) or
- (when such database is available), the amount that Medicare Parts A or B would pay (reduced for cost-sharing).

e. For any other billed charge not addressed in a-d above, the allowed charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by non-network providers.

The Plan's allowed charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term.

The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. If you use a non-network provider you may be balance billed by that provider, except for emergency services performed in an emergency room. These minimum payment standards for emergency services in a hospital emergency room do not apply in cases where state law prohibits a person from being required to pay balance-billed charges or where the Plan is contractually responsible for such charges. See also the definition of Balance Billing in this chapter; **or**

3. For an In-Network health care provider/facility whose network contract stipulates that they do not have to accept the network discount for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the allowed amount under this Plan is the discounted fee that would have been payable by the Plan had the claim been processed as an In-Network claim; **or**

4. The Health Care or Dental Care Provider's/facility's actual billed charge.

The Plan will not always pay benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible, Copayment and/or Coinsurance. This is because the Plan covers only the "allowed amount" for health care services or supplies.

Any amount in excess of the "allowed amount" does not count toward the Plan's annual Out-of-Pocket Limit. Participants are responsible for amounts that exceed "allowed amounts" by this Plan.

In the case where the PPO allowed amount on an eligible claim exceeds the actual billed charges, the participant will pay their coinsurance on the lesser amount, the billed charges, and the Plan will pay their coinsurance on the PPO allowed amount, plus, the Plan will pay the participant's additional coinsurance responsibility on the difference in the PPO allowed amount versus the actual billed charges.

Additionally, the Plan reserves the right to negotiate with a non-network provider to reduce their billed charges to a lower, discounted Allowed Charge amount. Such negotiation may be performed by the Plan Administrator or its designee. A designee may include, but is not limited to, a Utilization Management Company, Claims Administrator, attorney, stop loss carrier, medical claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowed Charge" amount upon which the Plan will base its payment for covered services for the non-network provider considering the plan's cost-sharing provisions, in-network/non-network plan design, and any Special Reimbursement Provisions adopted by the Plan.

Ambulance, Professional Ambulance Service: means a ground motor vehicle, helicopter, (rotorcraft), airplane (fixed wing) or boat that is:

a) licensed or certified for emergency patient transportation by the jurisdiction in which it operates; and
b) is specifically designed, constructed, modified and equipped with the intention to provide basic life support, intermediate life support, advanced life support, or mobile intensive care unit services by appropriately licensed and certified medical professionals; and
c) provides medical transport services for persons who are seriously ill, injured, wounded, or otherwise incapacitated or helpless and in need of immediate medical transportation; or
d) are unable to be transported between health care facilities in other than an ambulance (such as transport of an inpatient between hospitals to obtain a radiology procedure or transport from a hospital to a skilled nursing facility).

Non-emergency medical services include transportation of individuals who cannot use public or private transportation because of their Medically Necessary requirement to be positioned in a wheelchair or stretcher. Non-emergency medical services are payable by this Plan (see the Emergency services row in the Schedule of Medical Benefits).

Ambulatory Surgical Facility/Center (also called Outpatient Surgery): A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

1. It is licensed as an Ambulatory Surgical Facility/Center by the regulatory authority responsible for the licensing under the law of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets the following requirements:
    - is operated under the supervision of a licensed Physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.
    - requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
    - provides at least one operating room and at least one post-anesthesia recovery room.
    - is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
    - has trained personnel and necessary equipment to handle emergency situations.
    - has immediate access to a blood bank or blood supplies.
    - provides the full-time services of one or more registered nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room.
    - maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays), an operative report and a discharge summary.

An Ambulatory Surgical Facility/Center that is part of a Hospital, as defined in this chapter, will be considered an Ambulatory Surgical Facility/Center for the purposes of this Plan.

Ancillary services are, with respect to an In-Network health care facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and

Items and services provided by an Out-of-Network provider if there is no In-Network provider who can furnish such item or service at such facility.

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

Appliance: A device to provide or restore function or provide therapeutic (healing) effect.

- **Fixed Appliance:** A device that is cemented to the teeth or attached by adhesive materials.
- **Prosthetic Appliance:** A removable device that replaces a missing tooth or teeth.

Applied Behavior Analysis (ABA) Therapy: is the design, implementation, and evaluation of environmental modifications to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior. ABA strives to improve speech and social interaction skills and reduce disruptive behavior and includes instruction in a range of skills including speech, motor and socialization. ABA Therapy is a technique used for individuals diagnosed with Autism Spectrum Disorder that refers to disorders defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) manual as autistic disorder, Asperger's syndrome or pervasive developmental disorder. Programs based on learning theories and motivation such as Applied Behavior Analysis Therapy are not a covered benefit.

Appropriate: See the definition of Medically Necessary for the definition of Appropriate as it applies to medical services that are Medically Necessary.

Assistant Surgeon: An assistant surgeon is also referred to as an assistant at surgery or first assistant. A person who functions as an assistant surgeon actively assists the physician in charge of a surgical case (the surgeon) in performing a surgical procedure. This plan allows payment of an assistant surgeon under the following conditions:

a) the individual functioning as an assistant surgeon is properly licensed as a Physician, Nurse Practitioner, Certified Nurse Midwife, Physician Assistant, Registered Nurse First Assistant (RNFA), but not an employee of a hospital or surgical facility or an intern, or other trainee; and
b) use of an assistant surgeon is determined by the Plan Administrator or its designee to be Medically Necessary; and
c) the assistant surgeon actively participated in the surgical procedure (was not stand-by).

Balance Billing: A bill from a health care provider to a patient for the difference (or balance) between what this Plan pays and what the provider actually charged. Amounts associated with balance billing are not covered by this Plan, even if the Plan's Out-of-Pocket limits are reached. See also the Plan's definition of Allowed Amount. Note that amounts over the Allowed Amount do not count toward the Plan's Out-of-Pocket limit and may result in balance billing to you. Typically, In-Network providers do not balance bill except in situations of third-party liability claims. **Out-of-Network Health Care Providers commonly engage in balance billing a Plan participant for any balance that may be due in addition to the amount payable by the Plan.** Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or Deductibles) that exceed the plan's payment for a covered service. **Generally you can avoid balance billing by using In-Network providers. You will not be balance billed for Emergency services (including services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services) or certain services at an in-network hospital or ambulatory surgical center.**

Behavioral Health Disorders: A Behavioral Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual, or is identified in the current edition of the Diagnosis and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic case. Behavioral health disorders, includes, among other things, depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods, and provided by Behavioral Health Practitioners as defined in this chapter. Certain behavioral health disorders, conditions and diseases are specifically excluded from coverage as noted in the Medical Exclusions chapter of this document. See also the definition of Chemical Dependency and Substance Abuse.

Behavioral Health Practitioner: A psychiatrist (physician), psychologist or a mental health or substance abuse counselor or social worker who has a Master's degree or other health care provider, or other qualified health care provider, and who is legally licensed and/or legally authorized to practice or provide service, care or treatment of behavioral health disorders under the laws of the state or jurisdiction where the services are rendered; acts within the scope of his or her license.

Behavioral Health Treatment: Behavioral Health Treatment includes outpatient visits, other outpatient services, and inpatient services for a mental or substance abuse/substance use disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the Illness that is identified under the DSM code is considered a Behavioral Health Treatment for the purposes of this Plan.

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

Birthing Center: A specialized facility that is primarily of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

1. It is licensed by the regulatory authority having responsibility for the licensing under the law of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements:
   a) is a facility that has been established, equipped and operated for the purpose of providing prenatal care, delivery, immediate postpartum care, and care of a child born at the center.
   b) is equipped to perform routine diagnostic and laboratory examinations, including but not limited to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.

c) has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
d) provides at least 2 beds or 2 birthing rooms.
e) is operated under full time supervision of a licensed Physician, Registered Nurse (RN) or Certified Nurse Midwife.
f) has a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
g) has trained personnel and necessary equipment to handle emergency situations.
h) has immediate access to a blood bank or blood supplies.
i) has the capacity to administer local anesthetic and to perform minor surgery.
j) maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post-partum summary.
k) is expected to discharge or transfer patients within 48 hours following delivery.

A Birth (or Birthing) Center that is part of a Hospital, as defined in this chapter, will be considered to be a Birth (or Birthing) Center for the purposes of this Plan.

Bitewing X-rays: Dental x-rays showing the coronal (crown) halves of the upper and lower teeth when the mouth is closed.

Bridge, Bridgework:

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

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

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

Cardiac Rehabilitation: Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications in order to limit further cardiac damage and reduce the risk of death. Patients are to continue at home, the exercise and educational techniques they learn in this program. See the Schedule of Medical Benefits for information on when cardiac rehabilitation services are payable.

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

Chemical Dependency: This is another term for Substance Abuse. See the definitions of Behavioral Health Disorders and Substance Abuse.

Child(ren): See the definition of Dependent Child(ren).

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license.

Claim, Claimant: See the Claim Filing and Appeals Information chapter for the definition.

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

COBRA: means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. and refers to temporary continuation of health care coverage. See the COBRA chapter of this document for more information.

Coinsurance: That portion of Eligible Medical and Dental Expenses for which the covered person has financial responsibility to pay. In most instances, the Covered Individual is responsible for paying a fixed percentage of covered expenses after the Plan's Deductible has been met Coinsurance amounts are listed in the Schedule of Medical Benefits.

Compound Drugs: See the definition of Prescription Drugs.

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

Consortium: The Yuma Area Benefit Consortium (YABC) located in Yuma, Arizona.

Continuing Care Patient means an individual who, with respect to a provider or facility-

- is undergoing a course of treatment for a serious and complex condition from the provider or facility
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

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

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

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

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

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. This includes, but is not limited to, removal of tattoos, breast augmentation, or other medical/surgical treatment, prescription drugs and dental treatment to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cost-Efficient: See the definition of Medically Necessary for the definition of Cost-Efficient as it applies to medical services that are Medically Necessary.

Cost sharing: Means the amount a Participant or Dependent is responsible for paying for a covered item or service under the terms of the plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards Deductibles, but does not include amounts paid towards premiums, balance billing by Non-Contract Providers, or the cost of items or services that are not covered under the plan. The **Cost Sharing Amount** for Emergency and Non-emergency Services at Contract Facilities performed by Non-Contract Providers, and air ambulance services from Non-Contract Providers will be based on the Recognized Amount.

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

Covered Individual: Any employee, Spouse, Dependent Child, eligible Retiree, Governing Board member or ex-Governing Board member who is enrolled for coverage under the Plan and is actually covered by the Plan.

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

Crown: The portion of a tooth covered by enamel.

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

Deductible: The amount of eligible medical or dental expenses you are responsible for paying before the plan begins to pay benefits. **Individual Deductible:** The amount one covered person must pay before the plan begins to pay benefits for that person. **Family Deductible:** The amount that all covered family members must pay (except under the HDHP) before the plan begins to pay benefits for the family members. See also the Medical Expense Benefit chapter for details and exceptions related to the HDHP.

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

Dental Care Provider: A dentist or dental hygienist or other health care practitioner or nurse as those terms are specifically defined in this chapter who is legally licensed and who is a dentist or performs services under the direction of a licensed dentist; acts within the scope of his or her license.

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

Dental Subspecialty Areas:

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

Dentist: A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered; acts within the scope of his or her license.

Denture: A device replacing missing teeth.

Dependent: Any of the following individuals: Dependent Child(ren) or Spouse as those terms are defined in this document. See also the definition of Eligible Dependent.

Dependent Child(ren):

A. For the purposes of this Plan, a Dependent Child is any of the Employee's or Retiree's children listed below who are under the age of 26 (whether married or unmarried):
   1) **natural child**, or
   2) **stepchild**, or
   3) **legally adopted child**, or child placed for adoption with the employee or Retiree; (proof of adoption or placement for adoption may be requested), or
   4) child for whom the employee or Retiree has **legal guardianship** under a court order (proof of guardianship may be requested), or
   5) **foster child**, lawfully placed with the employee, for whom health coverage is not provided by the State (proof of foster child placement may be requested), or

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

B. **Disabled Adult Child**: Coverage can continue for an unmarried Dependent Child age 26 or older who is **permanently and totally disabled** with a disability that existed prior to the attainment of the Plan's age limit and the child is incapable of self-sustaining employment as a result of that disability. This Plan may require initial and periodic proof of disability. A child whose coverage has terminated coverage under this Plan due to reaching the age limit, and then becomes disabled, is not eligible to re-enroll as a disabled Dependent child under this Plan.

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

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

E. **The following individuals are not eligible under the Plan**: a spouse of a Dependent Child (e.g., employee's/retiree's son-in-law or daughter-in-law), and a child of a Domestic Partner.

F. Coverage of a Dependent Child ends at the **end of the month** in which that child:
   1) reaches his or her 26th birthday, (except for disabled adult children as noted above), or
   2) no longer meets the eligibility requirements of the Plan.

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

Dietician: A Registered Dietician is a professional who is qualified by training and examination to evaluate people's nutritional health and needs. To be payable under this Plan the dietician must be credentialed as a Registered Dietician (RD) by the American Dietetic Association. The Dietician must be legally licensed where state licensure is required.

Disabled/Disability: The inability of a person to be self-sufficient as the result of a physically or mentally disabling injury, illness or condition (such as intellectual disability, cerebral palsy, epilepsy or another neurological disorder, psychosis) and the person is permanently and totally disabled in that they are unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months and the condition was diagnosed by a physician and accepted by the Plan Administrator or its designee as a permanent and continuing condition. See the definition of Totally Disabled.

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

Durable Medical Equipment: Equipment that can withstand repeated use and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and is not disposable or nondurable and is appropriate for the patient's home. Durable medical equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds (with safety rails), electric and manual wheelchairs, mandibular advancement oral appliances for treatment of obstructive sleep apnea, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the definitions of Durable Medical Equipment, Nondurable Medical Supplies, Orthotic Appliance (or Device) and Prosthetic Appliance or Device (Medical).

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

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

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

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

1. they are Medically Necessary, as defined in this Definitions chapter; and
2. the charges for them are not in excess of the Allowed Amount, as defined in this Definitions chapter; and

3. coverage for the services or supplies is not excluded, as provided in the Medical and Dental Plan Exclusions chapters; and
4. the maximum plan benefit for those services or supplies has not been reached.

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

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or, with respect to a pregnant women, her unborn child in serious jeopardy.

Emergency Services means the following:

- An appropriate medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by an Out-of-Network Provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the Participant or Dependent is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The Participant or Dependent is supplied with a written notice, as required by federal law, that the provider is an Out-of-Network Provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any Network Providers at the facility who are able to treat you, and that you may elect to be referred to one of the Network Providers listed; and
- The Participant or Dependent gives informed consent to continued treatment by the Out-of-Network Provider, acknowledging that the Participant or Dependent understands that continued treatment by the Out-of-Network Provider may result in greater cost to the Participant or Dependent.

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

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

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

Enroll, Enrollment: The process of completing and submitting a written enrollment form indicating that coverage by the Plan is requested by the Employee/Retiree. An Employee/Retiree may request coverage for an Eligible Dependent only if he or she is or will be covered by the Plan. See the Eligibility chapter for details regarding the mechanics of enrollment.

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

Essential Health Benefits: The Affordable Care Act defines essential health benefits to include the following: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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

Exhausted (in reference to COBRA Continuation Coverage): For the definition of Exhausted in connection with COBRA Continuation Coverage as it relates to entitlement to Special Enrollment for coverage, see the section on Special Enrollment in the Eligibility chapter.

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

Experimental and/or Investigational: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as experimental and/or investigational.

The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

A service or supply will be deemed to be experimental and/or investigational if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for precertification under the plan's utilization management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply**:

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

approved by the FDA as an "investigational new drug for treatment use"; or
classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; or
approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was **not** approved for general use and the FDA has **not** determined that such drug should not be prescribed for a given type of cancer.

5. The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; or Phase III exclusion or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.
6. Note that under this medical plan, experimental, investigational or unproven does not include **routine costs associated with a certain "approved clinical trial" related to cancer or other life-threatening illnesses.** For individuals who will participate in a clinical trial, precertification is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial. The routine costs that are covered by this Plan are discussed below:
    a. "**Routine costs**" means services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered for a participant or beneficiary who is not enrolled in a clinical trial. However, the plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

b. An "**approved clinical trial**" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial's study or investigation must be (1) federally funded; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. "Federally funded" clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

c. A participant or beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual's referring physician is a participating health care provider in the plan who has determined that the individual's participation in the approved clinical trial is medically appropriate, or the individual provides the plan with medical and scientific information establishing that participation in the trial would be medically appropriate.

d. The plan may require that an eligible individual use an in-network provider as long as the provider will accept the patient. This plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.

e. The plan may rely on its Utilization Management Company or other medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process. See the Claim Filing and Appeals Information chapter for information on the appeal process of the Plan. Additionally, external review is available for an adverse determination related to coverage of routine costs in a clinical trial. See the Medical Network and Utilization Management chapter for information on precertification requirements.

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

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the health care provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer-reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia"; and "American Hospital Formulary Service";
5. The published opinions of: the American Medical Association (AMA), or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the published screening criteria of national insurance companies such as Aetna or CIGNA, or the American Dental Association (ADA), with respect to dental services or supplies.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
7. The latest edition of "The Medicare National Coverage Determinations Manual."

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

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

Federal Legend Drugs: See the definition of Prescription Drugs.

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

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

Formulary: A list of outpatient prescription drug products, including strength and dosages, available for use by Plan participants. A formulary is also called a Preferred drug list.

Gene Therapy: is a technique that uses human genes to treat or prevent disease in humans. Gene therapy involves introducing human DNA into an individual to treat a genetic disease. The new DNA usually contains a functioning gene to correct the effects of a disease-causing mutation. The technique can allow doctors to treat a disorder by inserting a gene into an individual's cells instead of using drugs or surgery. There are several approaches to gene therapy, including:

a) Replacing a mutated "faulty" gene that causes disease with a healthy copy of the gene.
b) Inactivating, or "knocking out," a mutated "faulty" gene that is not functioning properly.
c) Introducing a new gene into the body to help fight a disease or cure the disease.

Most often, human gene therapy works by introducing a healthy copy of a defective gene into the patient's cells. There have been rapid advancements in techniques that make it easier than ever to edit the human genome. Genome editing techniques, such as CRISPR/Cas9, allow editing of the genome, by removing, replacing, or adding to parts of the DNA sequence.

Although human gene therapy is a promising treatment option for conditions such as inherited disorders, some types of cancer, and certain viral infections, the technique remains risky and is often implemented for diseases that have no other treatment options or cures.

Generic (drug): A generic drug is a copy of an FDA approved brand-name drug that contains the same active ingredients as the brand-name drug and is the same in terms of dosage, safety, purity, strength, how it is taken, quality, performance and intended use. Generic drugs work in the same way and in the same amount of time as brand-name drugs. Generic drugs typically provide substantial dollar savings as compared to brand name drugs.

Genetic Counseling: Counseling services provided before Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman to allow the patient to make an informed decision.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Gnathologic Recording: A measurement of force exerted in the closing of the jaws.

Habilitative/Habilitation: Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal functional abilities. Examples of habilitative services includes physician-prescribed therapy for a child who is not walking or talking at the expected age.

Health Care Facility: (for non-emergency services) means each of the following:

- A hospital (as defined in section 1861(e) of the Social Security Act);
- A hospital outpatient department;
- A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
- An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Health Care Practitioner: A Physician, Behavioral Health Practitioner, Chiropractor, Dental Hygienist, Dentist, Nurse, (RN, LVN, LPN), Nurse Practitioner, Nurse Midwife, Physician Assistant Podiatrist, or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Registered Dietitian, licensed or certified Nutritionist, Certified Nutrition Specialist, Certified Clinical Nutritionist, Master's prepared Audiologist, Optometrist, Optician for vision plan benefits, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered and acts within the scope of his or her license and/or scope of practice.

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

Health Reform: see Affordable Care Act (ACA) in this chapter.

Home Health Care: Intermittent skilled nursing care services provided by a licensed home health care agency as those terms are defined in this chapter.

Home Health Care Agency: An agency or organization that provides a program of home health care and meets one of the following tests:

1. It is certified by Medicare and/or accredited by The Joint Commission (TJC); or
2. It is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it located; or
3. If licensing is not required, it meets all of the following requirements:
    - has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physicians or Registered Nurse to the home.
    - has a full-time administrator.
    - is run according to rules established by a group of professional Health Care Providers including Physicians and Registered Nurses.
    - maintains written clinical records of services provided on all patients.
    - its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available.
    - its employees are bonded and it maintains malpractice insurance coverage.

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

Hospital: means a class of health care institution that is a public or private facility or institution, licensed and operating as a hospital in accordance with the laws of the appropriate legally authorized agency, which:

1. provides care and treatment by Physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises; and
2. provides diagnosis and treatment on an inpatient basis for compensation; and
3. is approved by Medicare as a Hospital.

The facility may also be accredited as a hospital by The Joint Commission (TJC). A hospital may include inpatient acute facilities for Behavioral Health treatment that are licensed and operated according to law.

Any portion of a Hospital used as an Ambulatory Surgical/Outpatient Surgery Facility, Birth (or Birthing) Center, Hospice, Skilled Nursing Facility, Inpatient Rehabilitation facility, Subacute Care Facility/Long Term Acute Care facility or other residential treatment facility or place for rest, Custodial Care, or facility for the aged will **not** be regarded as a Hospital for any purpose related to this Plan.

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

Immediate Temporary Denture: A temporary denture that is placed immediately after the extraction of teeth.

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

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

Independent Freestanding Emergency Department: Means a health-care facility (not limited to those described in the definition of Health Care Facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

Infusion Therapy: Infusion therapy involves the administration of medication or nutrition through a needle or catheter. It is prescribed when a patient's condition is so severe that the condition cannot be treated effectively by oral medications or other nutrition routes. Commonly administered infusion therapy includes infusion of antibiotic, antifungal, antiviral, chemotherapy, hydration, pain management, parenteral nutrition, and total parenteral nutrition or TPN. Diseases commonly requiring infusion therapy include infections that are unresponsive to oral/intramuscular antibiotics, cancer and cancer-related pain, dehydration, gastrointestinal diseases or disorders which prevent normal functioning of the gastrointestinal system, etc.

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

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

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

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

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

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

Intensive Outpatient Program (IOP): means providing treatment in a structured therapeutic outpatient behavioral health environment with individual and/or group counseling treatment on a schedule that is typically no less than six hours per week (e.g., counseling provided at least 2-4 hours/day or evening, and held 3-7 times a week). Certain intensive outpatient programs can be structured to allow an individual to be able to participate in their daily affairs, such as work or school, and then participate in IOP treatment program in the morning or at the end of the day. The IOP is an outpatient program and does not include an overnight stay in a facility or an inpatient hospital admission. An IOP may be appropriate for individuals who do not require medically supervised inpatient treatment (including detoxification) and is an enhanced level of behavioral health support as compared to the standard outpatient visits that involve one 30/45/60-minute visit or two 30/45/60-minute visits per week to an outpatient behavioral health provider's office for counseling and/or medication management. Through a "step down" process, an IOP progressively transitions individuals to require less therapeutic support, to help the individual become more independent.

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

Look-Back Measurement Method: Under the look-back measurement method, the employer measures the hours of service of its employees over a measurement period and then offers coverage during an associated stability period to employees who achieved full-time status during the measurement period. Certain new employees may be measured during an initial measurement period during which their status as full-time or not is unknown and they do not have to be offered coverage during this measurement period. Ongoing employees are measured during a standard measurement period. New hire employees who are reasonably expected to be full-time employees under the Affordable Care Act (ACA) standard will be offered coverage by the first day of the fourth month after their start date, and they are subsequently also measured during the first standard measurement period that begins after their start date.

- ***New Employee:*** an employee who been employed by the employer for less than one complete standard measurement period.
- ***Part-Time Employee:*** a part-time employee is a new employee who is expected to average less than 30 hours of service per week during the initial measurement period, based on the facts and circumstances at the employee's start date.
- ***Variable Hour Employee:*** a variable hour employee is a new employee whose hours are expected to vary or otherwise be uncertain, and for this reason, the employer cannot determine whether the new employee is

reasonably expected to average at least 30 hours of service per week during the initial measurement period. This classification must be based on the facts and circumstances at the employee's start date.

- ***Seasonal Employees:*** a seasonal employee is one who is hired into a position for which the customary annual employment is six (6) months or less and employment occurs around the same time each year.
- ***Full-time Employee:*** an employee who averages at least 30 hours of service per week (130 hours of service per month) with the employer.
- ***Initial measurement period:*** means a period selected by an employer of at least 3 but not more than 12 consecutive months used by the employer as part of the look-back measurement method.\
- ***Ongoing Employee:*** An employee who has been employed by the employer for at least one complete standard measurement period.
- ***Standard measurement period***: means a period of at least 3 but not more than 12 consecutive months that is used by an employer as part of the look-back measurement method.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

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

Maxillary Disorders: Disorders of the upper jaw.

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

- **Limited Overall Maximum Plan Benefits** are the maximum amount of benefits payable on account of certain medical or dental services or supplies by the plan during the entire time a plan participant is covered under this plan and any previous medical and/or dental expense plan provided by the Consortium. such as corrective appliances and orthodontia. The services or supplies that are subject to Limited Overall Maximum Plan benefits and the limits of those benefits are identified in the Schedule of Medical Benefits.
- **Annual Maximum Plan Benefits** are the maximum amount of benefits payable each plan year on account of certain medical and/or dental expenses incurred by any covered plan participant or family of the plan participant under this plan and any previous medical and/or dental expense plan provided by the YABC Consortium, such as certain wellness benefits.

Medically Necessary:

A. A medical or dental service or supply will be determined to be "**Medically Necessary**" by the Plan Administrator or its designee if it:

1. is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it, or dentist if a dental service or supply is involved; and

2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted medical standards; and

3. is determined by the Plan Administrator or its designee to meet all of the following requirements:
   - it is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
   - it is not provided solely for the convenience of the patient, physician, hospital, health care provider, or health care facility; and
   - it is an "appropriate" service or supply given the patient's circumstances and condition; and
   - it is a "cost-efficient" supply or level of service that can be safely provided to the patient; and
   - it is safe and effective for the illness or injury for which it is used.

B. A medical or dental service or supply will be considered to be "**appropriate**" if:

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

C. A medical or dental service or supply will be considered "cost-effective" if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.
D. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical or dental coverage provided by the plan.
E. A hospitalization or confinement to a specialized health care facility will not be considered to be Medically Necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.
F. A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will **not** be considered to be Medically Necessary if it is furnished in a hospital or specialized health care facility or other more costly facility.
G. The non-availability of a bed in another specialized health care facility, or the non-availability of a health care practitioner to provide medical services, will **not** result in a determination that continued confinement in a hospital or other specialized health care facility is Medically Necessary.
H. A medical or dental service or supply will **not** be considered to be Medically Necessary if it does not require the technical skills of a health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any health care practitioner, or any hospital or specialized health care facility.

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

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

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

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

1. Presence of morbid obesity that has persisted for at least 5 years, defined as either:

    a. body mass index (BMI) exceeding 40; or

    b. BMI greater than 35 in conjunction with ANY of the following severe co-morbidities:
        1) coronary heart disease; or
        2) type 2 diabetes mellitus; or
        3) clinically significant obstructive sleep apnea; or
        4) high blood pressure/hypertension (BP > 140 mmHg systolic and/or 90 mmHg diastolic)

    AND
2. Patient has completed growth (18 years of age or documentation of completion of bone growth);
    AND
3. Patient has participated in a physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record. This physician-supervised nutrition and exercise program must meet ALL of the following criteria:
    a. Must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists; AND
    b. Nutrition and exercise program must be 6 months or longer in duration; AND
    c. Nutrition and exercise program must occur within the two years prior to surgery; AND
    d. Participation in physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who does not perform bariatric surgery. Note: A physician's summary letter is not sufficient documentation.
    NOTE: BMI is calculated by dividing the patient's weight (in kilograms) by height (in meters) squared:
    BMI = $\frac{\text{weight in kilograms}}{\text{(height in meters) times (height in meters)}}$

or compute using the National Heart, Lung and Blood Institute website: https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm.
To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by 0.0254.

Non-Network Emergency Facility: Means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively.

Non-Network Provider (or Non-Participating or Non-PPO Provider): Means a health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

Nondurable Medical Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, slings, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device).

No Surprises Act: means the federal No Surprises Act (Public Law 116-260, Division BB).

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), certified nurse midwife or licensed midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA), and authorized to administer anesthesia in collaboration with a Physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP), Family Nurse Practitioner (FNP) or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate Health Care Practitioners and bills and is able to be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered.

Nutritionist: means a professional who is qualified by training to evaluate people's nutritional health and needs, who plans food and nutrition programs, helps a person design meals/food choices to promote healthy eating habits and who assists the person in meeting necessary dietary modifications. To be payable by this Plan the professional must be licensed as a Nutritionist or is a Certified Nutrition Specialist or Certified Clinical Nutritionist.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of their license and acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living (such as eating, bathing, dressing) and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills in order to regain independence. Other occupational therapy services can include assessment of perceptual motor and sensory activity, the design, fabrication or application of selected support devices (orthotics) such as a wrist brace or ankle support, training on how to utilize prosthetic devices to maximize independence, guidance in the selection and use of adaptive equipment, teaching exercises to enhance functional performance and adaptation of environments for people with mental and physical disabilities.

Office Visit: A direct personal contact between a Physician or other Health Care Practitioner and a patient in the Health Care Practitioner's office, or via telephone or other virtual means, for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association or the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CPT or CDT coding. The following are not considered to be an office visit: A visit to a Health Care Practitioner's office where no office visit code is billed or a visit to a Health Care Practitioner's office for blood drawing, leaving a specimen, or receiving a routine injection. In addition, the Plan does pay for a telemedicine visit obtained through the Plan's exclusive Telemedicine Services Provider as explained on the Quick Reference Chart and Schedule of Medical Benefits.

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

Open Enrollment Period: The period during which an employee or Retiree may add coverages of dependents, drop coverages or dependents or select among the alternate health benefit programs that are offered by the Plan. The Plan's annual Open Enrollment Period is described in the Eligibility chapter of this document.

Ophthalmologist is a physician (MD or DO) licensed to practice ophthalmology, including eye surgery and prescription of drugs.

Optician means a person qualified to manufacture and dispense eyeglasses and/or contact lenses.

Optometrist is a person licensed to practice optometry.

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

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as to shorten or lengthen the horizontal, vertical or transverse dimensions of the jaw so that facial soft tissue, teeth and/or other facial structures are in aesthetic alignment/balance. Malposition can produce conditions such as Prognathism, Retrognathism, or Temporomandibular Joint (TMJ) syndrome/dysfunction. See the definitions of Prognathism, Retrognathism, and Temporomandibular Joint syndrome/dysfunction.

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

The term "Out-of-Network Rate": With respect to items and services furnished by a Non-Contract Provider, Non-Network emergency facility or Non-Contract Provider of ambulance services, means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (IDR) process;
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system; or
- If applicable, if a state law is in effect and applies, the amount determined in accordance with such law.
- the Allowed Charge described above.

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

Out-of-Pocket Limit: See the Out-of-Pocket Limit row in the Schedule of Medical Benefits.

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

Partial Day Care/ Partial Hospitalization: means treatment of mental, nervous, or emotional disorders and substance abuse at a hospital (on an outpatient basis) for at least three (3) hours, but not more than twelve (12) hours in a twenty-four (24) hour period, and the care does not include an overnight stay in a hospital/facility. Partial day care is active treatment that incorporates individualized treatment plans that describe the type, frequency, and duration of services as well as coordination of services around each patient's needs. The services must require a multidisciplinary team approach under the direction of a physician and reflect structure and scheduling. Treatment goals should be measurable, functional, regularly scheduled, Medically Necessary, and directly related to the partial day care program. Patients must be under care of a physician who certifies the medical necessity of the services. Patient must be able to participate and tolerate a minimum of 20 hours per week of therapeutic services. The services must be comprehensive, structured, multimodal treatment that necessitates medical supervision and coordination due to a mental disorder (i.e., mental health diagnosis) that severely interferes with daily life. Partial day care should include: individual or group psychotherapy, family counseling services, patient training and education and Medically Necessary diagnostic services related to mental health and/or substance abuse treatment.

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

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

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapist: A person legally licensed as a professional physical therapist who acts within the scope of their license, and acts under the direction of a physician to perform physical therapy services including the evaluation, treatment and education of a person using physical measures, therapeutic exercise, thermal (hot/cold) techniques and/or electrical stimulation to correct or alleviate a physical functional disability/impairment. Physical therapists may also perform testing and retraining of muscle strength, joint motion, or sensory and neurological function along with balance, coordination, and flexibility in order to enhance mobility and independence.

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform certain activities of daily living such as walking and getting in and out of bed.

Physician: A person legally licensed as a medical doctor (MD) or doctor of osteopathy (DO) or Doctor of Podiatric Medicine (DPM) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license.

Physician Assistant (PA): A person legally licensed as a Physician Assistant, who acts within the scope of his or her license and acts under the supervision of a Physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising Physician; and bill and be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered.

Placed for Adoption: For the definition of Placed for Adoption as it relates to coverage of adopted Dependent children, see the definition in the section on Adopted Dependent Children in the Eligibility chapter.

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

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

Plan Participant: The employee or Retiree who has enrolled for coverage under the plan. As used in this document, this term does **not** include the Spouse or Dependent Child(ren) of the plan participant.

Plan Sponsor: The YABC Board of Trustees.

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

Podiatrist: A person legally licensed as a doctor of podiatric medicine (DPM) and authorized to provide care and treatment of your Human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license.

Pontic: The part of a fixed bridge that is suspended between two abutments and replaces a missing tooth.

Practitioner: See the definition of Health Care Practitioner.

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

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

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

Prescription Drugs: For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend Drug:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. **Compound Drug:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.
3. **Brand drug:** means a drug that has been approved by the U.S. Food and Drug Administration (FDA) and that drug has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company who holds the patent has the right to sell that brand drug. A brand drug cannot have competition from a generic drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.
4. **Generic drug**: means a generic version of a brand-name drug. The generic drug must be the same (or bio-equivalent) in several respects: the active ingredients (those ingredients that are responsible for the drug's effects), the dosage amount, the way in which the drug is taken must be the same as the brand name drug, the safety must be the same and the amount of time the generic drug takes to be absorbed into the body must be the same as the brand name drug. A generic drug has been approved by the U.S. Food and Drug Administration (FDA) and is basically a "copy" of a brand name drug. Generic drugs can have different names, shapes, colors and inactive ingredients than the original brand name drug.
5. **Specialty drug**: see the separate definition of Specialty drug in this chapter.

Preventive Services/Preventive Care Benefits: are defined under the Patient Protection and Affordable Care Act (Health Care Reform) and include recommended services rated as "A" or "B" by the U.S. Preventive Services Task Force (USPSTF) with respect to the individual involved, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and preventive care and screenings for women and children as recommended by the Health Resources and Services Administration (HRSA).

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Prophylactic Surgery: A surgical procedure performed for the purpose of (1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on Genetic Information or Genetic Testing, or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages. An example of Prophylactic Surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer and/or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease.

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

Prosthesis: An artificial replacement of one or more natural teeth and/or associated structures.

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

Provider: See the definition of Health Care Provider.

Public Health Emergency: The Plan will provide coverage for services necessary for a condition related to any current nationally declared public health emergency, at the rate deemed by federal government mandate. Limited to the services of the government mandate, this provision shall override any potentially conflicting, specific exclusions, defined terms, or other plan provisions for these services, as required to provide the mandated services for the public health emergency. This shall remain in effect for the duration of the public health emergency, as declared by the Secretary of Health and Human Services (HHS).

Pulmonary Rehabilitation: Pulmonary Rehabilitation refers to a formal program of controlled exercise training and respiratory education under the supervision of qualified medical personnel capable of treating respiratory emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to their highest functional level of activity/endurance, decrease respiratory symptoms/complications, and encourage self-

management and control over their chronic lung problems. Patients are to continue at home, the exercise and educational techniques they learn in this program. Pulmonary rehabilitation services are payable for patients who have a chronic respiratory disorder such as chronic obstruction pulmonary disease, emphysema, pulmonary fibrosis, asthma, etc.

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

Qualifying Payment Amount (QPA): Means the amount calculated using the methodology described in 45 CFR § 149.140(a)(16).

Recognized Amount: Means (in order of priority) one of the following:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- An amount determined by a specified state law; or
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

For air ambulance services furnished by Non-Contract Providers, **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

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

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

Rehabilitation does not have the same meaning as Habilitation. Rehabilitation focuses on restoring/regaining functions that have been lost due to injury or illness, while Habilitation focuses on helping individual attain certain functions that they never have acquired. See also the definition of Habilitation.

See the Schedule of Medical Benefits and the Medical Exclusions chapter of this document to determine the extent to which Rehabilitation Therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy, Pulmonary Rehabilitation and Cardiac Rehabilitation.

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

Residential Treatment Facility/Care: is defined as a 24-hour level of care that operates 7 days a week for people with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders. To be payable by this Plan, such a facility must be licensed as a residential treatment facility. Licensure requirements for this residential level of care may vary by state.

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

Retiree: See the Eligibility chapter.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face. See also Orthognathic.

Retrospective Review: Review of health care services **after** they have been provided to determine if those services were Medically Necessary and/or if the charges for them are not in excess of the Allowed Amount.

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

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

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

Serious and Complex Condition: Means with respect to a Participant or Dependent under the Plan one of the following:

1) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent disability;

2) in the case of a chronic illness or condition, a condition that is—

f. is life-threatening, degenerative, potentially disabling, or congenital; and

g. requires specialized medical care over a prolonged period of time.

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

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

1. it is accredited by The Joint Commission (TJC) as a skilled nursing facility OR is recognized by Medicare as a skilled nursing facility; and
2. it is regularly engaged in providing room and board and continuously provided 24 hour-a-day Skilled Nursing Care of sick and injured or illness, maintains on its premises all facilities necessary for medical care and treatment; and
3. it provides services under the supervision of Physicians; and is authorized to administer medication to patients on the order of a licensed Physician; and
4. it provides nursing services by or under the supervision of a licensed registered nurse, with one licensed registered nurse on duty at all times; and
5. it is not (other than incidentally) a place for rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or have tuberculosis; and
6. it is not a hotel or motel.

A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Special Enrollment: The period of time pertaining to the enrollment of a Spouse or Dependent Children only under certain circumstances such as marriage, birth, adoption, placement for adoption or loss of other coverage. See also the Eligibility chapter on special enrollment provisions under this plan.

Specialized Health Care/Hospital Facilities: For the purposes of this plan, specialized health care facilities include ambulatory surgical/outpatient surgery facilities, behavioral health treatment facilities, birthing centers, hospices,

skilled nursing facilities, and subacute care facilities/long term acute care facilities, as those terms are defined in this Definitions chapter. See the definition of Substance Care Facility.

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

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

Speech Therapist: A person legally licensed as a professional speech therapist who acts within the scope of their license and acts under the direction of a physician to perform speech therapy services including the application of principles, methods and procedures for the measurement, testing, evaluation, prediction, counseling, instruction, or rehabilitation related to disorders of speech, voice, language, swallowing or feeding.

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure. Speech therapy for functional purposes, including but not limited to a speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin or childhood developmental speech delays/disorders are excluded from coverage.

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

Spouse: An employee or retiree's Spouse means a person of the opposite gender or same gender who is legally married. The Plan may require proof of the legal marital relationship. The following are not defined as a Spouse under this Plan: a legally separated Spouse (when legal separation is permitted by state law), a domestic partner, a civil union, or a divorced former Spouse of an employee or retiree, a common law marriage, or a spouse of a Dependent Child.

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

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

Subacute care facility is sometimes referred to as a specialty hospital or long-term care acute (LTAC) facility.

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

Substance Abuse/Substance Use Disorder: Alcohol and/or drug dependency as defined by the current edition of the ICD-CM manual. See the definitions of Behavioral Health Disorders and Chemical Dependency.

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

When the procedures will be considered to be separate procedures, the following percentages of the Allowed Amount will be allowed as the plan's benefit:

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

Primary procedure	100% of the Allowed Amount
Secondary and additional procedures	50% of the Allowed Amount per procedure

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

First site primary procedure	100% of the Allowed Amount
First site secondary and additional procedures	50% of the Allowed Amount per procedure
Second site primary and additional procedures	50% of the Allowed Amount per procedure

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

Termination (in the context of Continuity of Care): Includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Therapist: A person trained and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy who is legally licensed to perform such services (where licensing required by State law) and who works within the scope of his or her license and provides services under the direction of a Physician or Chiropractor, is allowed to bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered. For further information see the definition of Occupational, Physical and Speech Therapy.

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

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

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

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

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

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

See also the Utilization Management chapter of this document for information about precertification requirements for transplantation services.

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

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

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

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

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

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

Yuma Area Benefits Consortium (YABC): The participating employers in this consortium include: Arizona Western College, Crane Elementary School District No. 13 the City of Yuma, the Yuma County Intergovernmental Public Transportation Authority, Housing Authority of the City of Yuma, and the Yuma Metropolitan Planning Organization (YMPO).

Signature Page

The effective date of the amended and restated **Yuma Area Benefit Consortium (YABC)** Plan Document describing Medical Plan (including Prescription Drugs), Dental, and Vision Benefits is **July 1, 2023**.

It is agreed that the provisions of this document are correct and will be the basis for the administration of the **Yuma Area Benefit Consortium (YABC) Plan**.

Dated this 26th day of June, 2023.

On behalf of the YABC BOARD OF TRUSTEES,

Chairperson of the YABC Board