Mohave County Employee Benefit Trust

Group No.: 13862

Plan Document
and
Summary Plan Description

Originally Effective: January 1, 2001

Amended and Restated Effective: July 1, 2024

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TABLE OF CONTENTS

ESTABLISHMENT OF THE PLAN 1
GENERAL OVERVIEW OF THE PLAN 2
MEDICAL MANAGEMENT PROGRAM 6
MEDICAL SCHEDULE OF BENEFITS – EPO PLAN 10
PRESCRIPTION DRUG SCHEDULE OF BENEFITS – EPO PLAN 13
MEDICAL SCHEDULE OF BENEFITS – HDHP PLAN 15
PRESCRIPTION DRUG SCHEDULE OF BENEFITS – HDHP PLAN 18
ELIGIBILITY FOR PARTICIPATION 20
TERMINATION OF COVERAGE 26
ELIGIBLE MEDICAL EXPENSES 29
HINGE HEALTH PROGRAM 43
ALTERNATE BENEFITS 44
GENERAL EXCLUSIONS AND LIMITATIONS 45
PRESCRIPTION DRUG PROGRAM 51
COBRA CONTINUATION COVERAGE 57
CLAIM PROCEDURES 60
COORDINATION OF BENEFITS (COB) 70
SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT 73
DEFINITIONS 77
PLAN ADMINISTRATION 89
MISCELLANEOUS INFORMATION 90
HIPAA PRIVACY PRACTICES 92
HIPAA SECURITY PRACTICES 94
ARTICLE I NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT 95
ARTICLE II NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT 96
ARTICLE III NOTICE OF PRESCRIPTION DRUG COVERAGE AND MEDICARE 97
ARTICLE IV EXEMPTION FROM MENTAL HEALTH & SUBSTANCE USE DISORDER PARITY 99
ARTICLE V MEDICAID (AHCCCS) AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) 100
ARTICLE VI HIPAA PRIVACY AND SECURITY NOTICES 101
GENERAL PLAN INFORMATION 105

ESTABLISHMENT OF THE PLAN

Mohave County (the “Employer” or the “Plan Sponsor”) has adopted this amended and restated Plan Document and Summary Plan Description effective as of July 1, 2024 for the Mohave County Employee Benefit Trust (hereinafter referred to as the “Plan” or “Summary Plan Description”), as set forth herein for the exclusive benefit of its Employees and their eligible Dependents. The Plan was originally adopted by the Employer effective as of January 1, 2001.

Purpose of the Plan

The Plan Sponsor has established the Plan for your benefit and for the benefit of your eligible Dependents, on the terms and conditions described herein. The Plan Sponsor’s purpose in establishing the Plan is to help to protect you and your family by offsetting some of the financial problems that may arise from an Injury or Illness. To accomplish this purpose, the Plan Sponsor must attempt to control health care costs through effective plan design and the Plan Administrator must abide by the terms of the Plan Document and Summary Plan Description, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to manage their healthcare costs.

The Plan is not a contract of employment between you and your Employer and does not give you the right to be retained in the service of your Employer.

The purpose of this Plan is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain health care expenses. This Plan is maintained by the Plan Administrator and may be inspected at any time during normal working hours by you or your eligible Dependents.

Adoption of this Plan Document and Summary Plan Description

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document and Summary Plan Description (SPD) as the written description of the Plan. This Plan represents both the Plan Document and the Summary Plan Description. This Plan Document and SPD amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document and Summary Plan Description to be executed as of the date set forth below.

Mohave County

Dated: 9-11-2024

By: Ken Cunningham

Name: KEN CUNNINGHAM

Title: HUMAN RESOURCES DIRECTOR

GENERAL OVERVIEW OF THE PLAN

This Plan has incorporated the BlueCross BlueShield of Arizona (BCBSAZ) Exclusive Provider Organization (EPO) as part of the benefit design. An EPO is a group of Hospitals, Physicians, and other health care providers contracted to furnish medical care at negotiated rates. Use of EPO providers is **required** to receive the benefits described in this book.

All services received in Arizona must be rendered by a BlueCross BlueShield of Arizona network provider. Benefits for services performed by providers outside of the EPO networks will not be available (except in the case of an Emergency Medical Condition).

When you need medical care, select a provider from the EPO directory or contact BCBSAZ at (800) 232-2345 or online at www.azblue.com/CHSNetwork, then choose the Arizona option, to verify the doctor's current status as a network provider. Your ID card identifies the EPO Networks and it should always be presented when obtaining services. The "In-Network" provider will collect a Copayment when applicable, and will submit your claim for payment consideration. Meritain Health, Inc. will process your benefits at the appropriate level and send you an "Explanation of Benefits" showing the payment calculation and the amount of "patient responsibility".

If the need for emergency medical care occurs outside the EPO network, services may be considered under the Schedule of Benefits if it is determined by the Claims Administrator that immediate medical attention was required due to an Accident or Illness which was serious enough to constitute an "Emergency Medical Condition" as defined in this document.

If your EPO Physician needs to send you to another Physician or admits you to a Hospital, be sure that you are referred to a provider/facility that participates in the applicable EPO Network. A referral from an In-Network provider to any Out-of-Network provider (i.e., laboratory, radiology, Physician, etc.) does NOT make the claim from the Out-of-Network provider payable as In-Network.

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

Wrap Network

Your Plan also has an arrangement with a secondary Network, sometimes referred to as a "Wrap Network". The Wrap Network may be used when you or your Dependents Incur claims outside the Network service area. By way of example only, if you reside outside of the Network service area or are traveling outside of the Network service area, you may wish to use a Wrap Network provider. You may contact the Wrap Network listed on your Employee identification card to determine whether discounted rates are available through the Wrap Network. If you utilize a provider covered by the Wrap Network, your benefits will be paid at the Participating Provider benefit level.

EPO Non-Participating Provider Exceptions

Note: Use of a Non-Participating Provider may result in additional cost-sharing for a Covered Person, including balance bills for services over Usual and Customary amounts however the Usual and Customary provision will not apply if the service required precertification and the Plan's required procedures were followed (as described in the Medical Management Program section).

Unless otherwise described herein, covered services rendered by a Non-Participating Provider are paid at the Participating Provider level, subject to the Usual and Customary provision of the Plan when a:

(1) Covered Person has an Emergency Medical Condition requiring immediate care.*

(2) Covered Person receives services by a Non-Participating Provider who is under agreement with a Network facility.*

(3) Covered Person suffers from a covered Illness or Injury which requires treatment for which there is no Participating Provider who can provide such treatment and is confirmed by the Medical Management Program Administrator.

(4) Covered Person receives lactation consultations from a Non-Participating Provider.

***NOTE:** In the case of a Surprise Bill for covered services from a Non-Participating Provider who is under agreement with a Network facility and the Covered Person had no control of the Non-Participating Providers participation in their care or when a Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider, the cost share will be based on the median contract rate.

Continuity of Care (Keeping a provider you go to now)
You may have to find a new provider when:

(1) The Plan's Network changes and the provider you have now is not in the new Network; or

(2) You are already enrolled in the Plan and your provider stops participating in the Plan's Network.

However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery. Routine procedures, minor Illnesses and elective Surgical Procedures generally are not covered under this provision.

Contact the phone number on the back of your identification card to obtain further information on how to submit a request for continuity of care. If your request is approved to keep going to your current provider, you will be informed how long you can continue to see the provider. Reimbursement for approved continuity of care will be at the applicable Participating Provider benefit level subject to the Usual and Customary provision of the Plan.

Switching Between Medical Plans
Open enrollment is the time period that is set aside for Covered Employees to review their benefit options and make changes. If you decide to switch coverage between the EPO and High Deductible medical plans, here are some items you should consider:

(1) Per IRS regulations you will receive no credit for any Deductible or Out-of-Pocket amounts that you have paid this Plan year under the Plan you elected.

(2) Since this is a mid-year election, the full Deductible will begin again each January.

Costs
You must pay for a certain portion of the cost of Covered Expenses under the Plan, including (as applicable) any Copay, Deductible and Coinsurance percentage that is not paid by the Plan, up to the Out-of-Pocket Maximum set by the Plan.

EPO Plan

Coinsurance – EPO Plan
Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Coinsurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the Medical Schedule of Benefits.

Copay – EPO Plan
A Copay is the portion of the medical expense that is the Covered Person's responsibility, as shown in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible.

Deductible – EPO Plan
A Deductible is the total amount of eligible expenses as shown in the Medical Schedule of Benefits, which must be Incurred by a Covered Person during any Calendar Year before Covered Expenses are payable under the Plan, exceptions to the Deductible requirement are labeled as "Deductible Waived" in the Medical Schedule of Benefits.

Out-of-Pocket Maximum – EPO Plan
An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

The entire Out-of-Pocket Maximum must be satisfied; however each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum. Once the single Out-of-Pocket Maximum is satisfied, the Plan will pay 100% of Covered Expenses for that covered individual during the remainder of that Calendar Year.

Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, ("non-accumulating expenses") include:

(1) Charges over Usual and Customary Charges for Non-Participating Providers.

(2) Charges this Plan does not cover, including precertification penalties.

Reimbursement for these non-accumulating expenses will continue at the percentage payable shown in the Medical Schedule of Benefits, subject to the Plan maximums.

The Plan will not reimburse any expense that is not an eligible expense. In addition, a Covered Person must pay any expenses that are in excess of the Usual and Customary Charges for Non-Participating Providers. This could result in the Covered Person having to pay a significant portion of the claim. None of these amounts will accumulate toward the Covered Person's Out-of-Pocket Maximum.

Once the Covered Person has paid the Out-of-Pocket Maximum for eligible expenses Incurred during a Calendar Year, the Plan will reimburse additional eligible expenses Incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense or whether it is eligible for accumulation toward the Out-of-Pocket Maximum, please contact the Third Party Administrator for assistance.

HDHP Plan

Deductible - HDHP Plan

A Deductible is the total amount of eligible expenses as shown in the Medical Schedule of Benefits, which must be Incurred by a Covered Person during any Calendar Year before Covered Expenses are payable under the Plan, exceptions to the Deductible requirement are labeled as "Deductible Waived" in the Medical Schedule of Benefits.

Out-of-Pocket Maximum - HDHP Plan

On the HDHP Plan, the Out-of-Pocket Maximum is the same as the Deductible. This is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

The entire family Out-of-Pocket Maximum must be satisfied, however each individual in a family is not required to contribute more than the single Deductible/Out-of-Pocket amount to the family Deductible/Out-of-Pocket Maximum. Once the single Deductible/Out-of-Pocket Maximum is satisfied, the Plan will pay 100% of Covered Expenses for that covered individual during the remainder of that Calendar

Please note, however, that not all Covered Expenses are eligible to accumulate toward your Deductible/Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Deductible/Out-of-Pocket Maximum, ("non-accumulating expenses") include:

(1) Charges over Usual and Customary Charges for Non-Participating Providers.

(2) Charges this Plan does not cover, including precertification penalties.

The Plan will not reimburse any expense that is not an eligible expense. In addition, a Covered Person must pay any expenses that are in excess of the Usual and Customary Charges for Non-Participating Providers. This could result in the Covered Person having to pay a significant portion of the claim. None of these amounts will accumulate toward the Covered Person's Out-of-Pocket Maximum.

Once the Covered Person has paid the Out-of-Pocket Maximum for eligible expenses Incurred during a Calendar Year, the Plan will reimburse additional eligible expenses Incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense or whether it is eligible for accumulation toward the Out-of-Pocket Maximum, please contact the Third Party Administrator for assistance.

No Surprises Act Protections

The No Surprises Act (Title I of Division BB of the Consolidated Appropriations Act, 2021) (the "No Surprises Act") protects Covered Persons from surprise medical billing in certain situations. For No Surprises Act purposes, a Surprise Bill is generally a bill you receive for covered services in the following circumstances: (1) certain Emergency Services performed by a Non-Participating Provider; (2) certain non-Emergency Services performed by a Non-Participating Provider at a Participating Provider that is a Health Care Facility; and (3) air ambulance services performed by a Non-Participating Provider.

The No Surprises Act includes special reimbursement rules that apply to Surprise Bills when determining the amount that the Plan is required to pay to the Non-Participating Provider. When these provisions apply to Emergency Services, the Non-Participating Provider generally is prohibited from balance billing you for amounts exceeding your cost-sharing amount (e.g., your Copay, Deductible or Coinsurance) under the Plan. That is, if the No Surprises Act provisions apply, such a provider generally cannot directly bill you the difference between the amount the provider charges and the amount the Plan will pay plus your cost-sharing (i.e., balance billing). Any cost-sharing payments you make with respect to items or services covered by the No Surprises Act will count towards any Participating Provider Deductible and Out-of-Pocket Maximum. These special reimbursement rules also apply to the following covered non-Emergency Services when performed by a Non-Participating Provider at a Participating Provider that is a Health Care Facility (to the extent required under the No Surprises Act):

(1) Covered items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether provided by a physician or a non-Physician practitioner);

(2) Covered items and services provided by Assistant Surgeons, hospitalists and intensivists;

(3) Diagnostic services, including radiology and laboratory services;

(4) Covered items and services performed by a Non-Participating Provider when a Participating Provider is unavailable at the time the health care services are performed at a Participating Provider this is a Health Care Facility; and

(5) Covered items or services performed by a Non-Participating Provider as a result of unforeseen, urgent medical issues that arise at the time such items or service is performed.

Notwithstanding the preceding, in accordance with and to the extent permitted by the No Surprises Act, the Surprise Billing protections do not include a bill for medical items or services when a Participating Provider is available and you elect to receive items or services from a Non-Participating Provider or, with respect to non-Emergency Services (other than those specified above) performed by a Non-Participating Provider at a Participating Provider (that is a Health Care Facility) if the Non-Participating Provider has obtained your consent to receive the items or services after providing you with required notice. That is, in certain cases if the Non-Participating Provider follows the "notice and consent" procedures under the No Surprises Act and you consent, the Plan's normal reimbursement rules with respect to Non-Participating Providers will apply (to the extent permitted under the No Surprises Act) and you may be balance billed. Note that the "notice and consent" procedures do not apply to Non-Participating Providers of air ambulance services and do not apply in certain other circumstances (e.g., where a Non-Participating Provider provides items or services due to unforeseen urgent medical needs in certain cases, etc.) unless otherwise provided under the No Surprises Act and/or other binding, authoritative guidance under the No Surprises Act.

For any Surprise Bills, the Plan will reimburse the Non-Participating Provider an initial payment equal to the Recognized Amount and you will not be responsible for any Non-Participating Provider charges for items and services (pursuant to the Surprise Bill) in excess of your cost-sharing (e.g., your Copay, Deductible or Coinsurance) for Participating Providers based on that Recognized Amount.

Where air ambulance services are rendered by a Non-Participating Provider, to the extent necessary to comply with the No Surprises Act, the Plan shall apply the same cost-sharing (e.g., your Copay, Deductible or Coinsurance) to air ambulance services when rendered by a Non-Participating Provider as the cost-sharing that is applied to such services when rendered by a Participating Provider. For this purpose, air ambulance services generally means medical transport by a rotary wing air ambulance (e.g., helicopter), or fixed wing air ambulance (e.g., airplane).

MEDICAL MANAGEMENT PROGRAM

This Plan is contracted with American Health Group (AHG) to provide Medical Management. You, your eligible Dependents or a representative acting on your behalf, must call the Medical Management Program Administrator to receive certification of Inpatient admissions (other than admissions for an Emergency Medical Condition), as well as other non-Emergency Services listed below. This call must be made at least 72 hours in advance of Inpatient admissions or receipt of the non-Emergency Services listed below. Failure to obtain precertification or notify the Medical Management Program Administrator within the time frame indicated above may result in eligible expenses being reduced or denied. Please refer to the penalty section below.

Program Overview
Medical Management is a program designed to help ensure that you and your eligible Dependents receive necessary and appropriate healthcare while avoiding unnecessary expenses. The program consists of:

(1) Precertification of Medical Necessity. The following items and/or services must be precertified before any medical services are provided*:

(a) Chemotherapy - all settings including services rendered in a Physician's office

(b) Outpatient Surgical Procedures, excluding Surgery rendered in a Physician's office

(c) Outpatient diagnostic tests and imaging, limited to the following: CT/MRA/MRI/PET scans, scintimammography, capsule endoscopy and U.S. bone density (heel)

(d) Hospice care

(e) Infusion/ Injectable medications – in excess of $1,000 that are administered in all settings.

(f) Inpatient admissions, including Inpatient admissions to a Skilled Nursing Facility, Extended Care Facility, and Rehabilitation Facility and Inpatient admissions due to a Mental Disorder or Substance Use Disorder:

(i) If the Inpatient admission is with respect to an Emergency Medical Condition, you must notify the Medical Management Program Administrator within 48 hours or if later, by the next business day after the Emergency Medical Condition admission.

(g) Occupational therapy

(h) Physical therapy

(i) Psychological and neuropsychological testing

(j) Radiation therapy - all settings including services rendered in a Physician's office

(k) Rehabilitation services

(l) Speech therapy

***NOTE (BlueCross BlueShield of Arizona (BCBSAZ) network provider):** If services listed above are rendered by a BlueCross BlueShield of Arizona (BCBSAZ) network provider, the BlueCross BlueShield of Arizona (BCBSAZ) network provider is responsible to obtain the required precertification.

(2) Concurrent Review for continued length of stay and assistance with discharge planning activities.

(3) Retrospective review for Medical Necessity where precertification is not obtained or the Medical Management Program Administrator is not notified.

Medical Management Does Not Guarantee Payment
All benefits/payments are subject to the patient's eligibility for benefits under the Plan. For benefit payment, services rendered must be considered an eligible expense under the Plan and are subject to all other provisions of the Plan.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other healthcare provider.

How the Program Works

Precertification

Before you or your eligible Dependents are admitted to a medical facility or receive items or services that require precertification on a non-Emergency Medical Condition basis (when an Emergency Medical Condition is not involved), the Medical Management Program Administrator will, based on clinical information from the provider or facility, certify the care according to the Medical Management Program Administrator's policies and procedures.

The Medical Management Program is set in motion by a telephone call from you, the patient or a representative acting on your behalf or on behalf of the patient.

To allow for adequate processing of the request, contact the Medical Management Program Administrator at least 72 hours before receiving any item or service that requires precertification or an Inpatient admission for a non-Emergency Medical Condition with the following information:

(1) Name, identification number and date of birth of the patient;

(2) The relationship of the patient to the covered Employee;

(3) Name, identification number, address and telephone number of the covered Employee;

(4) Name of Employer and group number;

(5) Name, address, Tax ID # and telephone number of the admitting Physician;

(6) Name, address, Tax ID # and telephone number of the medical facility with the proposed date of admission and proposed length of stay;

(7) Proposed treatment plan; and

(8) Diagnosis and/or admitting diagnosis.

If there is an Inpatient admission with respect to an Emergency Medical Condition, you, the patient or a representative acting on your behalf or on behalf of the patient, including, but not limited to, the Hospital or admitting Physician, must contact the Medical Management Program Administrator within 48 hours after the start of the confinement or on the next business day, whichever is later.

Hospital stays in connection with childbirth for either the mother or newborn may not be less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother.

You, the patient and the providers are NOT REQUIRED to obtain precertification for a maternity delivery admission, unless the stay extends past the applicable 48- or 96-hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified with the Medical Management Program Administrator or a penalty will be applied.

The Medical Management Program Administrator, in coordination with the facility and/or provider, will make a determination on the number of days certified based on the Medical Management Program Administrator's policies, procedures and guidelines. If the confinement will last longer than the number of days certified, a representative of the Physician or the facility must call the Medical Management Program Administrator before those extra days begin and obtain certification for the additional time. If the additional days are not requested and certified, room and board expenses will not be payable for any days beyond those certified.

If the patient does not obtain precertification for their Inpatient admission at least 72 hours in advance of the admission or notify the Medical Management Program Administrator within 48 hours after an Emergency Medical Condition admission or if precertification is obtained or notification received outside the time frames specified, eligible expenses may be reduced or denied. Please refer to the penalty section below.

Second Surgical Opinions
Before approval of a requested Surgical Procedure, Medical Management Program Administrator may require the Covered Person to obtain a second opinion. The Medical Management Program Administrator will provide the Covered Person with the name of one or more Physicians that can provide the second opinion.

Penalty
If you fail to obtain precertification or fail to notify the Medical Management Program Administrator within the time periods described above, benefits under the Plan will be reduced as follows:

(1) Covered Expenses will be reduced by $300 per occurrence. The amount of the precertification penalty is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum*.

    ***NOTE (BlueCross BlueShield of Arizona (BCBSAZ) network provider):** If services listed above are rendered by a BlueCross BlueShield of Arizona (BCBSAZ) network provider, the BlueCross BlueShield of Arizona (BCBSAZ) Network provider is responsible to obtain the required precertification. Member is not responsible for precertification penalty.

If the Plan's required review procedures are not followed, a retrospective review will be conducted by the Medical Management Program Administrator to determine if the services provided met all other Plan provisions and requirements. If the review concludes the services were Medically Necessary and would have been approved had the required phone call been made, benefits will be considered, subject to the penalty outlined above. However, any charges not deemed Medically Necessary will be denied.

Discharge Planning
Discharge planning needs is part of the Medical Management Program. The Medical Management Program Administrator will assist and coordinate the initial implementation of any services the patient will need post hospitalization with the attending Physician and the facility. If the attending Physician feels that it is Medically Necessary for a patient to stay in the medical care facility for a greater length of time than has been precertified, the attending Physician or the medical facility must request the additional service or days.

Concurrent Inpatient Review
Once the Inpatient setting has been precertified, the on-going review of the course of treatment becomes the focus of the program. Working directly with your Physician, the Medical Management Program Administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

To File a Complaint or Request an Appeal to a Non-Certification
Verbal appeal requests and information regarding the appeal process should be directed to the Medical Management Program Administrator as identified on the General Plan Information page of this Plan Document. If this initial appeal is denied, you may follow the second level appeal procedures as outlined under Internal Review of Initially Denied Claims section of the Claim Procedures of this Plan Document.

Case Management
When a catastrophic condition, such as but not limited to, a spinal cord Injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the patient's condition is diagnosed, the patient might need extensive services or might be able to be moved into another type of care setting, even to the patient's home.

Case management is a program whereby a Case Manager contacts the patient to obtain consent for case management services. The Case Manager monitors the patient and explores, discusses and recommends coordinated and/or alternate types of appropriate medical care. The Case Manager consults with the patient, family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient.

This plan of care may include some or all of the following:

(1) Personal support to the patient;

(2) Contacting the family to offer assistance and support;

(3) Monitoring Hospital or skilled nursing care or home health care;

(4) Determining alternate care options; and

(5) Assisting in obtaining any necessary equipment and services.

Case management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The Case Manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan staff, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Medical Management will not interfere with your course of treatment or the Physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this Program.

The Medical Management Program Administrator contact information for this Plan is identified on the Employee identification card and also on the General Information page of this Plan.

MEDICAL SCHEDULE OF BENEFITS – EPO PLAN

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
LIFETIME MAXIMUM BENEFIT	Unlimited
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited
CALENDAR YEAR DEDUCTIBLE	
Per Person	$1,200
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)	
Single	$6,300
Family	$12,700
MEDICAL BENEFITS	
Allergy Services	
Allergy Testing	Paid under Physician Office Visit
Allergy Treatment	
With an office visit	Paid under Physician Office Visit
Without an office visit	$15 Copay, then 100% (Deductible waived)
Serum/Antigens	$15 Copay, then 100% (Deductible waived)
Ambulance Services	80% (Deductible waived)
NOTE: Non-Participating Providers are paid at Participating Provider level of benefits for Emergency Services.	
Anesthesiologist	80% after Deductible
Cardiac Rehabilitation	80% after Deductible
Chemotherapy (Outpatient – includes all related charges)	80% after Deductible
Chiropractic Care/Spinal Manipulation (including maintenance)	$30 Copay, then 100% (Deductible waived)
Calendar Year Maximum Benefit	30 visits
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	
Services performed inside of a Physician's office	Paid under Physician's Services Office Visit benefit
Services performed outside of a Physician's office	80% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	
Services performed inside of a Physician's office	Paid under Physician's Services Office Visit benefit
Services performed outside of a Physician's office	80% after Deductible
Durable Medical Equipment (DME)	80% after Deductible
Emergency Services – Emergency Medical Condition	$200 Copay, then Deductible, then 80%
NOTE: The Deductible will be waived if the person is admitted directly as an Inpatient to the Hospital.	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Emergency Room Services – Non-Emergency Medical Condition	Not Covered
Hemodialysis/Peritoneal Dialysis (Outpatient)	80% after Deductible
Hinge Health Program	There is no cost to the member for this program
NOTE: Please refer to the Hinge Health Program section of this Plan for a more detailed description of this benefit. If treatment is received from providers outside of the Hinge Health Network, standard Plan benefits will apply as outlined in the Medical Schedule of Benefits.	
Home Health Care	80% after Deductible
Hospice Care	80% after Deductible
Maximum Benefit	100 days per period of Hospice care
Hospital Services or Long-Term Acute Care Facility/Hospital (facility charges)	
Inpatient	80% after Deductible
Room and Board Allowance*	*Semi-Private Room rate
Intensive Care Unit	ICU/CCU Room rate
Miscellaneous Service and Supplies	80% after Deductible
Outpatient	80% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.	
Maternity (non-facility charges)*	
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100% (Deductible waived)
Lactation Consultations	100% (Deductible waived)**
All Other Prenatal and Postnatal Care	80% after Deductible (if billed globally); $30 Copay, then 100% (Deductible waived) (if billed separately)
Delivery	80% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.	
** Non-Participating Provider will be paid at the Participating Provider level of benefits but may be subject to balance billing for charges over Usual and Customary amounts.	
Medical and Surgical Supplies	80% after Deductible
Mental Disorders and Substance Use Disorders	
Inpatient	80% after Deductible
Outpatient	$30 Copay, then 100% (Deductible waived)
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.	
Outpatient Therapies (physical, speech/hearing, occupational)	80% after Deductible
Combined Calendar Year Maximum Benefit	40 visits
Physician's Services	
Inpatient/Outpatient Services	80% after Deductible
Office Visits/Office Surgery: Primary Care Physician	$30 Copay*, then 100% (Deductible waived)
Specialist	$50 Copay*, then 100% (Deductible waived)

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
All Other Services and Supplies Rendered During an Office Visit	$15 Copay**, then 100% (Deductible waived)
NOTE: Services for diagnostic testing, x-ray and lab work performed or referred outside the Physician's office, or for collected lab specimens by the Physician and then sent out, will incur separate fees in addition to this benefit as shown under the Diagnostic Testing, X-ray and Lab Services benefit.	
*Copay applies to all services during an office visit if a Physician is seen.	
**Copay applies to all services and supplies when a Physician is not seen.	
Preventive Services and Routine Care	
Preventive Services per Health Care Reform (PPACA) (includes the office visit and any other eligible item or service billed and received at the same time as any preventive service)	100% (Deductible waived)
Routine Care Not Covered Under the Preventive Services Benefit per Health Care Reform (PPACA)	$30 Copay, then 100% (Deductible waived)
NOTE: Copay is waived for services brought on-site through the Mohave In Motion Wellness Program.	
Radiation Therapy (Outpatient – includes all related charges)	80% after Deductible
Second Surgical Opinion*	100% (Deductible waived)
***NOTE:** When required by the Medical Management Program Administrator.	
Skilled Nursing Facility and Rehabilitation Facility	80% after Deductible
Combined Calendar Year Maximum Benefit	90 days
Sterilization (Elective)*	
Vasectomy	$100 Copay, then 100% (Deductible waived)
Tubal Ligation	80% after Deductible
***NOTE:** Services are in addition to any sterilization not otherwise covered under the Preventive Services benefit.	
Surgery (Inpatient/Outpatient/Ambulatory) (does not include Surgery in the Physician's office)	
Facility	80% after Deductible
Professional Fees	80% after Deductible
Miscellaneous	80% after Deductible
Teladoc Network Providers	
General Medical Consultations Behavioral Health Consultations	100%; Deductible waived 100%; Deductible waived
Telemedicine	100%; Deductible waived (Provider must bill with specific telemedicine codes - no maximums or exclusions applied)
Urgent Care Clinic	$75 Copay*, then 100% (Deductible waived)
*Copay applies per visit regardless of what services are rendered.	
All Other Eligible Medical Expenses	80% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – EPO PLAN

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Pharmacy.	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Copays and Coinsurance – combined with major medical) Single Family	 $6,300 $12,700
Retail Pharmacy: 30-day supply	
Generic Drug	$15 Copay
Preferred Drug	$40 Copay
Non-Preferred Drug	$80 Copay
Preventive Drug Required by Health Care Reform	$0 Copay (100% paid)
Specialty Pharmacy Network	
Specialty Drug (30-day supply)	$100 Copay
Specialty Drug (90-day supply)	$300 Copay
NOTE: Specialty Drugs MUST be obtained from the specialty pharmacy network. Refer to the Prescription Drug Card Program Administrator for full details.	
Access Guidance Services (provided by Navitus): The Plan works with the Access Guidance Services provided by Navitus to obtain copay assistance on your behalf. Coverage determinations for your requested drug must be directed to them. They may be contacted at (866) 333-2757 and will be able to address your questions. See section below for more information regarding this program.	
Retail Pharmacy: 90-day supply	
Generic Drug	$30 Copay
Preferred Drug	$100 Copay
Non-Preferred Drug	$240 Copay
Preventive Drug Required by Health Care Reform	$0 Copay (100% paid)
Mail Order Pharmacy: 90-day supply	
Generic Drug	$45 Copay
Preferred Drug	$120 Copay
Non-Preferred Drug	$240 Copay
Preventive Drug Required by Health Care Reform	$0 Copay (100% paid)
Proton Pump Inhibitors (i.e. Nexium, Prevacid, etc.)	50% Copay

Dispense as Written

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Access Guidance Services (provided by Navitus)
The Plan works with the Access Guidance Services to obtain copay assistance on your behalf. This program applies to certain drugs that have manufacturer-funded copay assistance programs available.

Under the Access Guidance Services, if the drug has copay assistance available, the amount you pay for select medications may be set to the maximum of the current benefit design, $0, or the amount determined by the manufacturer-funded copay assistance programs. To take advantage of this pricing, you will be required to remain enrolled in Navitus' program for obtaining manufacturer assistance, including copay assistance. Amounts paid by manufacturers on your behalf (along with other payments from manufacturers, such as manufacturer coupons) will not count toward your Out-of-Pocket Maximum or Deductible. Instead, only those payments made directly by you will count toward your Out-of-Pocket Maximum or Deductible. Once manufacturer-funded copay assistance is exhausted, the amount you pay will be no more than your benefit design.

Your Copay will default to the formulary's current tiered Copay if a drug does not qualify or is removed from the program.

Specialty Pharmacy Network
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained from the specialty pharmacy network. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

MEDICAL SCHEDULE OF BENEFITS – HDHP PLAN

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
LIFETIME MAXIMUM BENEFIT	Unlimited
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited
CALENDAR YEAR DEDUCTIBLE/OUT-OF-POCKET MAXIMUM (combined with Prescription Drug Card)	
Single Family	$3,250 $6,500
MEDICAL BENEFITS	
Allergy Services	100% after Deductible
Ambulance Services	100% after Deductible
NOTE: Non-Participating Providers are paid at Participating Provider level of benefits for Emergency Services.	
Anesthesiologist	100% after Deductible
Cardiac Rehabilitation	100% after Deductible
Chemotherapy (Outpatient – includes all related charges)	100% after Deductible
Chiropractic Care/Spinal Manipulation (including maintenance)	100% after Deductible
Calendar Year Maximum Benefit	30 visits
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	100% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	100% after Deductible
Durable Medical Equipment (DME)	100% after Deductible
Emergency Services – Emergency Medical Condition	100% after Deductible
Emergency Room Services – Non-Emergency Medical Condition	Not Covered
Hemodialysis/Peritoneal Dialysis (Outpatient)	100% after Deductible
Hinge Health Program	There is no cost to the member for this program
NOTE: Please refer to the Hinge Health Program section of this Plan for a more detailed description of this benefit. If treatment is received from providers outside of the Hinge Health Network, standard Plan benefits will apply as outlined in the Medical Schedule of Benefits.	
Home Health Care	100% after Deductible
Hospice Care	100% after Deductible
Maximum Benefit	100 days per period of Hospice care

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Hospital Services or Long-Term Acute Care Facility/Hospital (facility charges)	
Inpatient	100% after Deductible
Room and Board Allowance*	*Semi-Private Room rate
Intensive Care Unit	ICU/CCU Room rate
Miscellaneous Service and Supplies	100% after Deductible
Outpatient	100% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.	
Maternity (non-facility charges)*	
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100% (Deductible waived)
Lactation Consultations	100% (Deductible waived)**
All Other Prenatal and Postnatal Care	100% after Deductible
Delivery	100% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.	
** Non-Participating Provider will be paid at the Participating Provider level of benefits but may be subject to balance billing for charges over Usual and Customary amounts.	
Medical and Surgical Supplies	100% after Deductible
Mental Disorders and Substance Use Disorders	
Inpatient	100% after Deductible
Outpatient	100% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.	
Outpatient Therapies (physical, speech/hearing, occupational)	100% after Deductible
Combined Calendar Year Maximum Benefit	40 visits
Physician's Services	
Inpatient/Outpatient Services	100% after Deductible
Office Visits/Office Surgery	100% after Deductible
All Other Items and Services	100% after Deductible
Preventive Services and Routine Care	
Preventive Services per Health Care Reform (PPACA) (includes the office visit and any other eligible item or service billed and received at the same time as any preventive service)	100% (Deductible waived)
Routine Care Not Covered Under the Preventive Services Benefit per Health Care Reform (PPACA)	100% (Deductible waived)
NOTE: Services brought on-site through the Mohave In Motion Wellness Program are also covered at 100% (Deductible waived).	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Radiation Therapy (Outpatient – includes all related charges)	100% after Deductible
Second Surgical Opinion*	100% (Deductible waived)
***NOTE:** When required by the Medical Management Program Administrator.	
Skilled Nursing Facility and Rehabilitation Facility	100% after Deductible
Combined Calendar Year Maximum Benefit	90 days
Sterilization (Elective)*	
Vasectomy	100% after Deductible
Tubal Ligation	100% after Deductible
***NOTE:** Services are in addition to any sterilization not otherwise covered under the Preventive Services benefit.	
Surgery (Inpatient/Outpatient/Ambulatory) (does not include Surgery in the Physician's office)	
Facility	100% after Deductible
Professional Fees	100% after Deductible
Miscellaneous	100% after Deductible
Teladoc Network Providers	
General Medical Consultations Behavioral Health Consultations	100%; Deductible waived 100%; Deductible waived
Telemedicine	100%; Deductible waived (Provider must bill with specific telemedicine codes - no maximums or exclusions applied)
Urgent Care Clinic	100% after Deductible
All Other Eligible Medical Expenses	100% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – HDHP PLAN

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Pharmacy.	
CALENDAR YEAR DEDUCTIBLE (combined with major medical Deductible)	
Single	$3,250
Family	$6,500
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible – combined with major medical Out-of-Pocket)	
Single	$3,250
Family	$6,500
Retail Pharmacy: 30-day supply	
Generic Drug	100% after Deductible
Preferred Drug	100% after Deductible
Non-Preferred Drug	100% after Deductible
Preventive Drug Required by Health Care Reform	100% (Deductible waived)
Specialty Pharmacy Network	
Specialty Drug	100% after Deductible
NOTE: Specialty Drugs MUST be obtained from the specialty pharmacy network. Refer to the Prescription Drug Card Program Administrator for full details.	
Retail Pharmacy: 90-day supply	
Generic Drug	100% after Deductible
Preferred Drug	100% after Deductible
Non-Preferred Drug	100% after Deductible
Preventive Drug Required by Health Care Reform	100% (Deductible waived)
Mail Order Pharmacy: 90-day supply	
Generic Drug	100% after Deductible
Preferred Drug	100% after Deductible
Non-Preferred Drug	100% after Deductible
Preventive Drug Required by Health Care Reform	100% (Deductible waived)
Proton Pump Inhibitors (i.e. Nexium, Prevacid, etc.)	100% after Deductible

Dispense as Written
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Specialty Pharmacy Network
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained from the specialty pharmacy network. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

ELIGIBILITY FOR PARTICIPATION

Employee Eligibility
All active Employees of the Employer and Elected/Appointed Officials of Mohave County are eligible in accordance with the established policy of Mohave County provided they work at least 30 or more Hours of Service per week on a regular basis at their customary place of employment and perform all of the duties of their employment. Participation in the Plan will begin on the first day of the month following 30 days of employment provided all required election and enrollment forms are properly submitted.

You are not eligible to participate in the Plan if you are a Part-Time, temporary, leased or Seasonal Employee, an independent contractor or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency) or a person covered by a collective bargaining agreement that does not provide for participation in this Plan.

Determining Full-Time Employee Status for Ongoing Employees
In determining whether an Ongoing Employee is classified as a Full-Time Employee the Employer has set forth a Standard Measurement Period of 12 months followed by a Standard Stability Period of 12 months. If during the Standard Measurement Period, the Ongoing Employee is determined to be a Full-Time Employee, the Plan will have a 77 day Administrative Period to notify the Employee of his or her eligibility (and the eligibility of the Employee's eligible Dependents) to enroll in the Plan and to complete the enrollment process. An Employee who has been determined to be a Full-Time Employee during his or her Measurement Period will be offered single or family coverage, as applicable, that is effective as of the first day of the Employee's Stability Period

Determining Full-Time Employee Status for New Variable Hour or Part-Time Employees
In determining whether a new Variable Hour or Part-Time Employee will be considered as a Full-Time Employee during the Initial Stability Period, the Employer has set forth an Initial Measurement Period of 12 months followed by an Initial Stability Period of 12 months. If during the Initial Measurement Period, the Employee is determined to be a Full-Time Employee, the Plan will have a 30 day Administrative Period to notify the Employee of his or her eligibility to enroll in the plan and to complete the enrollment process (and the eligibility of the Employee's eligible Dependents).

An Employee who has been determined to be a Full-Time Employee during his or her Measurement Period will be offered single or family coverage, as applicable, that is effective as of the first day of the Employee's Stability Period. Notwithstanding any other provision to the contrary, the combined length of the Initial Measurement Period and the Administrative Period for a New Employee who is a Part-Time or Variable Hour Employee may not extend beyond the last day of the first calendar month beginning on or after the first anniversary of the date the Employee completes at least one Hour of Service with the Employer.

Material Change in Position or Employment Status for New Variable Hour or Part-Time Employee
An Employee who, during his or her Initial Measurement Period, experiences a material change in position or employment status that results in the Employee becoming reasonably expected to work at least 30 Hours of Service per week for the Employer will be treated as a Full-Time Employee to whom coverage under the Plan will be offered to the Employee and his or her eligible Dependents beginning on the earlier of:

(1) The fourth full calendar month following the change in employment status; or

(2) The first day of the Initial Stability Period (but only if the Employee averaged at least 30 Hours of Service per week during the Initial Measurement Period).

Dependent Eligibility
Your Dependents are eligible for participation in this Plan provided he/she is:

(1) Your lawful Spouse.

(2) Your Child until the end of the month in which he/she attains age 26.

(3) Your Child age 26 or older, who is unable to be self-supporting by reason of mental or physical disability, provided the Child suffered such disability prior to the end of the month in which he/she attained age 26. Your Child must be unmarried, primarily dependent upon you for support, reside with you and not eligible for any other coverage (other than Medicaid or Medicare). The Plan Sponsor shall require initial proof of your Child's disability and dependency, including a Physician's statement certifying your Child's physical or mental disability. The Plan Sponsor shall require subsequent proof of your Child's continuing disability and dependency no less frequently than one time per Plan Year. The Physician must be a licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Licensed Consulting Psychologist or Licensed Psychologist.

(4) A child for whom you are required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Plan Administrator at no cost.

You must submit the appropriate election and enrollment forms with the appropriate documents to substantiate eligibility, including but not limited to, marriage certificate, birth certificate showing the Employee or Employee's Spouse as parent, court documentation proving legal guardianship, adoption or a foster relationship, or divorce decree showing a medical benefits order to the Plan Administrator within 31 days after the Status Change Event. Coverage under the Plan will become effective on the first day of the month you submit the appropriate election and enrollment forms to the Plan Administrator.

In regards to a divorce, an ex-Spouse no longer meets the definition of a Dependent and no coverage is eligible. If the Plan is not notified within 31 days, as soon as the Plan becomes aware:

(1) The ex-Spouse will be retroactively cancelled back to the original effective date of the divorce;

(2) The right to continuation coverage will be considered forfeited; and

(3) Based on the requirement of Section 125 applicable premiums will continue until the next open enrollment period or qualifying event.

The below terms have the following meanings:

"Child" means your natural born son, daughter, stepson, stepdaughter, legally adopted Child (or a Child placed with you in anticipation of adoption), Eligible Foster Child or a Child for whom you are the Legal Guardian. Coverage for an Eligible Foster Child or a Child for whom you are the Legal Guardian will remain in effect until such Child no longer meets the age requirements of an eligible Dependent under the terms of the Plan, regardless of whether or not such Child has attained age 18 (or any other applicable age of emancipation of minors).

"Child placed with you in anticipation of adoption" means a Child that you intend to adopt, whether or not the adoption has become final, who would otherwise be eligible for enrollment if the Child was your natural born Child. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the Child in anticipation of adoption of the Child. The Child must be available for adoption and the legal process must have commenced.

"Eligible Foster Child" shall mean an individual who is placed with you by an authorized placement agency.

"Legal Guardian" means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual that is placed with such person by judgment, decree or other order of any court of competent jurisdiction.

"Spouse" means any person recognized as the covered Employee's husband or wife under the laws of the state where you live. Specifically excluded from this definition is a spouse by reason of common law marriage, whether or not permitted in your State.

The Plan Administrator may require documentation proving Dependent eligibility under the Plan.

When you and your Dependents are Covered Employees

When both you and your Spouse and/or Child are covered Employees, each of you must choose coverage as either an Employee or as a Dependent of an Employee. You may not be covered under this Plan as both an Employee and a Dependent. Eligible Dependent Children of 2 covered Members may be enrolled by either parent, but may not be enrolled as Dependents of both Members.

Court Ordered Coverage for a Child
Federal law requires the Plan, under certain circumstances, to provide coverage for your Children. The details of these requirements are summarized below.

The Plan Administrator shall enroll for immediate coverage under this Plan any Child, who is the subject of a "qualified medical child support order" ("QMCSO"). If you are ordered to provide such coverage for a Child and you are not enrolled in the Plan at the time the Plan Administrator receives a QMCSO, the Plan Administrator shall also enroll you for immediate coverage under this Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Plan Administrator determines that the order is a QMCSO. Any required contribution for coverage pursuant to this section will be deducted from your pay in accordance with the Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your Child and includes certain information concerning such coverage. The Plan Administrator will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO's, no Child is eligible for Plan coverage, even if you are required to provide coverage for that Child under the terms of a separation agreement or court order, unless the Child is an eligible Child under this Plan. Procedures for determining a QMCSO may be obtained, free of charge, by contacting the Plan Administrator.

Timely Enrollment
Once you are eligible to participate in the Plan, you must enroll for coverage by completing all election and enrollment forms and submitting them to your Benefits Department within 31 days of the effective date of coverage. In addition, as part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your Dependents. The Benefits Department may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.

If you fail to complete and submit the appropriate election and enrollment forms within the 31-day period described above, you will not be eligible to enroll in the Plan until the next open enrollment period or unless you experience a Special Enrollment Event or a Status Change Event.

Open Enrollment Period
You and your Dependents may enroll for coverage during the Plan's open enrollment period, designated by the Plan Sponsor and communicated to you prior to such open enrollment period. During this time you will be permitted to make changes to any existing benefit elections. Benefit elections made during the open enrollment period will be effective as of July 1 and will remain in effect until the next open enrollment period unless you experience or your Dependent experiences a Special Enrollment Event or Status Change Event.

Late Enrollment
If you did not enroll during your original 31-day eligibility period you may do so by making written application to the Benefits Department during the annual open enrollment period (refer to annual open enrollment period section above). In these circumstances, you and/or your eligible Dependents will be considered Late Enrollees.

Special Enrollment Event
A special enrollment event occurs when you or your Dependents suffer a loss of other health care coverage, when you become eligible for a state premium assistance subsidy or acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption. In these circumstances, you and/or your eligible Dependents will be considered Special Enrollees.

Each special enrollment event is more fully described below:

(1) **Loss of Other Coverage (other than under Medicaid or SCHIP).** If you declined enrollment for yourself or your Dependents (including your Spouse) because you or your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or of a tribal organization), you may enroll for coverage for yourself and/or your Dependents under this Plan if the other health coverage is lost as a result of one of the following:

    (a) The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted;

(b) Loss of eligibility under the other health coverage for reasons other than non-payment of the required contribution or premium, making a fraudulent claim or intentional misrepresentation of a material fact in connection with the other plan; or

(c) Employer contributions cease for the other health coverage.

If you are already enrolled in a benefit option available under the Plan and your Dependent lost his or her other health coverage, you may enroll in a different benefit option available under the Plan due to the special enrollment event of your Dependent.

You must submit the appropriate election and enrollment forms to the Benefits Department within 31 days after the date the other health coverage was lost. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to the Benefits Department.

(2) **Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy.** If you or your Dependents did not enroll in the Plan when initially eligible because you and/or your Dependents were covered under Medicaid or a state sponsored Children's Health Insurance Program (SCHIP) and your coverage involuntarily terminates or you or your Dependents become eligible for a state premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under this Plan for yourself and your Dependents after Medicaid or SCHIP coverage terminates or after you or your Dependents' eligibility for a state assistance subsidy under Medicaid or SCHIP is determined.

You must submit the appropriate election and enrollment forms to the Benefits Department within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after eligibility for a state premium assistance subsidy under Medicaid or SCHIP is determined. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to the Benefits Department.

(3) **Acquisition of a New Dependent.** If you acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll for coverage under this Plan for yourself and your Dependents. You must submit the appropriate election and enrollment forms to your Benefits Department within 31 days after the date you acquire such Dependent.

(a) Coverage becomes effective for a Dependent Child who is born after the date your coverage becomes effective as of such Child's date of birth provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 31 days after the Child's birth. Failure to enroll in the Plan, if required, within the 31 day described above will result in no coverage under the Plan. If coverage for the Child does not fall on the first of the month, contributions will not increase until the first of the following month.

(b) Coverage for a newly acquired Dependent due to marriage will be effective on the date of marriage provided you complete and submit the required election and enrollment forms within 31 days after your date of marriage. Failure to enroll in the Plan within the 31-day period described above will result in no coverage under the Plan. If coverage for the spouse does not fall on the first of the month, contributions will not increase until the first of the following month.

(c) Coverage for a newly acquired Dependent due to adoption (or placement with you in anticipation of adoption) will be effective as of the date of adoption (or placement in anticipation of adoption) provided you complete and submit the required election and enrollment forms within 31 days after adoption or placement in anticipation of adoption, as applicable. Failure to enroll in the Plan within the 31-day period described above will result in no coverage under the Plan. If coverage for the Child does not fall on the first of the month, contributions will not increase until the first of the following month.

Status Change Event

Generally your election under the Plan will remain in effect for the entire Plan Year unless you experience a Special Enrollment Event (described above) or a Status Change Event. If a Status Change Event occurs you may make a new election under the Plan provided your new election is consistent with the Status Change Event. A Status Change Event includes the following:

(1) A change in your legal marital status, including divorce, legal separation or annulment;

(2) The death of your Spouse or Dependent Child;

(3) Termination or commencement of employment by you, your Spouse or your Dependent Child that results in the gain or loss of eligibility under the Plan or another employer-sponsored benefit plan;

(4) A reduction or increase in your hours of employment or those of your Spouse or your Dependent Child, including a switch from part-time to full-time or commencement or return from an unpaid leave of absence, resulting in the gain or loss of eligibility under the Plan or another employer-sponsored benefit plan;

(5) A change due to your Dependent Child satisfying or ceasing to satisfy the requirements for Dependents under the Plan;

(6) A change in the place of residence or work of you, your Spouse or your Dependent Child resulting in the ability/inability to access the service of Participating Providers;

(7) Entitlement to or loss of entitlement to Medicare or Medicaid by you, your Spouse or your Dependent Child;

(8) Receipt of a Qualified Medical Child Support Order ("QMCSO") which requires that you provide the child named in the Order with health care coverage under the Plan. If the required coverage is different from your current coverage under the Plan, you may change your election accordingly;

(9) A change due to you, your Spouse or your Dependent Child gaining coverage under another employer's plan;

(10) A significant increase in the cost of your coverage under the Plan during the Plan Year. If the cost of your coverage under the Plan significantly increases during the Plan Year, you may choose one of the following options: (a) maintain existing coverage and agree to pay the increased cost; (b) revoke your existing election and elect similar coverage under another Plan option (if any); or (c) drop coverage under the Plan, but only if there is no similar option available under the Plan;

(11) Addition or significant improvement of a Plan option. If the Plan adds a new option or significantly improves an existing option, you may revoke your existing election and elect coverage under the new option. Any eligible Employee, regardless of whether or not he/she elected coverage under the Plan previously, may elect coverage under any new option or significantly improved option for himself or herself and any eligible Dependents;

(12) Significant Curtailment of Coverage without Loss. If your coverage under the Plan is significantly curtailed without a loss of coverage (for example, a significant increase in the Out-of-Pocket maximum you are required to pay), you may revoke your existing election under the Plan and elect coverage under a similar Plan option, if any. If no similar option is available, then you must maintain your existing election until the end of the current Plan Year;

(13) Significant Curtailment of Coverage with Loss. If your coverage under the Plan is significantly curtailed with a loss of coverage (for example, elimination of a benefit option under the Plan), then you may either revoke your existing election under the Plan and elect coverage under a similar Plan option (if any) or drop your existing coverage provided there is no similar Plan option available; and

(14) Change in Election under another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including another plan maintained by the Employer or a plan maintained by the employer of your Spouse or Dependent Child) provided the election change satisfied the regulations under Code Section 125 regarding permitted election changes or the election is for a period of coverage under the plan maintained by the other employer which does not correspond to the Plan Year of this Plan.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 31 days after the Status Change Event. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to the Plan Administrator.

In regards to a Status Change Event where eligibility is lost such as a divorce, death, or the loss of eligibility by a Dependent Child, if the Plan is not notified within 31 days of the Status Change Event, as soon as the Plan is notified or becomes aware of the loss of eligibility, the following will occur:

(1) Coverage for the affected Dependent will be cancelled as of the end of the month following the Status Change Event;

(2) Benefits paid by the Plan, if any, for services received after the Status Change Event will be recouped from the patient, the Employee or the Provider of Service;

(3) The right to be offered continuation of coverage under COBRA may be forfeited; and

(4) Based on the requirements of Section 125 applicable Dependent premiums may continue until the next open enrollment period, or eligible Status Change Event.

TERMINATION OF COVERAGE

Termination of Employee Coverage
Coverage under the Plan will terminate on the earliest of the following dates:

(1) The date the Plan terminates, in whole or in part;

(2) If you fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;

(3) The end of the month you report to active duty military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained below;

(4) The end of the month you cease to be eligible for coverage under the Plan;

(5) The end of the month you terminate employment or cease to be included in an eligible class of Employees;

(6) The end of the month you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud; and

(7) The end of the month you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact.

(8) The end of the month the Covered Employee or elected/appointed official voluntarily elects to be terminated from the Plan due to a qualifying event.

(9) If an Employee becomes ineligible for coverage under the Plan due to a reduction in work-hours below the minimum number of hours an Employee is required to work per week to be eligible to enroll in coverage, the Employee's coverage will terminate upon the start of the next Stability Period.

Termination of Dependent Coverage
Coverage under the Plan will terminate on the earliest of the following dates:

(1) The date the Plan terminates, in whole or in part;

(2) The end of the month the Plan discontinues coverage for Dependents;

(3) The end of the month your Dependent becomes covered as an Employee under the Plan;

(4) The end of the month coverage terminates for the Employee;

(5) If you and/or your Dependents fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;

(6) The end of the month the Dependent Spouse reports to active duty military service;

(7) The end of the month in which a Dependent ceases to be a Dependent as defined by the Plan;

(8) The end of the month your Dependent (or any person seeking coverage on behalf of your Dependent) performs an act, practice or omission that constitutes fraud; and

(9) The end of the month your Dependent (or any person seeking coverage on behalf of your Dependent) makes an intentional misrepresentation of a material fact.

Retroactive Termination of Coverage
Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

Rehire Provision – Affordable Care Act
After you become covered under the Plan, if your employment ends and you are rehired by the Employer within 13 weeks after your termination date for purposes of the Affordable Care Act, your coverage will take effect on the first day you report for employment with the Employer. The Waiting Period will be waived.

If your coverage resumes within the same Calendar Year, the Plan will consider coverage continuously in force for purposes of applying the Deductible, Out-of-Pocket Maximum, and Plan maximums.

If you were not covered under the Plan on the date of your termination or you are rehired by the Employer more than 13 weeks after your termination date, you will be treated as a new Employee and will be required to satisfy the Waiting Period.

Continuation of Coverage under the Family and Medical Leave Act (FMLA)
The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA), as amended and as promulgated in regulations issued by the Department of Labor.

During any leave taken under the FMLA, you may maintain coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during the leave period. Failure to make required payments within 30 days of the due date established by the Employer will result in the termination of coverage for you and/or your eligible Dependents.

If you fail to return to work after the FMLA leave, the Employer may have the right to recover its contributions toward the cost of coverage during the FMLA leave.

If coverage under the Plan terminates during the FMLA leave, coverage will be reinstated for you and/or your covered Dependents if you return to work at the end of the FMLA leave.

Continuation of Coverage under USERRA
You may elect to continue Plan coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if you are absent from work due to military service in the Uniformed Services (as defined under USERRA). You may elect to continue coverage for yourself and any of your Dependents that were covered under the Plan at the time of your leave. Your eligible Dependents do not have an independent right to elect coverage under USERRA; therefore unless you elect to continue coverage on their behalf, your eligible Dependents will not be permitted to continue coverage under USERRA separately.

To elect coverage under USERRA, you must submit your election to continue coverage under USERRA, on a form prescribed by the Plan Administrator to your Benefits Department within 60 days after the date of your leave. Coverage under the Plan will become effective as of the date of your leave and will continue for the lesser of (a) 24 months (beginning on the date your absence begins); or (b) the period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA.

If your leave is 31 days or more, you will be required to pay up to 102% of the full contribution under the Plan. If your leave is 30 days or less, you will not be required to pay more than the amount (if any) you would have paid had you remained an active Employee of the Employer. The Employer will notify you of the procedures for making payments under this Plan.

Continuation coverage provided under USERRA counts towards the maximum coverage period under COBRA continuation coverage.

An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No Waiting Period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the Waiting Period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

Continuation of Coverage for Certain Public Safety Employees
Pursuant to Arizona Revised Statute § 38-961, eligible Public Safety Employees who are injured while on duty, to the extent that they cannot perform the functions of their position, may be eligible to continue their coverage under this Plan under the same conditions and with the same coverage as an actively-at-work Employee. The Public Safety Employee must be receiving Workers' Compensation benefits and meet established injury standards as determined by the Employer. Continuation of coverage will be offered for a 6 month period. The Employer and employee obligations under this continuation of coverage are governed by, and interpreted according to, Arizona Revised Statute § 38-961. For specific information on this coverage option contact your Employer's Benefits Department.

Special Eligibility for Surviving Spouses and Surviving Unmarried Dependents of Certain Law Enforcement Officers
Pursuant to Arizona Revised Statute § 38-1114(B) and § 38-1141(B), certain Surviving Spouses and Unmarried Dependents of Law Enforcement Officers, as defined in Arizona Revised Statute § 38-1114(G)(1) and § 38-1141(G)(1), who were killed in the line of duty, or who died from injuries suffered in the line of duty, and who were enrolled in a Health Insurance Program defined in Arizona Revised Statute § 38-1114(B) and § 38-1141(B) at the time the Law Enforcement Officer was killed in the line of duty or died from injuries suffered in the line of duty, are eligible to continue obtaining, or may be enrolled to obtain, coverage under this Plan. Such eligibility ends for a Surviving Spouse under this section when they remarry, become Medicare eligible or die. Such eligibility ends for a Surviving Unmarried Dependent when they turn 18 years of age, or until they turn 23 years of age if they are a full time student.

The premium payable by the Participating Entity employer of the deceased Law Enforcement Officer is the amount the employer of the deceased Law Enforcement Officer would pay for an active Law Enforcement Officer for a family coverage premium or single coverage premium, whichever is applicable. If the employer currently pays a greater portion of the premium for a Surviving Spouse or a Surviving Dependent than stated above, the Surviving Spouse or Surviving Dependent shall receive the greater amount as payment toward coverage under the Plan.

ELIGIBLE MEDICAL EXPENSES

Eligible expenses shall be the charges actually made for services provided to the Covered Person and will be considered eligible only if the expenses are:

(1) Routine care or preventive services provided such services are ordered and performed by a Physician and not otherwise excluded under the Plan; or

(2) Due to Illness or Injury provided such services are ordered and performed by a Physician, Medically Necessary and not otherwise excluded under the Plan.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted. All eligible expenses Incurred at a Participating Provider will be reimbursed to the provider.

(1) **Allergy Services:** Allergy testing, serum and injections, when rendered by a Physician, or in the Physician's office. Injections of food allergy antigens, sublingual immunotherapy and the like are not considered eligible medical expenses. The allowance for antigens will be based on a 3-month supply. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(2) **Ambulance Service:** Professional ambulance service to transport the Covered Person:

 (a) To the nearest Hospital equipped to treat the specific Illness or Injury in an emergency situation; or

 (b) To another Hospital in the area when the first Hospital did not have services required and/or facilities to treat the Covered Person; or

 (c) To and from a Hospital during a period of Hospital confinement to another facility for special services which are not available at the first Hospital; or

 (d) From the Hospital to the patient's home or to a Skilled Nursing Facility, Rehabilitation Facility or any other type of convalescent facility nearest to the patient's home when there is documentation the patient required ambulance transportation.

 Professional ambulance charges for convenience are not covered.

 Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(3) **Ambulatory Surgical Center:** Services and supplies provided by an Ambulatory Surgical Center. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(4) **Anesthesia:** Charges by a licensed anesthesiologist for the administration of anesthetics, pre- and post-operative visits and the administration of fluids and/or blood incidental to the anesthesia or Surgical Procedure. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(5) **Bariatric Services:** Surgical consultations for Morbid Obesity. Surgical treatment for Morbid Obesity may be considered eligible if the Covered Person meets all of the following criteria and the procedure is performed by Participating Providers (surgeons, assistant surgeons, anesthesiologists etc.) at a Participating Provider facility known to have an effective program for doing such a Surgery and a follow-up program:

 (a) The person has been covered under this Plan for a minimum of 36 months immediately preceding the date of the procedure; and

 (b) The Covered Person is at least 18 years of age, physically mature, and is not older than 65 years of age; and

(c) Two separate Physicians confirm in writing that the Covered Person:

   (i) Is, and has been for 2 or more years prior to the procedure, Morbidly Obese; and

   (ii) Is an acceptable surgical interventional risk (i.e. he/she must otherwise be a good surgical candidate); and

   (iii) Does not have a specifically correctable cause of obesity, such as a glandular or endocrine problem;

(d) The Covered Person provides evidence of Physician documented compliance with a structured, medically guided weight reduction program for at least 6 months prior to the proposed Surgery and the Covered Person has failed to maintain weight loss; and

(e) A licensed psychologist or psychiatrist, a dietitian, an exercise physiologist and a surgeon have confirmed in writing that the Covered Person has met with them and the Covered Person is both physically and mentally prepared to undergo the proposed bariatric Surgery and a structured post-operative exercise, diet and related follow-up program; and

(f) The Covered Person provides written documentation from a licensed psychologist or psychiatrist confirming the absence of a significant psychopathology that may limit the Covered Person's understanding of the procedure, ability to comply with medical/surgical recommendations and post-surgery lifestyle changes necessary for the procedure to be successful.

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

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

(a) A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person;

(b) The Covered Person has a Body Mass Index (BMI) of 40 or more; or

(c) The Covered Person has a Body Mass Index (BMI) of 35 or more and the Covered Person also, at the same time, suffers from 2 or more co-morbid medical conditions such as life-threatening pulmonary problems, severe diabetes, or severe joint disease surgically treatable except for the obesity, but such conditions may be improved by the performance of the bariatric surgery.

The benefits payable for a bariatric Surgery, gastric bypass, or any other type of surgical weight loss procedure are limited that such a Covered Person is only eligible for such benefits one time during the life of the Covered Person, except for lap band fills/adjustments. Lap band fills/adjustments are limited to 5 fills in the first year following the lap band procedure and 2 fills per Plan Year thereafter.

(6) **Blood and Blood Derivatives:** Blood Transfusion services, including the cost of blood and blood products, to the extent they are not replaced or donated through the operation of a blood bank or otherwise.

(7) **Cardiac Rehabilitation:** Cardiac rehabilitation services which are rendered: (a) under the supervision of a Physician; and (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery or any other medical condition if medically appropriate; and (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a medical care facility.

Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(8) **Chemotherapy:** Services and supplies related to chemotherapy. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(9) **Chiropractic Care/Spinal Manipulation:** Charges for chiropractic care / spinal manipulations for the correction of structural imbalance, distortion, misalignment or subluxation of or in the vertebral column, by manual or mechanical means and the necessary adjunctive modalities (hot, cold therapy etc.). Includes x-rays and advanced imaging ordered by a Chiropractor. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(10) **Circumcision:** Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be considered as part of the mother's expenses.

(11) **Cleft Palate and Cleft Lip:** Services and supplies related to cleft palate and cleft lip. Cleft palate is defined as a birth deformity in which the palate (the roof of the mouth) fails to close, and cleft lip is defined as a birth deformity in which the lip fails to close. Eligible expenses include the following when provided by a Physician, or other professional provider:

(a) Oral and facial Surgery, surgical management and follow-up care by plastic surgeons and oral surgeons.

(b) Habilitative speech therapy.

(c) Otolaryngology treatment.

(d) Audiological assessments and treatment.

(e) Orthodontic Treatment.

(f) Prosthodontic treatment.

(g) Prosthetic treatment such as obturators, speech appliances and feeding appliances.

(12) **Cognitive Therapy:** Restorative or rehabilitative cognitive therapy under the recommendation of a Physician.

(13) **Cosmetic Procedures/Reconstructive Surgery:** Cosmetic procedures or Reconstructive Surgery will be considered eligible only under the following circumstances:

(a) Reconstructive surgery is required as the direct result of an Accidental Injury, an infection or disease of the involved part.

(b) For the correction of a Congenital Anomaly for a Dependent Child.

(c) Removal of a non-diseased breast during the same surgical session in which the diseased breast was removed.

(d) Charges for reconstructive breast Surgery following a mastectomy will be eligible as follows:

(i) Reconstruction of the breast on which the mastectomy has been performed;

(ii) Surgery and reconstruction of the other breast to produce symmetrical appearance; and

(iii) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

(e) Charges for prosthesis bras (up to 2 per year) and the related post mastectomy prosthetic devices.

The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the Covered Person.

(14) **Dental Care:** Dental services and x-rays rendered by Dentist or dental surgeon for:

(a) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

(b) Repair due to Accidental Injury to sound natural teeth, including the emergency replacement of sound natural teeth.

(c) Surgery needed to correct Accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

(d) Excision of benign bony growths of the jaw and hard palate.

(e) External incision and drainage of cellulitis.

(f) Incision of sensory sinuses, salivary glands or ducts.

(g) Tissue biopsies.

General anesthesia and Hospital expenses are covered for eligible dental care services that would require the service be performed in a Hospital to monitor the patient due to a serious underlying medical condition, such as heart condition, blood disorder, etc. or; is necessary due to Accidental Injury to sound natural teeth; or your Physician has certified the service cannot be performed in the Dentist's office due to age or condition of the Covered Person.

(15) **Diabetic Education:** The following diabetic education and self-management programs: diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with diabetes.

(16) **Diabetic Supplies:** All Physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes that are not covered under the Prescription Drug Program.

(17) **Diagnostic Testing, X-ray and Laboratory Services:** Diagnostic testing, x-ray and laboratory services, and services of a professional radiologist or pathologist for diagnostic or curative services related to an Illness or Injury, when ordered by a Physician. Dental x-rays are not eligible expenses, except as specified under Dental Care. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(18) **Durable Medical Equipment:** The rental of oxygen, wheelchairs, walkers, special Hospital beds, iron lungs and other Durable Medical Equipment subject to the following:

(a) The equipment must be prescribed by a Physician and Medically Necessary; and

(b) The equipment will be provided on a rental basis; however such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item (oxygen equipment is not limited to the purchase price); and

(c) Benefits will be limited to standard models as determined by the Plan; and

(d) The Plan will pay benefits for only one of the following unless Medically Necessary due to growth of the Covered Person or if changes to the Covered Person's medical condition requires a different product, as determined by the Plan: a manual wheelchair, motorized wheelchair or motorized scooter; and

(e) If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, malicious breakage or gross neglect, as determined by the Plan, are not covered; and

(f) Expenses for the rental or purchase of any type of air conditioner, air purifier or any other device or appliance will not be considered eligible.

(g) Benefits are not available to replace lost or stolen items.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(19) **Emergency Services/Emergency Room:** When you experience an Emergency Medical Condition, coverage for Emergency Services will continue until your condition is Stabilized and:

(a) Your attending Physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider if you need more care; and

(b) You are in a condition to be able to receive from the Non-Participating Provider delivering services the notice and consent criteria with respect to the services; and

(c) Your Non-Participating Provider delivering the services meets the notice and consent criteria with respect to the services.

If you go to an emergency room for what is not an Emergency Medical Condition, the Plan may not cover your expenses. See the Medical Schedule of Benefits and the General Exclusions and Limitations for specific Plan details. If your Physician decides you need to stay in the Hospital (emergency admission) or receive follow-up care, these are not Emergency Services. Different benefits and requirements apply.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(20) **Genetic Testing:** Diagnostic testing of Genetic Information and counseling when Medically Necessary. Genetic testing is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

(21) **Hemodialysis/Peritoneal Dialysis:** Treatment of a kidney disorder by hemodialysis or peritoneal dialysis as an Inpatient in a Hospital or other facility or for expenses in an outpatient facility or in the Covered Person's home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person's home as shown under the Durable Medical Equipment benefit. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(22) **Home Health Care:** Services provided by a Home Health Care Agency to a Covered Person in the home. The following are considered eligible home health care services:

(a) Home nursing care;

(b) Services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.);

(c) Visits provided by a medical social worker (MSW);

(d) Physical, occupational, speech/hearing, or respiratory/pulmonary therapy if provided by the Home Health Care Agency;

(e) Medical supplies, drugs and medications prescribed by a Physician;

(f) Laboratory services; and

(g) Nutritional counseling by a licensed dietician.

In no event will charges for custodial care, the services of a Close Relative, transportation services, housekeeping services and meals, mental health care, or substance abuse or chemical dependency treatment, etc., be considered an eligible expense.

Mileage charges may be eligible if the Covered Person resides in a remote area that does not have a local Home Health Care Agency.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(23) **Hospice Care:** Hospice care on either an Inpatient or outpatient basis for a terminally ill person rendered under a Hospice treatment plan. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of 6 months or less.

Covered services include:

(a) Room and board charges by the Hospice.

(b) Other Medically Necessary services and supplies.

(c) Nursing care by or under the supervision of a registered nurse (R.N.).

(d) Home health care services furnished in the patient's home by a Home Health Care Agency for health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.).

(e) Counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(24) **Hospital Services or Long-Term Acute Care Facility/Hospital:**

(a) Inpatient

Room and board, including all regular daily services in a Hospital or Long-Term Acute Care Facility/Hospital. Care provided in an Intensive Care Unit (including cardiac care (CCU) and burn units).

Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis.

(b) Outpatient

Services and supplies furnished while being treated on an outpatient basis.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(25) **Infertility Testing:** Diagnosis and testing of infertility (the inability to conceive). However, treatment, drugs or procedures for the promotion of conception will not be considered eligible (e.g., invitro fertilization, GIFT, artificial insemination, etc.).

(26) **Infusion Therapy (Outpatient):** Services, supplies and equipment necessary for infusion therapy provided:

(a) By a free-standing facility;

(b) By an outpatient department of a Hospital;

(c) By a Physician in his/her office; or

(d) In your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient infusion therapy services and supplies are Covered Expenses:

(a) The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;

(b) Professional services;

(c) Total parenteral nutrition (TPN);

(d) Chemotherapy;

(e) Drug therapy (includes antibiotic and antivirals);

(f) Pain management (narcotics); and

(g) Hydration therapy (includes fluids, electrolytes and other additives).

(27) **Lenses:** Initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye or for aphakic patients. Soft lenses or sclera shells intended for use as corneal bandages.

(28) **Maternity:** Expenses Incurred by all Covered Persons provided coverage is in effect at the time the actual charges are Incurred (i.e. at time of delivery) for:

(a) Pregnancy.

(b) Preventive prenatal and breastfeeding support as identified under the preventive services section below.

(c) Services provided by a Birthing Center (Hospital based or freestanding).

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

(e) Amniocentesis test(s).

(f) Up to one ultrasound per pregnancy (more than one only when it is determined to be Medically Necessary).

(g) Routine lab work.

(h) When not prohibited by state or local laws, medically required elective induced abortions only when carrying the fetus to full term would seriously endanger the life of the mother. If complications arise after the performance of any abortion for any Covered Person, any expenses Incurred to treat those complications will be eligible, whether the abortion was eligible or not.

Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission, unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified or a penalty may be applied.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(29) **Medical and Surgical Supplies:** Casts, splints, trusses, braces, crutches, orthotics, dressings and other Medically Necessary supplies ordered by a Physician. Charges for the following non-durable (disposable) supplies are eligible: a) sterile surgical supplies required following a covered Surgery; b) supplies required to operate/use Durable Medical Equipment or corrective appliances; c) supplies required for use by skilled home health or home infusion personnel, only for the duration of their services; d) anti-embolism garments (e.g., prescribed compression garments) up to 3 per Calendar Year.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(30) **Mental Disorders:** Covered charges for care, supplies and treatment of a Mental Disorder including, but not limited to treatment for autism, ADD and ADHD. Marital and relationship counseling. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(31) **Nutritional Counseling:** Services related to nutritional counseling for medical and mental health conditions (e.g., eating disorders such as bulimia and anorexia, diabetes mellitus, gastro-intestinal disorders, chronic obstructive pulmonary disease), in which dietary adjustment has a therapeutic role, when furnished by a provider (e.g., licensed nutritionist, registered dietician, or other qualified licensed health professionals such as nurses who are trained in nutrition) recognized under the Plan. Medically Necessary nutritional counseling is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

(32) **Nutritional Supplements:** Physician-prescribed nutritional supplements or other enteral supplementation necessary to sustain life for Covered Persons who are or will become malnourished or suffer from disorders, which left untreated will cause chronic disability or intellectual disability. Covered Expenses include rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation, and special dietary treatment when prescribed by a Physician for Covered Persons with inherited metabolic diseases, such as phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(33) **Occupational Therapy:** Rehabilitative occupational therapy (for short term progressive rehabilitation therapy) rendered by a qualified Physician or a licensed occupational therapist under the recommendation of a Physician for the area of the body that is within the scope of his/her license. Expenses for Maintenance Therapy or therapy primarily for recreational or social interaction will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(34) **Off-Label Drug Use:** Services and supplies related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

(a) The named drug is not specifically excluded under the General Exclusions and Limitations section of the Plan; and

(b) The named drug has been approved by the FDA; and

(c) The Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and

(d) If the drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information or NCCN Drugs and Biologics Compendium recognize it as an appropriate treatment for that form of cancer.

(34) **Physical Therapy:** Physical therapy rendered by a qualified Physician or a licensed physical therapist under the recommendation of a Physician for the area of the body that is within the scope of his/her license. Maintenance Therapy will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(35) **Physician's Services:** Services of a Physician for medical care or Surgery.

(a) Covered charges include services performed in a Physician's office on the same day for the same or related diagnosis. Services include, but are not limited to: examinations, x-ray and laboratory tests (including the reading or processing of the tests), supplies, injections, allergy shots, cast application and minor Surgery.

(b) For multiple or bilateral surgeries performed during the same operative session which are not incidental or not part of some other procedure and which add significant time or complexity (all as determined by the Plan) to the complete procedure, the charge considered will be: (i) 100% for the primary procedure; (ii) 50% for the secondary procedure, including any bilateral procedure; and (iii) 50% for each additional covered procedure. This applies to all Surgical Procedures, except as determined by the Plan.

(c) Charges for an assistant surgeon will be considered eligible expenses when medically required. If the assistant surgeon is a Participating Provider, the eligible charge amount will be 20% of the surgical allowance of that assistant surgeon's Participating Provider contract. If the assistant surgeon is a Non-Participating Provider and the assistant surgeon is an MD or DO Physician, the eligible charge amount will be up to 25% of the amount allowed for the surgeon. If the surgical assistant is a Non-Participating Registered Nurse First Assistant (RNFA), Certified Surgical Assistant (CSA), or Physician's Assistant (PA), the eligible charge will be up to 15% of the amount allowed for the surgeon. The services of a standby surgeon will only be covered when: a) a clear Medical Necessity exists, and b) the standby surgeon is gowned, scrubbed, and physically present in the surgical suite.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(36) **Podiatry:** Treatment for the following foot conditions: (a) bunions, when an open cutting operation is performed; (b) non-routine treatment of corns or calluses; (c) toenails when at least part of the nail root is removed or treatment of ingrown toenails; (d) any Medically Necessary Surgical Procedure required for a foot condition. In addition, orthopedic shoes will also be covered, as well as the initial purchase, fitting and repair of custom-fitted foot orthotics when determined to be Medically Necessary by the attending Physician are covered by the Plan. Foot orthotics and/or orthopedic shoes are limited to once every 12 months if over age 19, or once every 6 months if under age 19 as necessitated by growth.

(37) **Pre-Admission Testing:** Outpatient pre-admission testing performed prior to a scheduled Inpatient hospitalization or Surgery.

(38) **Prescription Drugs:** Prescription Drugs, injectables or supplies used for the treatment of a covered Illness or Injury, which are dispensed through the Physician's office, infusion center or other clinical setting, the Covered Person's home by a third party, or take-home Prescription Drugs from a Hospital are covered under the major medical benefits of this Plan and separate from the Prescription Drug Card Program benefits. Benefits will be paid the same as "All Other Eligible Expenses" listed in the Medical Schedule of Benefits.

Your Prescription Drug Card Program Administrator may have certain provisions regarding Specialty Drug coverage. In those cases, those drugs will only be payable under the major medical benefits if those drugs fall outside any specialty pharmacy network requirements, as applicable (as noted in the Prescription Drug Card Program section).

(39) **Preventive Services and Routine Care:** The following preventive services and routine care are paid as shown in the Medical Schedule of Benefits:

(a) Preventive Services

(i) Evidence-Based Preventive Services

Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (the "Task Force") with respect to the individual involved, except that with respect to breast cancer screening, mammography and prevention of breast cancer, the recommendations of the Task Force issued in 2016 will be considered the current recommendations until further guidance is issued by the Task Force or the Health Resources and Services Administration.

(ii) Routine Vaccines

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

(iii) Prevention for Children

With Respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

(iv) Prevention for Women

With respect to women, such additional preventive care and screenings, not otherwise addressed by the Task Force, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and published on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services). Those guidelines generally include the following:

(A) Well-woman visits. Well-woman preventive care visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The inclusion of a well-woman visit is not meant to limit the coverage for any other preventive service described elsewhere in this Plan document that might be administered as part of the well-woman visit.

Coverage for prenatal care is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman. In the event a provider bills a "maternity global rate", the portion of the claim that will be considered for prenatal visits and therefore, preventive care, is 40% of the "maternity global rate". As a result, 60% of the "maternity global rate" will be considered for delivery and postnatal care and the normal cost-sharing provisions would apply. Items not considered preventive (and therefore subject to normal cost-sharing provisions) include Inpatient admissions, high risk specialist units, ultrasounds, amniocentesis, fetal stress tests, delivery including anesthesia and certain pregnancy diagnostic lab tests.

(B) Screening for gestational diabetes.

(C) Human papillomavirus (HPV) testing. High-risk HPV DNA testing in women with normal cytology results. Screening is limited to women age 30 or older and is limited to 1 screening every 3 Calendar Years.

(D) Counseling annually for sexually transmitted infections (including for the human immunodeficiency virus (HIV)) and screening annually for HIV for all sexually active women. Limited to 2 counseling sessions per Calendar Year.

(E) Screening and counseling annually for interpersonal and domestic violence.

(F) Contraceptive methods and counseling, as prescribed by your Physician. All FDA approved contraceptive methods (see Preventive Drugs section below), sterilization procedures and patient education and counseling for women with reproductive capacity. Contraceptive counseling is limited to 2 visits per 12-month period.

For purposes of the above, the sterilization procedures to be considered preventive include any FDA approved sterilization implants and surgical sterilization either abdominally, vaginally or laparoscopically. Eligible charges for a sterilization procedure and all ancillary services will be covered when sterilization is the primary purpose of the services provided and/or if it is performed as a standalone procedure and billed as such. However, complications arising following a sterilization procedure are not covered as preventive services. Covered Expenses do not include charges for a sterilization procedure to the extent the procedure was not billed separately by the provider or because it was not the primary purpose of the procedure. To the extent sterilization is part of another procedure and/or is not a separate line on the bill, the sterilization procedure is not a Covered Expense.

(G) Breastfeeding support, supplies and counseling in conjunction with each birth, including the following:

(1) Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postnatal period (60 days from baby's date of birth). Lactation consultation is limited to 6 cumulative visits per 12-month period.

(2) Breastfeeding equipment will be covered, subject to the following:

(i) Rental of a Hospital grade electric pump while the baby is Hospital confined; and

(ii) Breastfeeding equipment and supplies including, but not limited to, double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies if requested during pregnancy or during the duration of breastfeeding, provided the Covered Person remains continuously enrolled in the Plan.

(3) For women using a breast pump from a prior pregnancy, 1 new set of breast pump supplies will be covered at 100% with each subsequent pregnancy for initiation or continuation of breastfeeding.

For a detailed listing of women's preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.hrsa.gov/womens-guidelines. For a paper copy, please

contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services), the above shall be deemed to be amended to cover such preventive services to the extent required by such guidelines.

(v) Preventive Drugs means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

For a detailed listing of preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.healthcare.gov/what-are-my-preventive-care-benefits. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered by the U.S. Department of Health and Human Services (HHS) the above shall be deemed to be amended to cover such preventive service to the extent required by the HHS.

(b) Routine Care

Charges Incurred for routine care such as routine physicals, routine laboratory tests and x-rays, routine mammograms, routine immunizations, hearing exams or flu vaccines.

The above routine care items are covered in addition to and to the extent they are not otherwise included for coverage under the Preventive Services section of the Plan.

(40) **Private Duty Nursing:** Private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to the following extent:

(a) Outpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature. Charges covered for Outpatient nursing care billed by a Home Health Care Agency are shown under Home Health Care Services and Supplies. Outpatient private duty nursing care not billed by a Home Health Care Agency must be supported by a certification and a treatment plan from the attending Physician.

(41) **Prosthetic Devices:** Artificial limbs, eyes or other prosthetic devices when necessary due to an Illness or Injury. This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered.

(42) **Qualified Clinical Trial Expenses:** Expenses that are, except as excluded below, healthcare items and services for the treatment of cancer or any other life threatening condition for a qualifying individual enrolled in a Qualified Clinical Trial that are otherwise consistent with the terms of the Plan and would be covered if the Covered Person did not participate in the Qualified Clinical Trial.

For purposes of this section, a "life threatening condition" means any condition or disease from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and a "qualifying individual" means any Covered Person who is eligible to participate in a Qualified Clinical Trial according to the trial protocol for treatment of cancer or any other life threatening condition that makes his or her participation in the program appropriate, as determined based on either (i) a conclusion of a referring health care professional or (ii) medical and scientific information provided by the Covered Person.

Notwithstanding the above, Qualified Clinical Trial expenses do not include any of the following:

(a) Costs associated with managing the research associated with the Qualified Clinical Trial; or

(b) Costs that would not be covered for non-Experimental and/or Investigational treatments; or

(c) Any item or service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(43) **Radiation Therapy:** Radium and radioactive isotope therapy treatment. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(44) **Reconstructive Surgery:** See Cosmetic Procedures/Reconstructive Surgery.

(45) **Rehabilitation Facility:** Inpatient care in a Rehabilitation Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Skilled Nursing Facility confinement; and (c) is not for Custodial Care.

See the Skilled Nursing Facility benefit for services and supplies provided for confinements in a Skilled Nursing Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(46) **Respiratory/Pulmonary Therapy:** Respiratory/pulmonary therapy under the recommendation of a Physician.

(47) **Routine Newborn Care:** Routine newborn care including Hospital nursery expenses and routine pediatric care while confined following birth will be considered as part of the mother's expense.

If the newborn is ill, suffers an Injury or requires care other than routine care, benefits will be provided on the same basis as any other eligible expense.

(48) **Second Surgical Opinion:** Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Covered Person.

Benefits for the second opinion will be payable only if the opinion is given by a Specialist who: (a) is certified in the field related to the proposed Surgery; and (b) is not affiliated in any way with the Physician recommending the Surgery.

If the second opinion conflicts with the first opinion, the Covered Person may obtain a third opinion, although this is not required.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(49) **Skilled Nursing Facility:** Skilled nursing care in a Skilled Nursing Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Rehabilitation Facility confinement; and (c) is not for Custodial Care.

See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(50) **Sleep Disorders**: Sleep disorder treatment for sleep apnea that is Medically Necessary.

(51) **Speech/Hearing Therapy:** Restorative or rehabilitative speech or hearing therapy rendered by a qualified Physician or a licensed speech or hearing therapist under the recommendation of a Physician, necessary because of loss or impairment due to an Illness, Injury or Surgery or therapy to correct a Congenital Anomaly. Speech therapy for the correction of stuttering, stammering, myofunctional or conditions of psychoneurotic origin, developmental delay or to change voice sound will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(52) **Sterilization:** Elective or medically required sterilization procedures (this does not include reversal of sterilization). Elective sterilization procedures are covered in addition to and to the extent they are not otherwise included for coverage under the preventive services section of the Plan. When a vasectomy is elected, only the Physician's charge for the Surgery in his/her office will be covered. Facility charges for vasectomies will not be eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(53) **Substance Use Disorders:** Charges for care, supplies and treatment of a Substance Use Disorder. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(54) **Teladoc Network Providers:** Teladoc provides 24/7/365 access to a national network of U.S. board-certified Physicians who can resolve many of your medical issues. Teladoc services involve the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact.

For any questions with respect to Teladoc, please contact the Plan Administrator. Coverage under this benefit does not include consults from your regular Physician; it only includes coverage for consults to the extent the Physician who is consulted participates in the Teladoc program. To learn more about Teladoc, see the Teladoc contact information under General Plan Information section of the Plan.

Teladoc benefits include:

- 24/7/365 access to a Physician online or by phone
- Fast treatment
- Talk to a Teladoc Physician from anywhere at home, work, or while traveling
- Save money by avoiding expensive urgent care or emergency room visits

Call Teladoc:

- When you need care now
- If you’re considering the emergency room or urgent care center for non-emergency issues
- On vacation, on a business trip, or away from home
- For short-term prescription refills

Teladoc providers treat conditions such as:

- Cold and flu
- Bronchitis
- Respiratory infection
- Sinus problems
- Allergies
- Urinary tract infection
- Pediatric care
- Poison ivy
- Pink eye
- Ear infections
- Behavioral health services by board certified psychiatrists, licensed psychologists, therapists, or counselors (i.e. anxiety, depression, PTSD/stress, panic disorder, family & marriage issues, eating disorders, grief, substance use, trauma, ADHD, and work pressures), subject to state and vendor restrictions

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(55) **Telemedicine:** Services related to the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact by a covered provider. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(56) **Transplants:** Services and supplies in connection with Medically Necessary non-Experimental and/or non-Investigational transplant procedures.

The transplant of organs from human to human, including bone marrow, stem cell and cord blood transplants. Transplants include only those transplants that: (a) are approved for Medicare coverage on the date the Transplant is performed; and (b) are not otherwise excluded by this Plan.

A transplant must be Medically Necessary and performed at a transplant facility in order to be considered for reimbursement under this Plan. These transplants will only be covered if:

(a) The Covered Person properly pre-certifies and maintains case management services throughout the course of the transplantation and post transplantation period as directed and coordinated by the Plan's medical review firm; and

(b) The procedure is performed at an <u>In-Network facility</u> known to have an effective program for doing such procedure. If there isn't an In-Network facility that is equipped to perform the transplant, Out-of-Network facilities may be allowed if approved in advance by the Claims Administrator and the re-insurance carrier.

(c) If both the donor and the recipient are covered under this Plan, eligible expenses Incurred by each person will be treated separately for each person.

(d) If the recipient is covered under this Plan, eligible expenses Incurred by the donor will be considered eligible if not covered by the donor's plan.

The Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology and pathology fees for the removal of the organ and a Hospital's charge for storage or transportation of the organ.

Exclusions:

(a) Non-human and artificial organ transplants;

(b) Donor charges when recipient is not covered under the Plan;

(c) The purchase price of any of bone marrow, organ, tissue or any similar items which are sold rather than donated; and

(d) Transplants which are not medically recognized and are Experimental and/or Investigational in nature.

(e) Skin and cornea transplants are not considered a transplant for the purpose of determining eligibility.

(f) If the procedure is performed at a Mayo facility in Arizona, the transplant charges and all necessary follow-up care related to the transplant will be paid for a period of up to 12 months at the Participating Provider level of benefits. Any care related to the transplant that is performed at the Mayo facility after 12 months of the transplant date will not be considered an eligible expense.

(57) **Urgent Care Clinic:** Services and supplies provided by an Urgent Care Clinic when immediate medical attention is necessary. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

HINGE HEALTH PROGRAM

The Hinge Health Digital Musculoskeletal (MSK) Clinic includes Prevention, Chronic, Acute, and Surgical programs. The program includes both an embedded Expert Medical Opinion service focused on elective MSK procedures as well as Enso, a groundbreaking wearable technology for pain management that is both non-addictive and non-invasive. You and your covered Dependents who meet participation criteria as established by Hinge Health have access to the following programs:

Prevention Program: This software only program (no sensors, coaching, or tablet) is designed to increase education regarding key strengthening and stretching activities around injury prevention. All Covered Persons have access to the Prevention Program; participation criteria does not apply.

Chronic Program: Personalized exercise therapy sessions guided by wearable motion-sensors, unlimited 1:1 access to personal health coach via email, text, phone, personalized educational content, and cognitive behavioral support. The Chronic Program pathways include: knee, neck, low back, hip, and shoulder.

Women's Pelvic Health (part of the Chronic program): Supports women at all stages of life, including pregnancy, postpartum, and menopause, when pelvic disorders are most common**.**

Acute Program: Live virtual sessions with a dedicated licensed physical therapist along with software guided rehabilitation and individual education. A user may only obtain 6 virtual physical therapy (PT) sessions per episode through Hinge Health prior to needing an in-person PT visit with their Physician or a qualified provider in physical therapy. The medical Plan of benefits will apply to the Covered Person's in-person PT visit. Once the in-person PT visit occurs and a plan of care is submitted, a Covered Person may receive an additional 6 virtual physical therapy sessions per episode before the process repeats.

Surgery Program: Provides Covered Persons with a dedicated physical therapist, a dedicated health coach, sensor-guided exercise therapy, and covers both pre- and post-surgical rehabilitation for the most common MSK surgeries. The Surgery Program is designed as a continuation of the Chronic Program but Covered Persons can enroll in the Surgery Program directly.

Expert Medical Opinion (EMO): EMO service focused on elective musculoskeletal procedures. EMO services are available to all Covered Persons; participation criteria does not apply.

For additional information about the Hinge Health Program, please visit the Hinge Health website at: www.hingehealth/meritainhealth or call (855) 902-2777.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

ALTERNATE BENEFITS

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternate treatment plan, in which case those charges Incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be Incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternate benefits at its sole discretion and only when and for so long as it determines that alternate treatment plan is Medically Necessary and cost effective. If the Plan elects to provide alternate treatment plan benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for such Covered Person in any other instance or for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

GENERAL EXCLUSIONS AND LIMITATIONS

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 Usual and Customary Charges, not covered by the Plan, in excess of any maximum Plan benefits. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

(1) **Abortions:** Expenses related to elective abortions will not be considered eligible, except as specified under the Maternity benefit under Eligible Medical Expenses.

(2) **Acupuncture/Acupressure:** Expenses for acupuncture and acupressure will not be considered eligible.

(3) **Adoption:** Expenses related to adoption will not be considered eligible.

(4) **Assistant Surgeon:** Expenses for assistant surgeon when the need for an assistant is not documented will not be considered eligible.

(5) **Assistive/Self-help Devices:** Expenses for assistive/self-help devices which do not serve a primary medical purpose and instead ease the performance of activities of daily living, including but not limited to feeding utensils, reaching tools, devices to assist with dressing and undressing, etc., will not be considered eligible.

(6) **Autopsies:** Expenses for autopsies will not be considered eligible (unless required by the Plan).

(7) **Biofeedback:** Expenses related to biofeedback will not be considered eligible.

(8) **Blood:** Expenses for autologous blood donations will not be considered eligible, unless the blood is actually used during a scheduled Surgery.

(9) **Cardiac Rehabilitation:** Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

(10) **Chelation Therapy:** Expenses for chelation therapy will not be considered eligible, unless due to heavy metal poisoning.

(11) **Close Relative:** Expenses for services, care or supplies provided by a person who normally resides in the Covered Person's home or by a Close Relative, whether relationship is by blood or law, will not be considered eligible, except as specified under Eligible Medical Expenses.

(12) **Complications:** Expenses for care, services or treatment required as a result of complications from a non-covered condition, Illness, treatment or procedure not covered under the Plan will not be considered eligible. This exclusion does not apply to complications from abortions as specified under Eligible Medical Expenses.

(13) **Convenience Items:** Expenses for personal comfort items or devices which do not meet the definition of Durable Medical Equipment or corrective appliances including but not limited to air conditioners, air purifiers, dehumidifiers, water purification systems, waterbeds, airbed systems, cervical pillows, whirlpools, spas and the like will not be considered eligible.

(14) **Cosmetic Procedures:** Expenses for Cosmetic, plastic and reconstructive procedures, or any complications thereof, will not be considered eligible, except as specified under Eligible Medical Expenses.

Expenses for breast reconstruction (except as covered under Eligible Medical Expenses) or charges for breast augmentation, breast reduction or prophylactic breast removal will not be considered eligible unless found to be medically necessary. Charges related to the removal of breast implants inserted for Cosmetic purposes will not be considered eligible regardless of the reason for removal.

Expenses for Cosmetic charges for services, supplies or Surgery which are primarily for personal comfort or primarily to improve or enhance personal appearance, including but not limited to, collagen injections, Botox injections, sclerotherapy, liposuction, tattoos or tattoo removal will not be considered eligible.

(15) **Counseling:** Expenses for religious, career, sexual, social adjustment, or financial counseling will not be considered eligible, except as specified under Eligible Medical Expenses.

(16) **Court Ordered:** Expenses for charges Incurred due to a court ordered treatment or hospitalization will not be considered eligible unless a clear Medical Necessity also exists.

(17) **Custodial Care:** Expenses for Custodial Care from an institution or part thereof which is primarily a place for rest, the aged, a hotel, health spa, fitness or weight reduction resort or similar institution or childcare, homemaker services or maintenance care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.

(18) **Dental Care:** Expenses Incurred in connection with dental care, treatment, x-rays, general anesthesia or Hospital expenses will not be considered eligible, except as specified under Eligible Medical Expenses. Removal of impacted teeth will not be considered eligible.

(19) **Developmental Delays:** Expenses in connection with the diagnosis and treatment of developmental delays, including, but not limited to therapies will not be considered eligible. This exclusion does not apply to developmental delays that are considered Mental Disorders or Substance Abuse Disorders and expenses covered as a preventive service as specified under the Eligible Medical Expenses section of the Plan.

(20) **Disposable (Non-Durable) Supplies:** Expenses for disposable (non-durable) supplies, including but not limited to diapers, incontinence pads and bandages will not be considered eligible, except as covered under Eligible Medical Expenses.

(21) **Durable Medical Equipment:** Expenses for replacement of lost or stolen items or replacement due to misuse, malicious breakage or gross neglect will not be considered eligible.

(22) **Education:** Expenses for education expenses for job training will not be considered eligible.

(23) **Emergency Room, if not for an Emergency Medical Condition:** Expenses for Emergency room expenses for treatment of a condition that is not considered an Emergency Medical Condition will not be considered eligible.

(24) **Exams:** Expenses for examinations, vaccinations, inoculations or immunizations related to employment, premarital or pre-adoptive requirements, issuance of insurance, obtaining a license, judicial or administrative procedures, or travel to foreign countries will not be considered eligible.

In addition, examinations or tests not incidental to or necessary to diagnose an Injury or Illness except the coverage for the routine care specifically allowed will not be considered eligible, except as otherwise covered as a preventive service or as specified under the Eligible Medical Expenses section of the Plan.

(25) **Exercise:** Expenses for or related to health club/exercise/gym memberships, aerobic and strength conditioning, back schools or back strengthening programs, and exercise equipment rental or purchase, health spas, or fitness resorts or similar institutions for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

(26) **Experimental and/or Investigational:** Expenses for treatment, procedures, devices, drugs, or medicines which are determined to be Experimental and/or Investigational will not be considered eligible, except for Off-Label Drug Use or when such expenses are considered Qualified Clinical Trial Expenses.

(27) **Foot Care:** Expenses for routine foot care, treatment of weak, unstable or flat feet will not be considered eligible.

(28) **Gambling Addiction:** Expenses for services related to gambling addiction will not be considered eligible.

(29) **Gender Reassignment:** Expenses in connection with gender reassignment will not be considered eligible.

(30) **Gene Therapies:** Expenses relating to gene therapies, xenographs or cloning will not be considered eligible.

(31) **Governmental Agency:** Expenses for services and supplies which are provided by any U.S. Governmental or state agency or political subdivision, including but not limited to active duty in the armed forces, Medicare, Medicaid, CHAMPUS or any treatment paid for by any governmental program for which the Covered Person is not liable for payment will not be considered eligible, unless the Covered Person is legally required to pay and such expenses are eligible under the terms and conditions of this Plan. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

(32) **Hair Loss:** Expenses for hair loss or hair transplants such as wigs, or services/supplies for the prevention or restoration of natural hair loss (i.e.: Rogaine, Minoxidil) will not be considered eligible. This exclusion does not apply to the Medically Necessary treatment of alopecia areata.

(33) **Health Maintenance Organization (HMO):** Expenses for HMO providers when services are rendered to an HMO Covered Person will not be considered eligible.

(34) **Hearing Aids:** Expenses for hearing aids (including the fitting thereof) and supplies will not be considered eligible.

(35) **Home Modifications:** Expenses for elevators, chairlifts or other modifications to home, stairs or vehicles will not be considered eligible.

(36) **Homeopathic Treatment:** Expenses for naturopathic, holistic and homeopathic treatments or medicines, services, supplies, or accommodations will not be considered eligible.

(37) **Hospital/Healthcare Expenses:** Expenses for Hospital or other healthcare expenses if you leave against the medical advice of the attending Physician within 72 hours after admission will not be considered eligible.

(38) **Hypnotherapy:** Expenses for hypnotherapy will not be considered eligible.

(39) **Illegal Occupation/Felony:** Expenses for treatment received, including the use of ambulance services as described in the Eligible Medical Expenses section, for an injury or illness sustained while incarcerated or sustained during the commission of, or the attempted commission of, an assault, a felony or other criminal act whether or not there is a criminal charge or a conviction of a crime, if the offense is defined as a criminal act by the state in which the incident occurred, including injuries received while operating a motor vehicle in an illegal manner, driving while under the influence of alcohol or illegal drugs, negligent driving or driving at excessive speeds will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.

(40) **Infertility:** Expenses for confinement, treatment or services related to infertility (the inability to conceive) or the promotion of conception such as infertility drugs or ultra sounds associated with infertility medication therapy, collection of semen and/or ovum, artificial insemination, In-Vitro fertilization, Gamete Intro Fallopian Transfer (GIFT), Zygote Intra Fallopian Transfer (ZIFT), embryonic transfer, sperm donor costs, sperm banking and/or storage, sperm washing or any other similar procedure will not be considered eligible, except diagnosis and testing of infertility as specified under Eligible Medical Expenses.

Nothing in this section is intended to exclude coverage for any infertility counseling or treatment required to be covered (if any) as a preventive service under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines).

(41) **Magnet Therapy:** Expenses for magnetic therapy will not be considered eligible.

(42) **Maintenance Therapy:** Expenses for Maintenance Therapy of any type or therapy for coma stimulation Inpatient or outpatient when the individual has reached the maximum level of improvement will not be considered eligible.

(43) **Massage Therapy:** Expenses for massage therapy and rolfing will not be considered eligible, except when part of an overall patient treatment plan in conjunction with physical therapy and the services are provided by an eligible provider.

(44) **Medical Marijuana:** Expenses for medical marijuana will not be considered eligible.

(45) **Medically Necessary:** Expenses which are determined not to be Medically Necessary, as determined by the Plan or its designee, or are not necessitated as the result of existing symptoms of an Illness or Injury, or are not considered the standard medical treatment for the diagnosed condition will not be considered eligible, except as covered under the Eligible Medical Expenses section of the Plan.

(46) **Missed Appointments:** Expenses for completion of medical reports, itemized bills or claim forms, photocopying fees, mailing, shipping or handling expenses or broken appointments will not be considered eligible.

(47) **Music Therapy:** Expenses for music therapy will not be considered eligible.

(48) **Myofunctional Therapy:** Expenses for myofunctional therapy or the treatment of tongue thrusts will not be considered eligible.

(49) **Naturopathic Treatment:** Expenses for naturopathic treatment or services rendered by a naturopath will not be considered eligible.

(50) **Negotiations Directly with a Provider/Supplier/Facility Outside of the Plan:** Expenses for services negotiated by the Covered Person directly with a provider, supplier and/or facility (such as a cash paid negotiation or discounts for upfront payments, etc.) will not be considered eligible under the Plan.

(51) **No Legal Obligation:** Expenses for services provided for which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires this Employer's Plan to be primary.

(52) **Non-Covered Person:** Expenses for any Illness or Injury prior to a Covered Person's eligibility date as defined in Eligibility for Participation section of the Plan, or after the Covered Person's termination date defined in the Termination of Coverage section of the Plan will not be considered eligible.

(53) **Non-Covered Procedures:** Expenses for services related to medical care, services, supplies of a non-covered Surgery or procedure will not be considered eligible regardless of when the Surgery or procedure was performed.

(54) **Non-Participating Provider Services:** Expenses for services received by a Non-Participating Provider will not be considered eligible, except as specified under the General Overview of the Plan section.

(55) **Not Performed Under the Direction of a Physician:** Expenses for medical care, services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

(56) **Not Recommended by a Physician:** Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.

(57) **Nutritional Supplements:** Expenses for over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician, except as otherwise covered as a preventive service or as specified under Nutritional Supplements as shown under Eligible Medical Expenses.

(58) **Obesity:** Expenses for surgical and non-surgical care and treatment of obesity including weight loss or dietary control, whether or not it is in any case a part of a treatment plan for another Illness, will not be considered eligible, except as otherwise covered as a preventive service or under Bariatric Services under the Eligible Medical Expenses section of the Plan.

(59) **Occupational Therapy:** Expenses for occupational therapy or supplies primarily for recreational or social interaction will not be considered eligible, except during an Inpatient Hospital confinement or as covered under rehabilitation services or Home Health Care in the Eligible Medical Expenses section of the Plan.

(60) **Operated by the Government:** Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.

(61) **Orthognathic Surgery:** Expenses for orthognathic Surgery will not be considered eligible.

(62) **Outside the United States (U.S.):** Expenses for services or supplies if the Covered Person leaves the U.S. or the U.S. Territories for the express purpose of receiving medical treatment will not be considered eligible, except as the result of an Emergency Medical Condition or Accidental Injury that occurs while traveling outside the U.S. or U.S. Territories will be an eligible expense.

(63) **Over-the-Counter (OTC) Medication:** Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(64) **Personal Service Items:** Expenses for items such as guest meals, television, telephone, etc. when confined in a Hospital or health care facility will not be considered eligible.

(65) **Plan Maximums:** Expenses for charges in excess of Plan maximums will not be considered eligible.

(66) **Private Duty Nursing:** Expenses for private duty nursing will not be considered eligible while confined to a Hospital.

(67) **Prosthesis Replacement:** Expenses for replacement of prosthetic device unless necessitated by the growth of a child or the prosthesis has exceeded its maximum life expectancy will not be considered eligible.

(68) **Radioactive Contamination:** Expenses Incurred as the result of radioactive contamination or the hazardous properties of nuclear material will not be considered eligible.

(69) **Recreational and Educational Therapy:** Expenses for recreational and educational services; learning disabilities; behavior modification services (i.e. stress management, weight reduction, nutrition classes, etc.); vocational testing or training; any form of non-medical self-care or self-help training, including any related diagnostic testing; health club memberships; aquatic or pool therapies; will not be considered eligible, except to the extent such expenses are part of the Hinge Health Program. This exclusion will not apply to expenses that are Mental Disorders or Substance Use Disorders.

(70) **Refractive Errors:** Expenses for radial keratotomy, Lasik Surgery or any Surgical Procedure such as keratomileusis surgery, refractive keratoplasties, etc. to correct refractive errors of the eye will not be considered eligible.

(71) **Refunds:** Expenses for services or supplies that are discounted or reimbursed by a refund or rebate will not be considered eligible.

(72) **Required by Law:** In any case where an individual is required by law to maintain insurance coverage (or to maintain any other security or reserve amount in lieu of insurance coverage), expenses of a Covered Person that would be paid by such insurance coverage are not eligible expenses, regardless of whether the individual is in fact covered under such coverage. For purposes of any required automobile, motorcycle or other vehicle coverage, otherwise eligible expenses below the minimum required coverage or the actual coverage elected, whichever is higher, will be excluded from coverage under this Plan.

(73) **Riot/Revolt:** Expenses resulting from a Covered Person's participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

(74) **Services Not Permitted Under Applicable State or Local Laws:** Some state or local laws restrict the scope of health care services that a provider may render. In such cases, the Plan will not cover such health care services.

(75) **Sexual Dysfunction/Impotence:** Expenses for services, supplies including but not limited to sex change operations, drugs, penile prosthetic implants or similar devices related to sexual dysfunction/ impotence not related to organic disease will not be considered eligible. Expenses for sex therapy will not be considered eligible.

(76) **Sleep Disorder:** Expenses for treatment, services and supplies for sleep disorders will not be considered eligible, except for the condition of sleep apnea.

(77) **Smoking Cessation:** Expenses for smoking and tobacco cessation programs, including smoking/tobacco deterrents such as smoking aids, devices, or drugs (i.e. Nicorette and Nicoderm) will not be considered eligible, unless otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(78) **Stand-by Physician:** Expenses for technical medical assistance or stand-by Physician services will not be considered eligible. Expenses for services as a standby pediatrician during childbirth will not be considered eligible unless a high risk factor was indicated during the covered pregnancy.

(79) **Sterilization:** Expenses for the reversal of elective sterilization will not be considered eligible.

(80) **Sublingual Immunotherapy:** Expenses for sublingual immunotherapy will not be considered eligible.

(81) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan will not be considered eligible, including but not limited to pre-pregnancy, conception, prenatal, childbirth and postnatal expenses.

(82) **Temporomandibular Joint Dysfunction (TMJ):** Expenses for surgical or non-surgical care or treatment related to Temporomandibular Joint Dysfunction or Syndrome (TMJ), craniomandibular disorders, reconstruction of the maxilla or mandible for micrognathism, or retrognathism will not be considered eligible.

(83) **Travel:** Expenses for travel (transportation, lodging, meals and related expenses) by a Covered Person, a Physician or any healthcare provider will not be considered eligible, except as specified under Eligible Medical Expenses.

(84) **Usual and Customary Charge:** Expenses in excess of the Usual and Customary Charge will not be considered eligible.

(85) **Vision Care:** Expenses for vision care, including eye exams, professional services for diagnosis or treatment relating to eye refractive error, orthoptic or visual training, vision therapy, testing for visual acuity, field charting, or for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices will not be considered eligible except as specified under Eligible Medical Expenses section of the Plan. However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye or for aphakic patients. This exclusion does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages and as otherwise covered as a preventive service under the Eligible Medical Expense section of the Plan.

(86) **Wage or Profit:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for wage or profit (including self-employment) will not be considered eligible.

(87) **War:** Expenses for the treatment of Illness or Injury resulting from actively participating in a war or any act of war or terrorism, whether declared or undeclared, civil war, hostilities, or invasion, or while in the armed forces of any country or international organization will not be considered eligible.

(88) **Worker's Compensation:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Worker's Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Worker's Compensation or similar law and have reached the maximum reimbursement paid under Worker's Compensation or similar law will not be eligible for payment under this Plan.

PRESCRIPTION DRUG PROGRAM

Navitus is the Prescription Drug Program Administrator for your plan. For more information about your prescription benefits, please call Navitus at (855) 673-6504, or visit their website at www.navitus.com.

DEFINITIONS:

Brand Name Drug shall mean and refer to Prescription Drug(s) protected by a patent issued to the original innovator or marketer of such product. The patent prohibits the manufacture by other companies without the consent of the patent holder, so long as the patent remains in effect.

Claim shall mean a request for payment of benefits for Covered Pharmaceuticals that are dispensed to a Covered Person.

Copays shall mean and refer to those payments which Navitus may charge a Covered Person at the time of the provision of Prescription Drug Services. In cases where the applicable Copay is greater than the applicable Drug Costs, Navitus shall charge the lessor of the Copay or the Drug Costs, but in no case shall the Drug Costs be less than Usual, Customary and Reasonable.

Generic Drug shall mean and refer to Prescription Drug(s), whether identified by its chemical, proprietary or non-proprietary name, which is accepted by the FDA as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

Mail Service Pharmacy shall mean and refer to those facilities which are duly licensed to operate pharmacy(ies) at the respective locations of such facilities and which are owned and operated by, or contracted with, Administrator and are available to provide pharmacy related services to Covered Persons.

Member(s) shall mean an enrollee or Covered Dependent or Spouse of an enrollee who is enrolled at month end for the prior month in a program of Navitus's for which Prescription Drug Program Services are provided by Administrator hereunder.

Non-Preferred Brand Drug shall mean formulary brand drugs which are a brand-name Prescription Drug that has one or more therapeutic alternatives available either a Generic Drug or a formulary brand drug. A non-preferred drug is a drug that has been reviewed by the Pharmacy and Therapeutics Committee who have determined that a therapeutically-equivalent and more cost-effective drug is available.

Pharmacy Benefit Program shall mean and refer to the benefit, program, or plan pursuant to which its Covered Persons are offered the provision of Prescription Drug Products as a covered benefit of each Health Plan.

Pharmacy Program Specifications shall mean and refer to those written descriptions of the Pharmacy Benefit Program offered under each Client Agreement, which descriptions shall include, without limitation, eligibility requirements; benefit definitions; list of covered pharmacy benefits and applicable Copays; number of days supply for acute and maintenance medications; edits; list of any exclusions and/or limitations, including dispensing limitations, if any; eligible Covered Person LD. specifications, if applicable; and any and all manuals, or other information respecting each Pharmacy Benefit Program necessary to fulfill the obligations herein. Navitus may add new Pharmacy Program Specifications or amend, revise, or terminate existing Pharmacy Program Specifications upon 45 calendar days prior written notice to Administrator.

Preferred Brand Drug shall mean formulary brand-name drugs that have been reviewed and approved by the Pharmacy and Therapeutics Committee and have been selected for formulary inclusion based on its proven clinical and cost-effectiveness.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

Services shall mean and refer to those services to be furnished by Administrator to Navitus or its Pharmacy Benefit Program pursuant to the terms of the Agreement.

Specialty Pharmacy shall mean and refer to the program pursuant to which Covered Persons are offered the provision of injectable medications, ancillary products and/or other services or products as a covered benefit under the Pharmacy Benefit Program of the Plan.

Specialty Drug means those Prescription Drugs, medicines, agents, substances and other therapeutic products that include one or more of the following particular characteristics:

(10) Address complex, chronic diseases with many associated co-morbidities (e.g., cancer, rheumatoid arthritis, hemophilia, multiple sclerosis);

(11) Require a greater amount of pharmaceutical oversight and clinical monitoring for side effect management and to limit waste;

(12) Limited pharmaceutical supply chain distribution as determined by the applicable drug's manufacturer; and/or

(13) Relative expense.

PROGRAM INFORMATION

Prior Authorization is a process used to promote access to safe and cost-effective Prescription Drugs by obtaining approval before benefits can be used to pay for certain prescriptions or refills such as ADHD medications, oral contraceptives, and growth hormones. This edit ensures that medications are prescribed and used according to nationally-recognized practice guidelines or from FDA labeling restrictions.

Clinical Drug Utilization Reviews (CDUR) encompass a collection of edits used to monitor appropriate prescription drug usage. These types of edits include correct drug quantities, first-line therapies, correct daily doses, and drugs targeted for specific age and gender uses.

Quantity Limit provides close monitoring of some medications to ensure they are not overused or misused. As higher doses can cause serious side effects and add additional costs to the payer, a Quantity Limit edit can provide assurance that patients consult with their Physician for continued therapy at appropriate and safe dosing schedules.

Dose Optimization (or dose consolidation): Dose Optimization normally involves the conversion from twice-daily dosing of a Prescription Drug to a once-daily dosing schedule. This edit may increase compliance and dramatically decrease costs. Only drugs that have been approved by the Food and Drug Administration (FDA) for once daily dosing and have different strengths available at similar costs are included in the program.

Age and Gender Restrictions: Certain Prescription Drugs have been studied and proven to be effective in only one gender or are associated with specific ages.

Step Therapy recommends that a Covered Person use the most cost-effective and safe drug therapy first before other more costly or risky alternative therapies may be tried or prescribed. This step-by-step order follows best practice prescribing guidelines, and provides equivalent and often less toxic outcomes at a lower cost.

Dispense As Written: The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Specialty Pharmacy Network
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained from the specialty pharmacy network. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Access Guidance Services (provided by Navitus) (EPO Plan ONLY)
The Plan works with the Access Guidance Services to obtain copay assistance on your behalf. This program applies to certain drugs that have manufacturer-funded copay assistance programs available.

Under the Access Guidance Services, if the drug has copay assistance available, the amount you pay for select medications may be set to the maximum of the current benefit design, $0, or the amount determined by the manufacturer-funded copay assistance programs. To take advantage of this pricing, you will be required to remain enrolled in Navitus' program for obtaining manufacturer assistance, including copay assistance. Amounts paid by manufacturers on your behalf (along with other payments from manufacturers, such as manufacturer coupons) will not count toward your Out-of-Pocket Maximum or Deductible. Instead, only those payments made directly by you will count toward your Out-of-Pocket Maximum or Deductible. Once manufacturer-funded copay assistance is exhausted, the amount you pay will be no more than your benefit design.

Your Copay will default to the formulary's current tiered Copay if a drug does not qualify or is removed from the program.

COVERED EXPENSES
The Plan pays for Covered Expenses (including dispensing fees) for prescription products Incurred by a Covered Person in accordance with the Prescription Schedule of Benefits and at the contracted amount minus the Copay. Please note Prescription Drugs are subject to the cost-sharing provisions described in the Prescription Drug Schedule of Benefits unless the Prescription Drug qualifies as a Preventive Drug (as described previously).

Expenses are not paid for prescription products purchased before coverage with this Plan begins or after coverage under this Plan or provision terminates.

Covered Benefits
The following are considered covered benefits:

(1) Prescription products that are:

  (a) Necessary for the care and treatment of an Illness or Injury and prescribed by a duly licensed medical professional; and

  (b) Can be obtained only by prescription and dispensed in a container labeled Rx only; and

  (c) The following non-prescription products prescribed by a duly licensed medical professional:

    (i) Compounded medications of which at least one ingredient is a Prescription Drug;

    (ii) Any other medications which, due to state law, may only be dispensed when prescribed by a duly licensed medical professional; and

    (iii) Non-prescription, or over-the-counter, products determined by the Pharmacy and Therapeutics Committee to be appropriate for coverage when accompanied by a prescription; and

    (iv) In an amount that does not to exceed the day's supply outlined in the Prescription Schedule of Benefits.

(2) Injectable insulin and the following diabetic supplies as prescribed by a duly licensed medical professional:

(a) Lancets, alcohol swabs, reaction treating tablets, blood glucose monitors, blood test strips, insulin syringes and needles and anti-diabetic products.

(3) Non-combination Prescription requiring products containing folic acid or vitamins A, D, E or K.

(4) Prescription prenatal vitamins.

(5) Anabolic steroids.

(6) Prescription Drugs obtained in a foreign country due to an emergency medical situation when a Foreign Claim Form is signed. Retail brand discounts and preferred brand Copays will apply.

(7) Contraceptive products which are self-administered and limited to oral tablets, patches, and self-insertable vaginal devices containing contraceptive hormones regardless of the purpose.

(8) Prescription Drugs lost as a direct result of a natural disaster. Covered Persons will be given the opportunity to prove that Medically Necessary prescriptions were lost due to a natural disaster. Acceptable proof could include, but is not necessarily limited to, proof of other filed claims of loss (homeowner's, property, etc.).

(9) Mail order prescriptions: The Plan pays for Covered Expenses Incurred by a Covered Person for prescription products dispensed through the mail order pharmacy identified by the Pharmacy Benefit Administrator. Prescription products may be ordered by mail with a Copay from the Covered Person for each prescription or refill. The Copay is shown on the Prescription Schedule of Benefits. By law, prescription products cannot be mailed to a Covered Person outside the United States.

(10) Specialty Pharmacy Program: The Plan pays for Covered Expenses Incurred by a Covered Person through the Specialty Pharmacy vendor(s) identified by the Pharmacy Benefit Administrator. Prescription products included in the Specialty Pharmacy program shall be ordered from the Specialty Pharmacy vendor(s) or retail pharmacy with a specialty Copay from the Covered Person for each prescription or refill. The specialty Copay is shown on the Prescription Summary of Benefits.

(11) Preventive Drugs.

PRESCRIPTION PRODUCT EXCLUSIONS

Benefits will NOT be provided for any of the following:

(1) Charges in excess of the contracted amount.

(2) Therapeutic devices or appliances, including hypodermic needles, syringes (except as stated above), support garments, and other non-medical substances, without regard to their intended use.

(3) Immunization agents, biological sera, blood, or blood plasma.

(4) Urine testing strips.

(5) Tobacco deterrent products (except as provided as a Preventive Drug under Health Care Reform).

(6) Prescription products used to enhance sexual function or satisfaction.

(7) Products labeled as/for any of the following: Caution-limited by federal law to investigational use, experimental drugs (even if a charge is made to the Covered Person), approved prescription products prescribed for Experimental and/or Investigational purposes, and products prescribed in Experimental and/or Investigational dosages.

(8) Any charge for the administration of prescription products.

(9) Any medication, prescription, or non-prescription taken or administered at the place where it is dispensed.

(10) Any medication meant to be taken by or administered to the Covered Person, in whole or in part, while the Covered Person is treated at a Hospital, Physician's office, or extended care facility (but is instead self-administered or administered elsewhere), unless expressly designated by the Pharmacy Benefits Administrator.

(11) Refilling a prescription in excess of the number specified on the prescription or any refill dispensed after one year from the order of the medical professional.

(12) Prescription products not dispensed by a licensed pharmacist or medical professional.

(13) Prescription products dispensed in a foreign country if the Covered Person traveled solely for the purpose of re importing Prescription Drugs into the United States and/or used other means to ship or bring prescription products from a foreign country into the United States.

(14) Prescriptions that are Cosmetic in nature unless the prescription is necessary to ameliorate a deformity arising from or directly related to: a congenital abnormality, personal Injury resulting from an Accident or trauma, or a disfiguring disease.

(15) Prescription products that may be received without charge under local, state, or federal programs, including worker's compensation.

(16) Replacement prescription products resulting from loss, theft, or damage, except in the case of loss due directly to a natural disaster.

(17) Rogaine or any other Cosmetic hair growth prescription products.

(18) Prescription products when a Prior Authorization is needed but not requested; and prescription products when a Prior Authorization is requested but denied.

(19) Prescription products available over-the-counter that, by federal or state law, do not require a prescription order and any medications that are equivalent to over the counter medications unless the product is a non-prescription (or over-the-counter) product determined by the Pharmacy and Therapeutics Committee to be appropriate for coverage when accompanied by a prescription. This exclusion does not apply to Preventive Drugs covered under Preventive Services.

(20) Anorectics or any other products used for the purpose of weight control.

(21) Prescription topical acne products for a Covered Person over age 24, unless determined Medically Necessary by the Plan.

(22) Prescription Drugs for treatment of Attention Deficit Disorder (ADD) over age 19.

(23) Approved prescription products with no approved Food and Drug Administration (FDA) indications for the purpose for which prescribed.

(24) Oral medications for Cosmetic management of onychomycosis, unless determined Medically Necessary by the Plan.

(25) Infertility products, unless used to sustain a Covered Person's pregnancy.

(26) Prescription products that are determined by the Pharmaceutical and Therapeutics Committee to be either marginally effective and/or are excessive in cost when compared to alternative medication(s) for the same condition.

(27) Growth hormone products, unless determined Medically Necessary by the Plan.

(28) All illegal medications or supplies, even if prescribed by a duly licensed medical professional.

(29) Fluoride preps both oral and topical (except as provided as a Preventive Drug under Health Care Reform).

(30) All Durable Medical Equipment (DME) and supplies, except as noted for diabetic supplies.

(31) Therapeutic devices or appliances, support garments, and other non-medical substances.

(32) Respiratory/pulmonary therapy supplies and devices (e.g. spacers).

(33) Metabolic infant formula; nutritional diet supplements.

(34) Vaccines and immunizations (except as provided as a Preventive Drug under Health Care Reform).

(35) All vitamins, except as noted under “Covered Drugs” or as provided as a Preventive Drug under Health Care Reform).

(36) The Covered Person still has a right to purchase excluded products, even if the requested medication or supply is not covered; however, the entire cost of the product will be the Covered Person’s responsibility.

Pharmacy and Therapeutics Committee Product Reviews
The Pharmacy and Therapeutics Committee may, in its professional judgment, modify medications and supplies on the Preferred Products List as follows:

(1) Place products on the Preferred Products List and remove products from the Preferred Products List.

(2) Place certain products on the Prior Authorization list and remove products from the Prior Authorization list.

(3) Place certain categories of products on a Step Therapy program and remove products from the Step Therapy program.

(4) Categorize certain non-prescription products (over-the-counter products) as a Covered Expense.

(5) Place medications into and remove medications from the Specialty Pharmacy program.

Actions by the Pharmacy and Therapeutics Committee take place quarterly, as medical technology evolves, as indications, or FDA guidelines change.

The Pharmacy Benefits Administrator will inform Covered Persons of the actions taken by the Pharmacy and Therapeutics Committee as appropriate, including when benefits under this Plan are affected.

Coordination of Benefits
This Plan does not coordinate prescription benefits.

COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a "qualifying event".

Qualified Beneficiary
In general, you, your Spouse and any Dependent Child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan is considered a "qualified beneficiary".

In addition, any Dependent Child who is born to or placed for adoption with you during a period of COBRA continuation coverage is considered a "qualified beneficiary".

Each qualified beneficiary (including a Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

Qualifying Event
If you are a covered Employee, you, your Spouse and/or Dependent Child will become a qualified beneficiary if you lose your coverage under the Plan because of either one of the following qualifying events:

(1) Your hours of employment are reduced; or

(2) Your employment ends for any reason other than your gross misconduct.

You, your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 18 months provided you elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage.

You, your Spouse and Dependent Child have an independent right to elect COBRA Continuation Coverage. You and/or your Spouse may elect coverage on behalf of either one of you and parents may elect coverage on behalf of their Dependent Child.

If you are the Spouse and/or Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:

(1) Your spouse/parent-Employee dies;

(2) Your spouse/parent-Employee becomes entitled to Medicare benefits (under Part A, Part B or both); or

(3) You/your parents become divorced or legally separated.

Your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 36 months provided such Spouse and/or Dependent Child provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA Continuation Coverage and their obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If you are a Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose coverage under the Plan because you cease to be eligible for coverage under the Plan as a Dependent Child. You may elect to continue coverage under the Plan for up to a maximum period of 36 months provided you provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of; (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage and your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Extension of 18-Month Continuation Coverage Period

If you, your Spouse or Dependent Child is determined to be disabled by the Social Security Act (SSA); you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to your Employer on a date that is both within 60 days after the later of (a) the date of the SSA determination; (b) the date coverage under the Plan would end due to the qualifying event; or (c) the date you are given notice of your obligation to provide such notice and before the end of the initial 18-month period of coverage. If you are later determined not disabled by SSA, you must notify your Employer within 30 days following the later of (a) the date of the SSA determination; or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and any Dependent Child in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. To qualify for this extension in coverage, notification must be given to your Employer within 60 days after the later of (a) the date coverage under the Plan would end due to the qualifying event or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Notice Requirement

The notice must be postmarked (if mailed) or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan or if you are eligible for an extension of COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

For qualifying events such as divorce or legal separation of the Employee and Spouse or a Dependent Child's loss of eligibility under the Plan, the notice must contain the following information:

(1) Name and address of the covered Employee or former employee;

(2) Name and address of your Spouse, former Spouse and any Dependent Children;

(3) Description of the qualifying event; and

(4) Date of the qualifying event.

In addition to the information above, if you, your Spouse or any Dependent Child is determined by SSA to be disabled within 60 days after your COBRA continuation coverage begins, the notice must also contain the following information:

(1) Name of person deemed disabled;

(2) Date of disability determination; and

(3) Copy of SSA determination letter.

If you cannot provide a copy of the decree of divorce or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage or extension of such coverage, will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified in the request, the notice may be rejected.

In addition to accepting a letter with the information described above, the Plan Sponsor, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse may obtain a copy by requesting it from the Plan Sponsor at the address provided in this notice.

Notice must be sent to the COBRA Administrator at:

Meritain Health, Inc.
ATTN: COBRA Department
P.O. Box 860093
Minneapolis, MN 55486-0093
Fax: (716) 319-5736

Termination of COBRA Continuation Coverage
COBRA continuation coverage automatically ends 18, 29 or 36 months (whichever is applicable) after the date of the qualifying event; however coverage may end before the end of the maximum period on the earliest of the following events:

(1) The date the Plan Sponsor ceases to provide any group health plan coverage;

(2) The date on which the qualified beneficiary fails to pay the required contribution;

(3) The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise) or entitled to either Medicare Part A or Part B (whichever comes first); or

(4) The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage
Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. The amount you are required to pay for COBRA continuation coverage is 102% of the actual cost of coverage you elect, unless you qualify for the 11-month period of extended coverage due to disability (as specified above). In the event of disability, you may be required to pay up to 150% of the actual cost of coverage you elect for the 11-month extension period.

Additional Information
Additional information about the Plan and COBRA continuation coverage is available from the Plan Sponsor, who is identified on the General Plan Information page of this Plan.

Current Addresses
In order to protect your family's rights, you should keep the Plan Sponsor informed of any changes in the addresses of family members.

CLAIM PROCEDURES

This Plan has incorporated the BlueCross BlueShield of Arizona Network into the benefit program. All medical claims submitted are reviewed and re-priced in accordance with the applicable negotiated fee schedule. Meritain Health, Inc. has partnered with BlueCross BlueShield of Arizona (BCBSAZ) for electronic claims submission. Electronic claims will be routed via BCBSAZ for re-pricing and then will be forwarded to Meritain Health, Inc. by BCBSAZ for processing. Claims submitted via paper will be submitted directly to Meritain Health, Inc. for processing.

When using PHCS of Utah contracted providers, as well as Intermountain Healthcare (IHC) non-contracted providers and facilities, those claims will be subject to the claims procedures listed below.

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information. The Employee identification card will show your Participating Provider Network and the Medical Management Administrator.

At the time you receive treatment, show the Employee identification card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to:

Meritain Health, Inc.
P.O. Box 853921
Richardson, TX 75085-3921
(866) 300-8449

Most claims under the Plan will be “post service claims.” A “post service claim” is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

(1) The date of service;

(2) The name, address, telephone number and tax identification number of the provider of the services or supplies;

(3) The place where the services were rendered;

(4) The diagnosis and procedure codes;

(5) The amount of charges (including Network repricing information);

(6) The name of the Plan;

(7) The name of the covered Employee; and

(8) The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a “claim” since an actual written claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Timely Filing
All claims must be filed with the Third Party Administrator within 12 months following the date services were Incurred. Claims filed after this time period will be denied.

Procedures for all Claims
The Plan's claim procedures are intended to reflect the Department of Labor's claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant (i.e. you and your covered Dependents) must follow the procedures outlined in this section. There are 4 different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3)

Pre-Service Claims; and (4) Post-Service Claims. The procedures for each type of claim are more fully described below:

(1) **Urgent Care Claims.** If your claim is considered an urgent care claim, the Claims Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient information to determine whether or to what extent, benefits are covered or payable under the Plan. If you fail to provide sufficient information for the Plan to decide your claim, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

    A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. In determining if the initial claim for benefits should be treated as an urgent care claim, the Plan will defer to a determination, if any, by an attending provider that the claim should be treated as an urgent care claim, if that determination is timely provided to the Plan.

(2) **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Claims Administrator will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

    Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies and the Claims Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

(3) **Pre-Service Claims.** For a pre-service claim, the Claims Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Claims Administrator needs additional time to process a claim, the Claims Administrator may extend the time to notify you of the Plan's benefit determination for up to 15 days provided that the Claims Administrator notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Claims Administrator expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

    A claim for benefits is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(4) **Post-Service Claims.** For a post-service claim, the Claims Administrator will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Claims Administrator needs additional time to process a claim, the Claims Administrator may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Claims Administrator notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any other claim for health benefits that is not a pre-service claim or an urgent care claim).

A claim is NOT:

(1) A request made by someone other than the Covered Person or his/her authorized representative;

(2) A request made by a person who will not identify him/herself (anonymous);

(3) 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;

(4) A request for prior approval of Plan benefits where prior approval is not required by the Plan;

(5) 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.

(6) A request that the Plan provide an exception to the Plan benefits and terms (i.e. treat an out-of-network benefit as an in-network benefit, authorize payment of non-covered benefits).

Manner and Content of Notice of Initial Adverse Determination
If the Plan Administrator denies a claim, it must provide to you in writing or by electronic communication:

(1) An explanation of the specific reasons for the denial;

(2) A reference to the Plan provision or insurance contract provision upon which the denial is based;

(3) A description of any additional information or material that you must provide in order to perfect the claim;

(4) An explanation of why the additional material or information is necessary;

(5) Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;

(6) A statement describing your right to request an external review (or, if applicable, to request a second level appeal) or, if applicable, to bring an action for judicial review;

(7) A copy of any rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon your request and without charge); and

(8) If the adverse determination is based on the Plan's Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

Any notice of adverse determination also will include the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

For an adverse determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than 3 days after the oral notification.

Internal Review of Initial Adverse Benefit Determination
If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the procedures described below.

You have 180 days after you receive notice of an initial adverse determination within which to request a review of the adverse determination. For a request for a second level appeal, you have 60 days after you receive notice of an adverse determination at the first level of appeal to request a second level appeal of the adverse determination.

If you request a review of an adverse determination within the applicable time period, the review will meet the following requirements:

(1) The Plan will provide a review that does not afford deference to the adverse determination that is being appealed and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse determination that is the subject of the appeal and who is not a subordinate of the individual who made that adverse determination.

(2) The appropriate named fiduciary of 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 before making a decision on review of any adverse determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.

(3) The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an adverse determination, without regard to whether the advice is relied upon in making the adverse determination on review.

(4) For a requested review of an adverse determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.

(5) The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(6) You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of its determination on review to give you a reasonable opportunity to respond prior to such determination.

(7) The Plan will ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

(8) The Plan will provide you with continued coverage pending the outcome of an internal appeal.

All requests for review of initial adverse benefit determinations (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P.O. Box 660908
Dallas, TX 75266-0908

Deadline for Internal Review of Initial Adverse Benefit Determinations

(1) Urgent Care Claims. The Plan provides for 2 levels of appeal for urgent care claims. For each level of appeal, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 36 hours after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

(2) Pre-Service Claims. The Plan provides for 2 levels of appeal for a pre-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

(3) Post-Service Claims. The Plan provides for 2 levels of appeal for a post-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

Manner and Content of Notice of Decision on Internal Review of Initial Adverse Benefit Determinations

Upon completion of its review of an initial adverse determination (or a first-level appeal adverse determination), the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse determination, the notice will include:

(1) A description of the Plan’s decision;

(2) The specific reasons for the decision;

(3) The relevant Plan provisions or insurance contract provisions on which its decision is based;

(4) A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;

(5) A statement describing your right to request an external review (or, if applicable, to request a second level appeal),or, if applicable, to bring an action for judicial review;

(6) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to you upon request;

(7) If the adverse determination on review is based on a Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request.

(8) If the adverse determination is based on the Plan's Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

Any notice of adverse determination will include the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Calculation of Time Periods

For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review of an adverse benefit determination) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

Adverse Determination

For purposes of the Plan's claim procedures, an "adverse determination" is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary or appropriate. Adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

Review of Issues That Are Not a Claim as Defined in This Plan

A Covered Person may request review of an issue (That is not considered a claim for purposes of these procedures and not eligible for review as defined in this plan) by writing to the Plan Sponsor whose contact information is listed on the quick reference information page in this Plan Document. The request will be reviewed by the Plan Administrator at their next regularly scheduled Board of Trustees meeting. The Plan Participant will be sent written notification of the Trustees final decision within 30 days following the meeting. The decision of the Plan Administrator shall be final and binding on all parties.

Plan's Failure to Follow Procedures

If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy (including any available external review process) under state or federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

However, the Plan will not be treated as failing to follow its claim procedures and you will not be deemed to have exhausted the Plan's administrative remedies merely because of a failure by the Plan that would be considered (based on applicable regulations) a "*de minimis* violation" that does not cause and is not likely to cause prejudice or harm to you as long as the Plan can demonstrate that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you. You may request a written explanation of any violation by the Plan of these procedures. If you request such an explanation, the Plan will provide it within 10 days and, if applicable, the explanation will include a specific description of the Plan's reasons for asserting that the violation does not cause the Plan's internal claim procedures to be exhausted. If a court or external review rejects your request for an immediate review (based on a claim that you should be deemed to have exhausted the Plan's internal claim procedures), because the court or external reviewer determines that the "*de minimis* violation" exception applies, the Plan will provide to you a notice of your right to resubmit your internal appeal with a reasonable time (no longer than 10 days) after the court or external reviewer makes such a determination. Any applicable time limit for you to re-file your claim will begin to run when you receive that notice from the Plan.

External Review of Adverse Benefit Determinations

If you have exhausted the Plan's internal appeal process (or if you are eligible to request an external review for any other reason under the above procedures), you may request an external review of the Plan's final adverse determination for certain health benefit claims.

The Plan will provide for an external review process in accordance with applicable state law (if any). If no external review process exists under applicable state law or if the state law external review process does not meet certain minimum standards of the NAIC Uniform Health Carrier External Review Model Act (or the temporary "NAIC-similar" standards described in Department of Labor Technical Release 2011-02), the Plan will provide for an external review process that meets federal law requirements. Governmental plans that are not eligible to participate in a qualifying state process must elect to participate in a federal process administered by HHS or in the federal external review process that applies to ERISA-governed, self-funded Plans. If the Plan elects to participate in the federal external review process that applies to an ERISA self-funded plan, the external review procedures described below will apply.

Note that the federal external review process (including the expedited external review process described later in these procedures) is <u>not</u> available for review of all internal adverse determinations. Specifically, federal external review is not available for review of an internal adverse determination that is based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan. Also, the federal external review process is available only for:

(1) An adverse determination that involves medical judgment (including, but not limited to determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the Plan's determination that a treatment is Experimental or Investigational), as determined by the external reviewer;

(2) A rescission of coverage;

(3) An adverse determination for Surprise Bills (medical and air ambulance bills), including determination of whether an adverse determination is subject to Surprise Bill provisions;

(4) An adverse determination involving whether a Covered Person is entitled to a reasonable alternative standard for a reward under the Plan’s wellness program (if any); and

(5) An adverse determination involving whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) and its implementing regulations (if applicable and which generally require, among other things, parity in the application of medical management techniques).

For any adverse determination for which external review is available, the federal external review requirements are as follows:

(1) You have 4 months following the date you receive notice of the Plan’s final internal adverse determination within which to request an external review. The request for an external review must be submitted to the following address:

Appeals Department
P.O. Box 660908
Dallas, TX 75266-0908

(2) Within 5 business days following the date the Plan receives your external review request the Plan will complete a preliminary review. The Plan will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the U.S. Department of Health and Human Services Health Insurance Assistance Team (HIAT).

(b) If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(3) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within 5 business days following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.

(4) The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within 10 business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.

(5) Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO's notice is required to contain the following:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Expedited External Review
You may request an expedited external review if you have received:

(1) An initial internal adverse determination if the adverse determination involves a medical condition for which the time frame for completion of an expedited internal appeal under the Plan's internal claim procedures 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

(2) A final internal adverse determination, if you have a medical condition where 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 if the final internal adverse determination concerns an admission, availability of care, continued stay or health care item or service for which you received Emergency Services but have not been discharged from a facility.

The following requirements apply to an expedited external review:

(1) Immediately following the date the Plan receives the external review request the Plan will complete a preliminary review. The Plan will notify you in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.

    (a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will include contact information for the Employee Benefits Security Administration.

    (b) If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(2) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) to make a determination on the request for external review. The Plan will promptly forward to the IRO, by any available expeditious method (e.g. telephone, facsimile, etc.), all information and materials relevant to the final internal adverse determination.

(3) The IRO must provide notice to the claimant and the Plan (either in writing or orally) as expeditiously as the claimant's medical condition or circumstance require and no later than 72 hours after it receives the expedited external review request from the Plan. If notice is not provided in writing, the IRO must provide written notice to you and the Plan as confirmation of the decision within 48 hours after the date of the notice. The IRO's notice is required to contain the following information:

    (a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

    (b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

    (c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

    (d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

    (e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;

    (f) A statement that judicial review may be available to you; and

    (g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Effect of External Review Determination
A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable state or federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

State Insurance Laws
Nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law.

Statute of Limitations for Plan Claims
Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered). You must also comply with the Arizona Revised Statutes Section 12-821.01 before bringing a legal action against the Plan or its agents, employees, or Trustees.

Appointment of Authorized Representative
A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Third Party Administrator. However, in connection with a claim involving urgent care or services rendered by a Participating Provider, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Claims Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition for coverage.

COORDINATION OF BENEFITS (COB)

Benefits Subject to This Provision
This provision applies to all benefits provided under any section of this Plan.

Excess Insurance
If at the time of Injury, Illness, 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 the Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

(1) Any primary payer besides the Plan;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(3) Any policy of insurance from any insurance company or guarantor of a third-party;

(4) Worker's Compensation or other liability insurance company; or

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Vehicle Limitation
When medical payments are available (or, under applicable law should be available) under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification. If medical payments would have been available under a vehicle insurance policy if minimum legally required levels of coverage had been in effect, but the minimum level of coverage was not in effect, the Plan shall pay excess benefits only, determined as if the minimum legally required level of coverage had been in effect at the applicable time.

Allowable Expenses
"Allowable expenses" shall mean any Medically Necessary, Usual and Customary item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered in the amount that would be payable in accordance with the terms of the Plan shall be deemed to be the benefit.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as allowable expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

Other Plan
"Other Plan" means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

(1) Group, blanket or franchise insurance coverage;

(2) Any group Hospital service prepayment, group medical or dental service prepayment, group practice or other group prepayment coverage;

(3) Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, school insurance or employee benefit organization plans;

(4) Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;

(5) Coverage under any Health Maintenance Organization (HMO); or

(6) Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of Injuries arising out of a motor vehicle Accident and any other medical and liability benefits received under any automobile policy.

Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled “Order of Benefit Determination” will pay as if there were no other plan involved. When this Plan is secondary, this Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. When there is a conflict in the order of benefit determination, this Plan will never pay more than 50% of allowable expenses.

Order of Benefit Determination
For the purposes of the section entitled “Application to Benefit Determinations,” the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim:

(1) A plan without a coordinating provision will always be the primary plan;

(2) The plan covering the person directly rather than as an employee's dependent is primary and the other plans are secondary.

(3) Active/laid-off or Retirees: The plan which covers a person as an active employee determines its benefits before the Plan which covers a person as laid-off or retired. If the Plan which covers that person has not adopted this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

(4) Dependent children of parents not separated or divorced or unmarried parents living together: The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent and if as a result the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(5) When none of the above determine which Plan is primary, the plan covering the person the longest will be primary.

When dependent children are covered under more than one plan as a result of a divorce or legal separation, the Primary Plan order of responsibility will be determined as follows:

(1) First: The plan where the dependent child is covered as a result of a divorce decree or court ordered "Qualified Medical Child Support Order" (QMCSO) which establishes financial responsibility for the medical expenses.

(2) Second: The plan of the natural or adoptive parent who has custody of the dependent child.

(3) Third: The plan of the stepparent, provided the child’s permanent primary residence is with the stepparent.

(4) Fourth: The plan of the natural or adoptive parent who does not have custody.

(5) Fifth: When the court decree does not specify which parent is responsible for the child's health care expenses, the "Birthday Rule" as defined above will apply.

(6) When none of the above determine which plan is Primary, the plan covering the dependent child the longest will be Primary.

When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare.

In accordance with federal law, the following rules apply in determining whether Medicare or Plan coverage is primary health care coverage:

(1) The Working Aged Rule: Medicare benefits are secondary to benefits payable under the Plan for individuals entitled to Medicare due to being age 65 or over and who have Plan coverage as a result of his or her current employment status (or the current employment status of a Spouse). When you or your Spouse become eligible for Medicare due to the attainment of age 65, you or your Spouse may still be eligible for benefits provided under the Plan based on your current employment status.

    If, as a result, you have or your Spouse has primary coverage under the Plan, the Plan will pay the portion of your Incurred expenses that are normally covered by the Plan. All or part of the remaining amount, if any, may be paid by Medicare if the expenses are Covered Expenses under Medicare and the portion of the expenses covered by Medicare exceeds the portion covered by the Plan. If the expenses are not covered by the Plan but are Medicare-Covered Expenses, then Medicare will process its payment of the expenses as if you do not have Plan coverage.

(2) The Working Disabled Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals under age 65 entitled to Medicare on the basis of disability (other than end-stage renal disease) and who are covered under the Plan as a result of current employment status with an employer. That is, if you or your Dependents are covered by the Plan based on your current employment status, Medicare benefits are secondary for you or your covered Dependents entitled to Medicare on the basis of disability (other than end-stage renal disease). In this case the Plan is primary.

(3) End-Stage Renal Disease Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals eligible for or entitled to Medicare benefits on the basis of end-stage renal disease ("ESRD") or entitlement to Medicare due to ESRD. (Special rules apply if you were entitled to Medicare based on age or disability prior to becoming eligible for Medicare due to ESRD.) Because an ESRD patient can have up to a 3-month wait to obtain Medicare coverage, the Plan's primary payment responsibility may vary up to 3 months. If the basis of your entitlement to Medicare changes from ESRD to age or disability, the Plan's primary payment responsibility may terminate on the month before the month in which the change is effective and the rules set forth above, if applicable, will apply. The Third Party Administrator can provide you with more detailed information on how this rule works.

Medicare and COBRA

If you have existing Medicare Benefits (Part A or B) or become effective on or before the day you elect COBRA coverage, you are eligible for COBRA continuation of coverage.

For most COBRA beneficiaries (e.g., the working aged or disabled Medicare beneficiaries), Medicare rules state that Medicare will be primary to COBRA continuation coverage and this would apply to this Plan’s Continuation of Benefits (COBRA) coverage. For an ESRD-related Medicare beneficiary, COBRA continuation coverage (if elected) is generally primary to Medicare during the 30-month coordination period.

If you become entitled to Medicare after enrollment through COBRA, your COBRA medical benefits may be terminated. Please see Termination of COBRA Continuation Coverage for more information.

Coordination of Benefits with TRICARE

The Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Payment Condition

(1) The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by or results from the acts or omissions of you and/or your Dependents, plan beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns (collectively referred to hereinafter in this section as “Covered Person”) 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 guarantor(s) of a third party (collectively “coverage”)

(2) The Covered Person, 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 100% of the Plan’s conditional payment of benefits or the full extent of payment from anyone or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. The Plan shall have an equitable lien on any funds received by the Covered Person 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 Covered Person agrees to include the Plan’s name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

(3) In the event a Covered Person settles, recovers or is reimbursed by any coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person 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 Covered Person(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 Covered Person 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 Covered Person is entitled, regardless of how classified or characterized, at the Plan’s discretion, if the Covered Person fails to so pursue said rights and/or action.

(2) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person may have against any coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan’s behalf and function as a trustee as it applies to those funds until the Plan’s rights described herein are honored and the Plan is reimbursed.

(3) The Plan may, at its discretion, in its own name or in the name of the Covered Person, 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 Covered Person 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) Workers' 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 Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person 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 Covered Person is fully compensated by his or 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 subrogation 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 Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

(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 Covered Person, 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 Covered Person.

(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 Illness, Injury, disease or disability.

Participant is a Trustee Over Plan Assets

(1) Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Participant understands that he/she is required to:

(a) Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

(b) Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

(c) In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

(d) Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

(2) To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

(3) No participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance
If at the time of Injury, Illness, 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 provided for under the Plan's "Coordination of Benefits" section. The Plan's benefits shall be excess to:

(1) The responsible party, its insurer or any other source on behalf of that party;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(3) Any policy of insurance from any insurance company or guarantor of a third party;

(4) Workers' Compensation or other liability insurance company; or

(5) 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
Benefits paid by the Plan, funds recovered by the Covered Person and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person or filing of bankruptcy by the Covered Person, 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
In the event that the Covered Person 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 and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person and all others that benefit from such payment.

Obligations
(1) It is the Covered Person'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 Illness, 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;

(f) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;

(g) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan beneficiary may have against any responsible party or coverage;

(h) To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;

(i) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and

(j) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

(2) If the Covered Person 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 Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

(3) The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Persons' cooperation or adherence to these terms.

Offset
If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status
(1) In the event the Covered Person 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
The Plan Sponsor 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 Sponsor may amend the Plan at any time without notice.

Severability
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.

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan's right to subrogation and reimbursement may be subject to applicable state subrogation laws.

DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Plan. There may be additional words or terms that have a meaning that pertains to a specific section and those definitions will be found in that section provided, however, that any such capitalized word shall have such meaning when used in any other section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan. Please refer to the appropriate sections of this Plan for that information.

Accident means a non-occupational sudden and unforeseen event, definite as to time and place or a deliberate act resulting in unforeseen consequences.

Administrative Period means the optional period, during which an Employer can determine which Employees are Full-Time Employees, notify and enroll eligible Employees in coverage, etc. (similar to an open enrollment period). This period cannot be longer than 90 days and cannot be used to reduce or lengthen the Measurement or Stability Periods. The Administrative Period includes all periods, other than the Initial Measurement Period, between the day he or she completes at least one Hour of Service with the Employer of a New Employee who is a Part-Time or Variable Hour Employee and the first day of the Employee's Initial Stability Period.

Ambulatory Surgical Center means a free-standing surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

Assistant Surgeon means a Physician who actively assists the Physician in charge of a case in performing a Surgical Procedure. Depending on the type of Surgery to be performed, an operating surgeon may have one Assistant Surgeon, or 2 Assistant Surgeons if Medically Necessary. The technical aspects of the Surgery involved dictate the need for an Assistant Surgeon.

Birthing Center means a place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) is operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Calendar Year means January 1 – December 31.

Close Relative means a Covered Person's spouse, parent (including step-parents), sibling, child (by blood or marriage), grandparent or in-law.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time.

Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Coinsurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the Medical Schedule of Benefits.

Concurrent Review means the Medical Management Program Administrator will review all Inpatient admissions for a patient's length of stay. The review is based on clinical information received by the Medical Management Program Administrator from the provider or facility.

Congenital Anomaly means a physical developmental defect that is present at birth.

Copay is the portion of the medical expense that is your responsibility, as shown in the Medical Schedule of Benefits – EPO Plan. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible.

Cosmetic means any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease.

Covered Expense means:

(1) An item or service listed in the Plan as an eligible medical expense for which the Plan provides coverage.

(2) For Prescription Drug expenses, any Prescription Drugs or medicines eligible for coverage under the Prescription Drug Program.

Covered Person means, individually, a covered Employee and each of his or her Dependents who are covered under the Plan.

Custodial Care means care or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, and preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Deductible (EPO) is the total amount of eligible expenses as shown in the Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan, exceptions to the Deductible requirement are labeled as “Deductible waived” in the Medical Schedule of Benefits.

Deductible (HDHP Plan) is the total amount of eligible expenses as shown in the Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan, exceptions to the Deductible requirement are labeled as “Deductible waived” in the Medical Schedule of Benefits. The family Deductible maximum, as shown in the Schedule of Benefits, is the maximum amount which must be Incurred by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to a family Deductible.

Dentist means an individual who is duly licensed to practice dentistry or to perform oral Surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

Dependent is a Covered Person, other than the Employee**,** who is covered by the Plan pursuant to the terms and conditions set forth in the "Eligibility for Participation" section of the Plan.

Durable Medical Equipment means equipment that:

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of an Illness or Injury; and

(4) Is appropriate for use in the home.

Emergency Medical Condition means a medical condition (including a Mental Disorder or Substance Use Disorder) manifesting itself 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 a condition described in clause (1) (placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child), (2) (resulting in serious impairment to bodily functions), or (3) (leading to serious dysfunction of any bodily organ or part) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)).

Notwithstanding the preceding or anything in the Plan to the contrary, to the extent that the above definition is inconsistent with the applicable provisions of the No Surprises Act (and any binding, authoritative guidance issued under the No Surprises Act), the provisions of the No Surprises Act (and such binding, authoritative guidance issued under the No Surprises Act) shall control.

Emergency Services, with respect to an Emergency Medical Condition, means (1) an appropriate medical screening examination (as required under Section 1867 of the Social Security Act (42 U.S.C. 1395dd) (or as would be required under such section if such section applied to an independent freestanding emergency department) 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 (b) 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 (42 U.S.C. 1395dd) (or as would be required under such section if such section applied to an independent freestanding emergency department) to Stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

Emergency Services also includes certain post-stabilization services furnished by a Non-Participating Provider or a Non-Participating Provider emergency facility (after a Covered Person is Stabilized and as part an outpatient observation or an Inpatient or outpatient stay with respect to the visit in which the initial services described in (a) above were provided to the extent required under the No Surprises Act), unless each of the following conditions is met:

(1) The attending emergency Physician or treating provider has determined that you are able to travel using nonmedical transportation or non-emergency medical transportation to an available Participating Provider (including a participating facility) located within a reasonable travel distance, taking into account your medical condition and any other relevant factor;

(2) If the provider is a Non-Participating Provider: (a) the provider gives you notice (in the manner required under the No Surprises Act) that the services rendered will be performed by a Non-Participating Provider and you consent to waive your rights to the protections under the Surprise Billing requirements of the No Surprises Act; and (b) you or your authorized representative (as determined under state law and the applicable provisions of the No Surprises Act) are in a condition to provide informed, voluntary consent in accordance with applicable state law; and

(3) The provider satisfies any additional applicable state law requirements and any additional requirements provided in binding, authoritative guidance issued pursuant to the No Surprises Act (as applicable to the Plan).

Notwithstanding the preceding or anything in the Plan to the contrary, to the extent that the above definition is inconsistent with the applicable provisions of the No Surprises Act (and any binding, authoritative guidance issued under the No Surprises Act), the provisions of the No Surprises Act (and such binding, authoritative guidance issued under the No Surprises Act) shall control.

Employee is defined in the "Eligibility for Participation" section of the Plan.

Employer means Mohave County, or any successor thereto.

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

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

(1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or

(2) If the drug, device, medical treatment or procedure or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed, and approved by the treating facility's Institutional Review Board or other body serving a similar function or if federal law requires such review or approval, then it is deemed to be Experimental and/or Investigational; or

(3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials or is the subject of the research, Experimental, study, Investigational or other arm of on-going Phase III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational; or

(4) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational.

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

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

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

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment, or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Administrator.

FMLA means the Family and Medical Leave Act of 1993, as may be amended from time to time.

Foster Child is defined in the "Eligibility for Participation" section of the Plan.

Full-Time Employee means for a New Employee, an Employee who upon hiring is reasonably expected to work, on average, at least 30 Hours of Service per week. A Full-Time Employee (and his or her eligible Dependents) must be offered coverage no later than 90 days from the day he or she completes at least one Hour of Service with the Employer (or at the end of the Waiting Period). For an Ongoing Employee, it is defined to mean an Employee who has been determined during the Measurement Period to average at least 30 Hours of Service per week.

Health Care Facility means a: (1) a Hospital; (2) a Hospital outpatient department; (3) a critical access Hospital; and (4) an Ambulatory Surgical Center.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide healthcare planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

Hospice means an agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) has obtained any required state or governmental Certificate of Need approval; (2) provides 24-hour-a-day, 7 days-a-week service; (3) is under the direct supervision of a duly qualified Physician; (4) has a nurse coordinator who is a registered nurse (R.N.) with 4 years of full-time clinical experience, at least 2 of which involved caring for terminally ill patients; (5) has a social-service coordinator who is licensed in the jurisdiction in which it is located; (6) is an agency that has as its primary purpose the provision of hospice services; (7) has a full-time administrator; (8) maintains written records of services provided to the patient; (9) the employees are bonded and it provides malpractice and malplacement insurance; (10) is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist or a certified respiratory therapist; and (12) provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

Hospital means a facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat Illnesses or Injuries on an Inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has 24-hour-a-day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental Disorders or Substance Use Disorders which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home or a similar institution.

Hour(s) of Service mean each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer (or a related Employer) and each hour for which an Employee is paid, or entitled to payment by the Employer (or a related Employer) for 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, but excluding Hours of Service to the extent that the compensation for those services constitutes income from sources outside the United States or performed as (1) a bona fide volunteer (as defined in Treas. Reg. Section 54.4980H-1(a)(7)) or (2) part of a federal or state work study program. For purposes of this definition, a related Employer is any entity that must be treated as part of the same “applicable large employer” as the Employer for purposes of Code Section 4980H, as determined at the time that the applicable Hour of Service is performed or credited.

For Employees paid on an hourly basis, an Employer must calculate actual Hours of Service from records of hours worked and hours for which payment is made or due (the “actual method”). For Employees paid on a non-hourly basis, the Employer must calculate Hours of Service based on the actual method or, provided doing so does not substantially understate the Employee’s hours, using an equivalency method where the Employee is credited with either: (1) 8 Hours of Service for each day for which the Employee would be required to be credited with one Hour of Service; or (2) 40 Hours of Service for each week for which the Employee would be required to be credited with at least one Hour of Service.

Illness means a non-occupational bodily disorder, disease, physical sickness, pregnancy (including childbirth and miscarriage), Mental Disorder or Substance Use Disorder.

Incurred means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are Incurred for the various steps or phases

as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Information means information about genes, gene products and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility); and (2) establishing contribution or premium accounts for coverage under the Plan.

Initial Measurement Period means the “look back period” during which an Employer measures the Hours of Service for its New Employees in order to determine their status as a Full-Time Employee or Part-Time Employee which may begin on the day the New Employee completes at least one Hour of Service with the Employer or any date up to and including the first day of the first calendar month (or, if later, the first day of the first payroll period) starting on or after the date the Employee completes at least one Hour of Service for the Employer. For purposes of this definition, an Employee who has been rehired by the Employer is treated as a New Employee for the Employer on his or her most recent reemployment date only if more than 13 consecutive weeks have passed since the Employee was last credited with an Hour of Service with the Employer (or with any affiliated company organization that is required to be treated as the same Employer for purposes of Code Section 4980H).

Initial Stability Period means the Stability Period New Employees must satisfy if a New Employee who is a Part-Time or Variable Hour Employee is determined to average less than 30 Hours of Service per week during his or her Initial Measurement Period. The Initial Stability Period must not be more than one month longer than the Initial Measurement Period and must not exceed the remainder of the first entire Standard Measurement Period (plus Administrative Period) for which the Employee has been employed. If a New Employee who is a Part-Time or Variable Hour Employee is determined to average at least 30 Hours of Service per week during the Initial Measurement Period, the Initial Stability Period must be a period of at least 6 consecutive calendar months and no shorter in duration than the Initial Measurement Period.

Injury means physical damage to the body, caused by an external force and which is due directly and independently of all other causes, to an Accident.

Inpatient means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for room and board is made by the Hospital.

Intensive Care Unit means a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a “coronary care unit” or an “acute care unit.” It has: (1) facilities for special nursing care not available in regular rooms and wards of the Hospital; (2) special life saving equipment which is immediately available at all times; (3) at least 2 beds for the accommodation of the critically ill; and (4) at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original eligibility period. A Special Enrollee is not considered a Late Enrollee.

Legal Guardian is defined in the "Eligibility for Participation" section of the Plan.

Lifetime Maximum means the maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan may provide for a Lifetime Maximum benefit for specific types of medical treatment. Any Lifetime Maximum will be shown in the applicable Schedule of Benefits or the applicable Covered Expenses section of the Plan.

Long-Term Acute Care Facility/Hospital (LTACH) means a facility that provides specialized acute care for medically complex patients who are critically ill; have multi-system complications and/or failures and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour-a-day, 7 days a week basis. The severity of the LTACH patient's condition requires a Hospital stay that provides: (1) interactive Physician direction with daily on-site assessment; (2) significant ancillary services as dictated by complex, acute medical needs - such as full service and laboratory, radiology, respiratory care services, etc.; (3) a patient-centered outcome-focused, interdisciplinary approach requiring a Physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care; (4) clinically competent care providers with advanced assessment and intervention skills; and (5) education for the patient and family to manage their present and future healthcare needs.

Maintenance Therapy means medical and non-medical health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient is not changing or does not require continued administration by medical personnel.

Measurement Period means the "look back period" during which an Employer measures the Hours of Service for its Employees in order to determine their status as a Full-Time Employee or Part-Time Employee. This period can be between 3 and 12 consecutive calendar months.

For purposes of computing average Hours of Service for an Employee during any Measurement Period, any portion of that Measurement Period that qualifies as "special unpaid leave" will be disregarded. For purposes of this definition, "special unpaid leave" means unpaid leave for jury duty, unpaid leave that is subject to the Family and Medical Leave Act of 1993, or unpaid leave that is subject to the Uniformed Services Employment and Reemployment Rights Act of 1994.

For Employees paid on a biweekly basis, the determination of Hours of Service credited for a Measurement Period begins with the first day of the pay period that includes the first day of the Measurement Period and ends with the last day of the last pay period that ends on or before the last day of that Measurement Period.

Medically Necessary/Medical Necessity means treatment is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

(1) "Proven" means the care is not considered Experimental and/or Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.

(2) "Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness or a clinical condition.

(3) "Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Plan.

All criteria must be satisfied. When a Physician recommends or approves certain care it does not mean that care is Medically Necessary.

Medicare means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

New Employee means any Employee who has yet to be employed for a full Standard Measurement Period or who resumed employment with the Employer (or a related entity that would be considered the same Employer for purposes of Code Section 4980H) after at least 13 consecutive weeks during which the Employee was not credited with an Hour of Service for the Employer (or a related entity).

Non-Participating Provider means a health care practitioner or health care facility that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Ongoing Employee is a current Employee who has worked at least one Standard Measurement Period, as defined by this Plan.

Orthodontic Treatment means the corrective movement of teeth to treat a handicapping malocclusion of the mouth.

Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Plan Year before the percentage payable under the Plan increases to 100%.

The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Calendar Year.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum, if applicable, is the maximum amount that must be satisfied by covered family members during a Calendar Year. The entire family Out-of-Pocket Maximum must be satisfied; however each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum before the Plan will pay 100% of Covered Expenses for any Covered Person in the family during the remainder of that Calendar Year.

Part-Time Employee means for any New Employee, an Employee who the Employer reasonably expects to work, on average, less than 30 Hours of Service per week during the Initial Measurement Period. For an Ongoing Employee, an Employee who has been determined during the Standard Measurement Period to average less than 30 Hours of Service per week.

Participating Provider means a health care practitioner or health care facility that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Physician means a legally licensed Physician or practitioner who is acting within the scope of their license under the laws of the state in which they practice. The definition of Physician includes, but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Speech or Hearing Therapist, Speech Pathologist, Licensed Midwife, Nurse Practitioner (N.P.), Physician's Assistant (P.A.), Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), Licensed Independent Substance Abuse Counselor (LISAC), Psychiatric Nurse Practitioner (PSYNP), Master Social Worker (MSW), Master Science Nurse (MSN), Master in Arts in Guidance and Counseling (MA), Master Education in Guidance and Counseling (MED) and Master in Counseling (MA). An employee of a Physician or a resident who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

Plan means the Mohave County Employee Benefit Trust.

Plan Administrator means the administrator of the Plan

Plan Sponsor means Mohave County or any successor thereto.

Plan Year means the period from July 1 - June 30 each year.

Prescription Drug means any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, "Caution: federal law prohibits dispensing without prescription," (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

Primary Care Physician means a licensed Physician practicing in one of the following fields: (1) family practice; (2) general practice; (3) internal medicine; (4) obstetrics and gynecology; (5) pediatrics; or (6) chiropractic.

Qualified Clinical Trial means a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening condition and is described in (1), (2) or (3) below:

(1) The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

    (a) The National Institutes of Health;

    (b) The Centers for Disease Control and Prevention;

    (c) The Agency for Health Care Research and Quality;

    (d) The Centers for Medicare & Medicaid Services;

    (e) A cooperative group or center of one of the entities described in (a) through (d) above;

    (f) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants; or

    (g) The Department of Veteran Affairs; the Department of Defense or the Department of Energy, if (i) the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Recognized Amount means either (1) the amount established through an all-payer rate setting model (if any) that applies to the Plan and/or provider under section 1115A of the Social Security Act; (2) the amount required under any state law (if any) that applies to your situation and service (i.e., state surprise medical billing law) where (a) does not apply; or (3) the lesser of billed charges or the “qualifying payment amount” (if (1) and (2) do not apply). The “qualifying payment amount” is the amount determined by the Plan in accordance with the applicable requirements of the No Surprises Act. In the case of any air ambulance services, item (3) above will apply unless otherwise provided under the No Surprises Act (and/or other binding, authoritative guidance under the No Surprises Act).

Reconstructive Surgery means Surgery that is incidental to an Injury, Illness or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such Surgery as Cosmetic when a physical impairment exists and the Surgery restores or improves function. Additionally, the fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Illness or Congenital Anomaly does not classify Surgery to relieve such consequences or behavior as Reconstructive Surgery.

Rehabilitation Facility means a facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed as an acute Rehabilitation Facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (7) 24 hour nursing services are available; and (8) the confinement is not for Custodial Care or maintenance care.

Seasonal Employee means an Employee who is hired into a position that recurs annually at about the same time each year for which the customary annual employment is 6 months or less.

Security Standards mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

Semi-Private Room means a Hospital room shared by 2 or more patients.

Skilled Nursing Facility is a facility that meets all of the following requirements:

(1) It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, developmentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Special Enrollee is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original eligibility period and who later enrolls in the Plan due to a Special Enrollment Event.

Specialist means a licensed Physician that provides services to a Covered Person within the range of their specialty (e.g. cardiologist, neurologist, etc.).

Specialty Drug is defined in the "Prescription Drug Program" section of the Plan.

Spouse is defined in the "Eligibility for Participation" section of the Plan.

Stability Period means the period during which Employees are considered Full-Time Employees or Part-Time Employees based on the Employee's Hours of Service during the Measurement Period, regardless of how many hours the individual works during the Stability Period.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment for the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions (1) there is adequate time to effect a safe transfer to another Hospital before delivery; and (2) transfer will not pose a threat to the health or safety of the woman or her unborn child to deliver (including the placenta).

Standard Measurement Period means the "look back period" during which an Employer measures the Hours of Service for its Ongoing Employees in order to determine their status as a Full-Time Employee or Part-Time Employee.

Standard Stability Period for Ongoing Employees, must be at least 6 consecutive calendar months long, and must not be shorter than the Employer's elected Standard Measurement Period. (For example, if the Employer chose a 12 month Standard Measurement Period, the Standard Stability Period would also have to be 12 months.)

Substance Use Disorder means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

Surgery or **Surgical Procedure** means any of the following:

(1) The incision, excision, debridement or cauterization of any organ or part of the body and the suturing of a wound;

(2) The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

(3) The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;

(4) The induction of artificial pneumothorax and the injection of sclerosing solutions;

(5) Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;

(6) Obstetrical delivery and dilation and curettage; or

(7) Biopsy.

Surprise Bill/Surprise Billing happens when people unknowingly get care from providers that are outside of their health Plan's Network and can happen for both emergency and non-emergency care.

Third Party Administrator means Meritain Health, Inc., P.O. Box 853921, Richardson, TX 75085-3921.

Urgent Care Clinic means a facility that treats an urgent condition that requires prompt medical attention but is not a life-threatening Emergency Medical Condition. A board-certified Physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Clinic, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition. Additionally, this will not include an emergency room of a Hospital or a free-standing emergency room facility.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as may be amended from time to time.

Usual and Customary Charge (U&C) means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual that will be subject to a Usual and Customary determination. Subject to the rest of this definition, the Usual and Customary Charge means the lesser of the charge by other providers in the same geographic area or billed charges for the same or comparable service or supply. From time to time, the Plan may enter into an agreement with a Non-Participating Provider (directly or indirectly through a third party) which sets the rate the Plan will pay for a service or supply. In these cases the Usual and Customary Charge will be the rate established in such agreement with the Non-Participating Provider.

The Plan may reduce the Usual and Customary Charge by applying reimbursement policies administered by the Plan's Third Party Administrator. These reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

(1) The duration and complexity of a service;

(2) Whether multiple procedures are billed at the same time but no additional overhead is required;

(3) Whether an Assistant Surgeon is involved and necessary for the service;

(4) If follow up care is included;

(5) Whether there are any other characteristics that may modify or make a particular service unique; and

(6) When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

The reimbursement policies utilized are based on review of the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which are otherwise consistent with Physician or dental specialty society recommendations; and the views of Physicians and Dentists practicing in the relevant clinical areas.

The Usual and Customary Charge for covered services will be based on the median contract rate when a Covered Person had no control over the services performed by a Non-Participating provider who is under agreement with a Network facility or when the Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider.

Variable Hour Employee is an Employee who, at the time of hire, the Employer cannot reasonably determine if he or she will average at least 30 Hours of Service per week.

Waiting Period means the 30 consecutive days of full-time employment all new Covered Employees and Elected/Appointed Officials have to satisfy before becoming eligible to enroll in the Plan.

PLAN ADMINISTRATION

Delegation of Responsibility
The Plan Administrator has authority for the control and management of the operation and administration of the Plan. Per ARS 11-981 the Plan Sponsor has delegated fiduciary and other responsibilities to the Plan Administrator. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan.

Authority to Make Decisions
The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to you and/or your Dependent's rights and to decide questions of Plan interpretation and those of fact and law relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that you and/or your Dependent (as applicable) are entitled to them.

The duties of the Plan Administrator include the following:

(1) To administer the Plan in accordance with its terms;

(2) To determine all questions of eligibility, status and coverage under the Plan;

(3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

(4) To make factual findings;

(5) To decide disputes which may arise relative to a Covered Person's rights;

(6) To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;

(7) To keep and maintain the Plan documents and all other records pertaining to the Plan;

(8) To appoint and supervise a Third Party Administrator to pay claims;

(9) To perform all necessary reporting as required by federal or state law;

(10) To establish and communicate procedures to determine whether a child support order or decree is a QMCSO;

(11) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and

(12) To perform each and every function necessary for or related to the Plan's administration.

The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services.

Amendment or Termination of Plan
The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part upon a 30-day notice.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

MISCELLANEOUS INFORMATION

Assignment Of Benefits

No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in the Plan's QMCSO procedures.

Clerical Error

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to you and/or your Dependents have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity with Applicable Laws

This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of Plan. It is intended that the Plan will conform to the requirements of any applicable federal or state law.

Cost of the Plan

The Employer is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan, including, but not limited to, payment of Plan expenses from the Employers' general assets. The amount of contribution (if any) for your coverage or coverage for your Dependents will be determined from time to time by the Employer, in their sole discretion.

Indemnification of Trustees

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

Interpretation of this Document

The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Plan are used for convenience of reference only. You and your Dependents are advised not to rely on any provision because of the heading.

The use of the words, "you" and "your" throughout this Plan applies to eligible or covered Employees and, where appropriate in context, their covered Dependent*s*.

Minimum Essential Coverage

Refer to the Employer's Summary of Benefits and Coverage (SBC) for determination as to whether the Plan provides "minimum essential coverage" within the meaning of Code Section 5000A(f) and any accompanying regulations or guidance and whether it provides "minimum value" within the meaning of Code Section 36B(c)(2)(C)(ii) and any accompanying regulations or guidance (e.g. the Plan provides at least 60% actuarial value).

No Contract of Employment

This Plan and any amendments constitute the terms and provisions of coverage under this Plan. The Plan shall not be deemed to constitute a contract of any type between the Employer and any person or to be consideration for or an inducement or condition of the employment of any Employee. Nothing in this Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

Release of Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or person covered for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Worker's Compensation
This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any Workers' Compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that you received or are eligible to receive Workers' Compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement you receive from Workers' Compensation. The Plan will exercise its right to recover against you. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

(1) The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

(2) No final determination is made that the Injury or Illness was sustained in the course of or resulted from your employment;

(3) The amount of Workers' Compensation benefits due specifically to health care expense is not agreed upon or defined by you or the Workers' Compensation carrier; or

(4) The health care expense is specifically excluded from the Workers' Compensation settlement or compromise.

You are required to notify the Plan Sponsor immediately when you file a claim for coverage under Workers' Compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so or to reimburse the Plan for any expenses it has paid for which coverage is available through Workers' Compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

HIPAA PRIVACY PRACTICES

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with HIPAA's standards for privacy of individually identifiable health information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

(1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

(2) Modifying, amending or terminating the Plan.

"Summary health information" is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but that excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by 5-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes
Except as described under "Disclosure of Summary Health Information to the Plan Sponsor" above or under "Disclosure of Certain Enrollment Information to the Plan Sponsor" below or under the terms of an applicable individual authorization, the Plan may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the Plan. The Plan Sponsor by formally adopting this Plan document, certifies that it agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;

(2) Ensure that any agents, 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 PHI;

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(5) Make available PHI in accordance with section 164.524 of the privacy standards;

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;

(7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services ("HHS"), for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards;

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:

   (a) The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.

   (b) In the event any of the individuals described in (a) above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

(1) The Plan documents have been amended to incorporate the above provisions; and

(2) The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Information
Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose Information, including Information about testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include Information.

"Underwriting purposes" is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); and (3) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, "underwriting purposes" does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

In accordance with HIPAA's standards for security (the "Security Standards"), to enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(1) Implement and maintain administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.

(2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.

(3) Ensure that any agent, including any business associate or subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI.

(4) Report to the Plan any Security Incident of which it becomes aware.

(5) The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

ARTICLE I

NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

(1) All stages of reconstruction of the breast on which the mastectomy was performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) Prostheses; and

(4) Treatment of physical complications of the mastectomy, including lymphedema.

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

ARTICLE II

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

STATEMENT OF RIGHTS

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., the Covered Person's Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). Precertification is still required for the delivery and for newborn placement in an intensive care nursery. Pre-certification is also required for any length of stay period in excess of the minimum (48 or 96 hours), even though not required for the minimum length of stay period.

ARTICLE III

NOTICE OF PRESCRIPTION DRUG COVERAGE AND MEDICARE

**Important Notice About Your
Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current Prescription Drug coverage with the Mohave County Employee Benefit Trust (MCEBT) and about your options under Medicare's Prescription Drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare Prescription Drug coverage in your area. Information about where you can get help to make decisions about your Prescription Drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's Prescription Drug coverage:

(1) Medicare Prescription Drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

(2) It has determined that the prescription drug coverage offered by the MCEBT is, on average for all plan participants, expected to pay out as much as standard Medicare Prescription Drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current Prescription Drug coverage, through no fault of your own, you will also be eligible for a 2 month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

Your current MCEBT medical coverage pays for other health expenses in addition to Prescription Drugs. If you and/or your Covered Dependents enroll in a Medicare drug plan, you and/or your Covered Dependents will still be eligible to receive medical and Prescription Drug benefits through MCEBT. If you and/or your Covered Dependents enroll in a Medicare drug plan, in general, the following guidelines listed below apply.

(1) If you are an active Covered Employee, or the Covered Dependent of an active Covered Employee, you are required to obtain your outpatient Prescription Drug benefits through your MCEBT plan first. You can then file on a secondary basis with your Medicare drug plan.

(2) If you are a COBRA participant, or the Covered Dependent of a COBRA participant, you are required to obtain your outpatient Prescription Drugs through your Medicare drug plan first. Secondary coverage is not available through MCEBT

Important: You can only waive Prescription Drug coverage by waiving the entire MCEBT medical/prescription plan coverage for yourself and your Covered Dependents. Remember, if you do waive your MCEBT coverage, you can only re-enroll in the MCEBT medical plan coverage during the next Open Enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with MCEBT and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable Prescription Drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare Prescription Drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through MCEBT changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer Prescription Drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare Prescription Drug coverage:

(1) Visit www.medicare.gov.

(2) Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

(3) Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare Prescription Drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: July 01, 2024

Name of Entity/Sender: Mohave County Employee Benefit Trust

Address: 700 West Beale Street
Kingman, AZ 86401

Phone Number: (928) 753-0736

ARTICLE IV

EXEMPTION FROM MENTAL HEALTH & SUBSTANCE USE DISORDER PARITY

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

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

The exemption from this federal requirement was in effect for the first Plan Year beginning July 1, 2010. This election has been renewed for subsequent Plan Years.

If you have any questions regarding this election to exempt the MCEBT from the requirements of mental health parity, please feel free to contact your Benefits Department.

ARTICLE V

MEDICAID (AHCCCS) AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Medicaid (AHCCCS) And The Children's Health Insurance Program (Chip) Offer
Free Or Low Cost Health Coverage To Children And Families

If you are eligible for health coverage from your Employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid (AHCCCS in Arizona) or CHIP programs to help people who are eligible for Employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your Covered Dependents are already enrolled in Medicaid (AHCCCS) or CHIP, you can contact the Arizona Medicaid (AHCCCS) or CHIP office to find out if premium assistance is available.

If you or your Covered Dependents are NOT currently enrolled in Medicaid (AHCCCS) or CHIP, and you think you or any of your Covered Dependents might be eligible for either of these programs you can contact:

ARIZONA – CHIP
Website: http://www.azahcccs.gov/applicants/default.aspx
Phone: 602-417-5422

Or

Dial **1-877-KIDS NOW** or www.insurekidsnow.gov
to find out how to apply

Once it is determined that you or your Covered Dependents are eligible for premium assistance under Medicaid (AHCCCS) or CHIP, your employer's health plan is required to permit you and your Covered Dependents to enroll in the plan – as long as you and your Covered Dependents are eligible, but not already enrolled in the Employer's Plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

To research the availability of, and your eligibility for, premium assistance in other states, please contact the following agencies:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

ARTICLE VI

HIPAA PRIVACY AND SECURITY NOTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.** Effective Date of this Notice is September 23, 2013.

Your Rights

You have the right to:
- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:
- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:
- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records
- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for 6 years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information in the General Plan Information section of the Plan.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will provide a copy to you.

Additional information

After reading this Notice, if you have questions about the Plan's health information HIPAA Administrative Simplification Policies and Procedures or if you need additional information, you should contact:

Mohave County Employee Benefit Trust's (MCEBT's) Privacy Officer:
c/o Human Resources Director
700 West Beale Street
Kingman, AZ 86401
(p) (928) 753-0736
(f) (928) 753-0783

GENERAL PLAN INFORMATION

Name of Plan:	Mohave County Employee Benefit Trust
Plan Sponsor:	Mohave County 700 West Beale Street Kingman, AZ 86401 (928) 753-0736
Plan Administrator:	Mohave County Employee Benefit Trust 700 West Beale Street Kingman, AZ 86401 (928) 753-0736
Plan Sponsor EIN:	86-6000539
Plan Year:	July 1- June 30
Meritain Health, Inc. Group Number	13862
Third Party Administrator:	Meritain Health, Inc. P.O. Box 853921 Richardson, TX 75085-3921 (602) 789-1170 or (866) 300-8449 Fax No.: (716) 319-5736 www.meritain.com
COBRA Administrator:	Meritain Health, Inc. ATTN: COBRA Department P.O. Box 860093 Minneapolis, MN 55486-0093 Fax: (716) 319-5736
Medical Management Program Administrator:	American Health Group 2152 South Vineyard, #103 Mesa, AZ 85210 (602) 265-3800 or (800) 847-7605
Teladoc Program Administrator:	Teladoc, Inc. 1945 Lakepoint Drive Lewisville, TX 75057 (800) 835-2362 www.teladoc.com
Prescription Drug Program Administrator:	Navitus (855) 673-6504 www.navitus.com
Agent for Service of Legal Process:	Mohave County Employee Benefit Trust Attention: Human Resources Director 700 West Beale Street Kingman, AZ 86401 (928) 753-0736

Exclusive Provider Organizations *Names of Physicians & Hospitals in the EPO Networks*	BlueCross BlueShield of Arizona P.O. Box 13466 Phoenix, AZ 85002 (800) 232-2345 www.azblue.com/CHSNetwork Aetna Choice® POS II (800) 343-3140 www.aetna.com/docfind/custom/mymeritain
Trustee(s):	A list of trustees is available upon request and free of charge by contacting the Plan Sponsor.

The Plan is a legal entity. Legal notice may be filed with and legal process served upon, the Plan Administrator.