Arizona School Boards Association Insurance Trust Employee Benefit Plan

Group No.: 13632

Plan Document
and
Summary Plan Description

Originally Effective: July 1, 1981

Amended and Restated Effective: July 1, 2016

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ARIZONA SCHOOL BOARDS ASSOCIATION INSURANCE TRUST

TO: ALL COVERED PERSONS

The "ARIZONA SCHOOL BOARDS ASSOCIATION INSURANCE TRUST" has established this benefit Plan for the Participating Districts' covered Employees, Retirees and their covered Dependents. This is a self-funded benefit Plan. This revised Plan of benefits is effective as of 12:01 a.m. Mountain Standard Time on July 1, 2015.

Please read this booklet carefully as it will assist you in understanding the benefits provided by this Plan. All benefit payments are processed in accordance with the provisions of this Plan document. The purpose of this Plan document is to describe the provisions of the Plan which provide for payment of benefits for medical, dental, vision and prescription drug expenses. This Plan is maintained exclusively for the benefit of covered Employees, Retirees and their Dependents of the Participating Districts of the Arizona School Boards Association.

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

(1) Receive approval from ASBAIT Medical Management prior to receiving any items or services that require precertification. Please refer to the Medical Management Program section of this Plan for a list of services requiring precertification.

(2) Receive care from a provider in your Network.

(3) Have surgery and x-ray/laboratory work done on an outpatient basis whenever possible.

(4) Review all Hospital and Physician billings and the Explanation of Benefits to be sure you and the Plan have only been billed for the services you received.

(5) **TAKE CARE OF YOURSELF!** Eat right, control your weight, exercise, stop smoking, never drink and drive, and always wear your seat belt. Good habits will help you live a long happy life and will save money too.

IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR COVERAGE

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

TO YOUR GOOD HEALTH!

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ESTABLISHMENT OF THE PLAN

Arizona School Boards Association Insurance Trust (ASBAIT) (the "Trust" or "Plan Sponsor") has adopted this amended and restated Plan Document and Summary Plan Description effective as of July 1, 2016 for the Arizona School Boards Association Insurance Trust Employee Benefit Plan (hereinafter referred to as the "Plan" or "Summary Plan Description"), as set forth herein. The Plan was originally adopted by the Plan Sponsor effective as of July 1, 1981. Each Participating School District (the "Participating School"), with the consent of the Plan Sponsor, has adopted this Plan Document and Summary Plan Description effective as of the effective date of the participation agreement by and between the Plan Sponsor and each Participating School. The Plan Sponsor and each Participating School, as applicable, has adopted this Plan Document and Summary Plan Description for the exclusive benefit of its Employees, Retirees and their eligible Dependents.

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 and each Participating School's purpose of adopting 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 and each Participating School must attempt to control health care costs through effective plan design and 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 the Trust or any Participating School and does not give you the right to be retained in the service of the Trust and/or any Participating School.

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 Sponsor.

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.

GENERAL OVERVIEW OF THE PLAN

The Plan Sponsor has entered into an agreement with one or more networks of Participating Providers (Hospitals, Physicians and Dentists) called "Networks". One Network available under the Plan is through BlueCross BlueShield of Arizona (BCBSAZ). All other available Networks are identified on the Employee identification card. These Networks offer you health care services at discounted rates. Using a Network provider will normally result in a lower cost to the Plan as well as a lower cost to you. There is no requirement for anyone to seek care from a provider who participates in the Network. The choice of provider is entirely up to you.

Non-Participating Provider Exceptions
Covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level when a:

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

(2) Covered Person receives services by a Non-Participating Provider (e.g. anesthesiologists, radiologists, pathologists, etc.) who is under agreement with a Network facility.

The above exceptions do not apply to your dental benefits under the Plan.

Not all providers based in Network Hospitals or medical facilities are Participating Providers. It is important when you enter a Hospital or medical facility that you request that ALL Physician services be performed by Participating Providers. By doing this, you will always receive the greater Participating Provider level of benefits.

A current list of Participating Providers is available, without charge, through the Claims Administrator at www.meritain.com or, with respect to BCBSAZ providers you may contact BCBSAZ at (800) 232-2345 (or www.azblue.com/CHSnetwork). If you do not have access to a computer at your home, you may contact the Claims Administrator or the Network at the phone number on the Employee identification card to obtain a paper copy of the Participating Providers available.

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

You have a free choice of any provider and you, together with your provider, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The Participating Providers are independent contractors; neither the Plan, the Plan Sponsor or the Claims Administrator make any warranty as to the quality of care that may be rendered by any Participating Provider.

Wrap Network
Your Plan also has an arrangement with Aetna, 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 of the state of Arizona. 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. If you utilize a provider covered by the Wrap Network, your benefits will be paid at the Participating Provider benefit level.

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.

Coinsurance
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.

There may be differences in the Coinsurance percentage payable by the Plan depending upon whether you are using a Participating Provider or a Non-Participating Provider. These payment levels are also shown in the Medical Schedule of Benefits.

Copay
A Copay is the portion of the medical expense that is your 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
Note: This provision only applies to medical benefits under the Plan. Please refer to the Dental Expenses section of the Plan for information regarding the dental Deductible.

A Deductible is the total amount of eligible expenses as shown in the Medical Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan. The family Deductible maximum, as shown in the Medical 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.

$1300 HDHP Plan: The entire family Deductible must be satisfied by one individual or collectively before benefits will be paid at the Coinsurance rate.

If the Deductible is satisfied in whole or in part by eligible expenses Incurred during October, November or December, those expenses will apply to the Deductible applicable in the next Calendar Year. This provision does not apply if you participate in the HDHP Plans.

Out-of-Pocket Maximum
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 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.

Your Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers. 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) Dental and vision benefits (if applicable), other than those dental and vision expenses paid under the major medical component of the Plan.

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

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

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

Once you have 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 your Out-of-Pocket Maximum, please contact the Claims Administrator for assistance.

Integration of Deductibles and Out-of-Pocket Maximums
Note: This provision only applies to medical benefits under the Plan. Please refer to the Dental Expenses section of the Plan for the integration of Deductibles applicable to those benefits.

If you use a combination of Participating Providers and Non-Participating Providers, your total Deductible amount and Out-of-Pocket Maximum amount required to be paid are separate amounts and do not integrate. In other words, you will be required to satisfy the Deductible amount and Out-of-Pocket Maximum amount for Participating Providers and Non-Participating Providers separately.

MEDICAL MANAGEMENT PROGRAM

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. 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. 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.

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) Dialysis - all settings including services rendered in a Physician's office
- (c) Durable Medical Equipment (other than breast pumps covered as a preventive service) – in excess of $1,500 of the allowed amount per item
- (d) Hospice care
- (e) Inpatient admissions, including inpatient admissions to a Skilled Nursing Facility, Extended Care Facility, Rehabilitation Facility and inpatient admissions due to a Mental Disorder or Substance Use Disorder
- (f) Radiation - all settings including services rendered in a Physician's office
- (g) Imaging, limited to the following: CT/MRA/MRI/PET scans, scintimammography, capsule endoscopy and U.S. bone density (heel)
- (h) Morbid Obesity (surgical treatment only)
- (i) Oncotype Diagnostic Testing
- (j) Outpatient Surgical procedures, excluding Surgery rendered in a Physician's office
- (k) Pain management injections, including services rendered in a Physician's office
- (l) Transplants

(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 (that is 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 Trust and/or Participating School 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.

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 for the facility and the surgeon will be reduced by 20% per occurrence and this penalty amount will accumulate toward any Out-of-Pocket Maximum limit.

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.

Concurrent Review, 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 Information page of this Plan.

Case Management
When a catastrophic condition, such as 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 alternative 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.

ASBAIT NURSE HEALTH COACHING PROGRAM

The Nurse Health Coaching Program is a wellness benefit offered by the Employer to reduce the health risks of a Covered Person. The program is offered to help those Covered Persons with an ongoing or chronic medical condition better control and manage their condition and promote healthy lifestyle choices. Participation in this program is completely voluntary and confidential.

Medical conditions targeted by the Nurse Heath Coaching Program include:

(1) Asthma

(2) Congestive Heart Failure (CHF)

(3) Chronic Obstructive Pulmonary Disease (COPD)

(4) Chronic pain caused by arthritis or low back pain

(5) Coronary Artery Disease (CAD)

(6) Diabetes

(7) High Cholesterol

(8) High Blood Pressure

In addition to the targeted conditions above, the Nurse Health Coaching Program can also help Covered Persons meet health-related challenges, such as losing weight, quitting tobacco use, eating better and routinely exercising. Participants in the benefit program will be assigned a personal nurse coach to help set targets and goals, provide health information and educational resources, and assist the participant in complying with their Physician's plan of care.

A Covered Person may contact the 24-hour Nurse Line, 7 days a week, at (877) 348-4533, Option 1, to discuss current Illnesses, health issues, treatments, lifestyle choices and self-care strategies or to access a health information library to research certain health information.

Covered Persons who have been treated for any of the targeted conditions above may be invited to participate in the Nurse Health Coaching Program. Invitees will receive information about the benefit program's resources and educational opportunities. Covered Persons not invited to participate in the program may enroll themselves if they think they will benefit from the program by calling (855) 527-2248.

ASBAIT WELLNESS PROGRAM

The ASBAIT Wellness Program consists of the ASBAIT Biometric Program and the ASBAIT Healthy U Safe U Wellness Program. Each program is more fully described below.

ASBAIT Biometric Program
The ASBAIT Biometric Program is offered by the Plan to reduce the health risks of an Employee. The ASBAIT Biometric Program is made up of several different components and is designed to provide an Employee with the tools and personal support they need to make positive lifestyle changes. Participation in this program is completely voluntary.

The ASBAIT Biometric Program is a biometric evaluation that consists of an on-site blood draw by a licensed phlebotomist for analysis of blood lipids, blood glucose and liver enzymes; a blood pressure reading; and a body mass index calculation.

Upon completion of the biometric evaluation, the covered Employee will receive a confidential, individual report that identifies any potential health risk factors and other valuable health information for making positive lifestyle changes. The information contained in this individual report provides general health information only and does not constitute medical advice. You should review this individual report with your health care provider.

The Plan Sponsor may offer an Employee that participates in the Plan an additional incentive if he or she elects to participate in the ASBAIT Biometric Program. The amount of the incentive (if any) is determined by the Plan Sponsor and communicated in the program welcome materials.

ASBAIT Healthy U Safe U Wellness Program
The ASBAIT Healthy U Safe U Wellness Program takes a “holistic” approach to health management and assists Participating Schools to motivate Employees to make lifestyle changes that affect their well being. Employees are provided educational materials, including a quarterly safety, health and wellness newsletter in English and Spanish, wellness surveys and an innovative incentive program. For more information, please visit www.edwardsrisk.com.

ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – COPAY GOLD 2016-2017

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE Single Family	 N/A N/A	 $900 $2,700
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes medical Deductible, medical Coinsurance, medical Copays and Precertification Penalties – combined with Prescription Drug Card) Single Family	 $6,350 $12,700	 N/A N/A
MEDICAL BENEFITS		
Allergy Serum & Injections		
Injections (If no office visit charge)	100% after $5 Copay per visit	50% after Deductible
Serum	100% after $40 Copay per visit	50% after Deductible
Ambulance Services		
Ground	100% after $50 Copay per trip	100% after $50 Copay per trip
Air Ambulance	100% after $200 Copay per trip	100% after $200 Copay per trip
Ambulatory Surgical Center	100% after $75 Copay per occurrence	50% after Deductible
Anesthesiologist	100% after $60 Copay per occurrence	50% after Deductible
Anti-Embolism Garments (e.g. Jobst)	100% after $50 Copay per pair	$50 Copay per pair, then 50% after Deductible
Calendar Year Maximum Benefit	3 pairs	
Cardiac Rehab (Outpatient)	100% after $30 Copay per visit	50% after Deductible
Chemotherapy (Outpatient)	100% after $50 Copay* per visit	50% after Deductible
*Copay applies to all related services and supplies related to a patient receiving chemotherapy even if chemotherapy is not administered at the time the services are rendered.		
Chiropractic Care/Spinal Manipulation	100% after $30 Copay per visit	50% after Deductible
Calendar Year Maximum Benefit	20 Visits	

ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – COPAY GOLD 2016-2017

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Diagnostic Testing, X-Ray and Lab Services (Outpatient)		
Any Single Service Costing Less Than $500	100% after $30 Copay	50% after Deductible
Any Single Service Costing $500 or More	100% after $50 Copay	50% after Deductible
Freestanding Laboratory	100% after $30 Copay	50% after Deductible
Oncotype Diagnostic Testing	100% after $50 Copay	50% after Deductible
Durable Medical Equipment (DME)	100% after $30 Copay (rental); 100% after $200 Copay (purchase)	50% after Deductible
Emergency Services		
Emergency Medical Condition		
Facility Charges	100% after $150 Copay*	Paid at Participating Provider level of benefits, unless otherwise required by law
Professional Fees and Ancillary Charges	100% after $40 Copay*	Paid at Participating Provider level of benefits, unless otherwise required by law
Non-Emergency Medical Condition		
Facility Charges	100% after $150 Copay*	50% after Deductible
Professional Fees and Ancillary Charges	100% after $40 Copay*	50% after Deductible
*NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the same Hospital utilized for Emergency Services.		
Foot Orthotics	100% after $50 Copay per orthotic	$50 Copay per orthotic, then 50% after Deductible
Maximum Benefit	Age 19 and over - 1 every 12 months; Under age 19 - 1 every 6 months	
Hearing Aids (including any office visit and any related services, includes cochlear Implants)	100% after $50 Copay	$50 Copay, then 50% after Deductible
Maximum Benefit	1 aid per ear per 36-month period	
Hemodialysis (Outpatient)	100% after $50 Copay per occurrence	50% after Deductible
Home Health Care	100% after $30 Copay per visit	50% after Deductible
Calendar Year Maximum Benefit	60 visits*	
*Home health aid supplies are not subject to the Calendar Year Maximum.		
Hospice Care		
Inpatient	100% after $250 Copay per admission	$300 Copay per admission, then 50% after Deductible
Outpatient	100% after $30 Copay per visit	50% after Deductible

ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – COPAY GOLD 2016-2017

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	100% after $250 Copay per admission	$300 Copay per admission, then 50% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*
Outpatient	100% after $75 Copay per occurrence	50% after Deductible
*Charges for a private room, that exceeds the cost of a semi-private room, are eligible only if prescribed by a Physician and the private room is Medically Necessary.		
Infusion Therapy in Facility or Physician's Office	100% after $40 Copay per occurrence	50% after Deductible
Maternity (Professional Fees)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%	50% after Deductible
Breast Pumps	100%	100%; Deductible waived
Lactation Consultations	100%	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	100% after $300 Copay per pregnancy	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Medical Supplies	100% after $30 Copay	50% after Deductible
Mental Disorders and Substance Use Disorders		
Inpatient		
Facility Charge	100% after $250 Copay per admission	$300 Copay per admission, then 50% after Deductible
Professional Fees	100% after $30 Copay	50% after Deductible
Outpatient Facility	100% after $75 Copay per occurrence	50% after Deductible
Office Visits	100% after $30 Copay	50% 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.		
Morbid Obesity (Surgical Treatment Only)		
Facility (Inpatient and outpatient)	100% after $250 Copay	50% after Deductible
Professional Services	100% after $75 Copay	50% after Deductible
Lifetime Maximum Benefit	1 Surgical Procedure	
Nutritional Food Supplements	50%	50% after Deductible

ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – COPAY GOLD 2016-2017

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Occupational Therapy (Outpatient)	100% after $30 Copay per visit	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 Visits	
Physical Therapy (Outpatient)	100% after $30 Copay per visit	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 Visits	
Physician's Services		
Inpatient/Outpatient Services		
Primary Care Physician	100% after $30 Copay*	50% after Deductible
Specialist	100% after $40 Copay*	50% after Deductible
Office Visits		
Primary Care Physician	100% after $30 Copay*	50% after Deductible
Specialist	100% after $40 Copay*	50% after Deductible
Physician Office Surgery		
Primary Care Physician	Under $1,000 - 100% after $30 Copay*; $1,000 or more - 100% after $50 Copay*	50% after Deductible
Specialist	Under $1,000 - 100% after $40 Copay*; $1,000 or more - 100% after $50 Copay*	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service billed and received at the same time as any preventive service)	100%	Not Covered
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100% up to $300 per Calendar Year, then 10%	Not Covered
Flu Vaccinations/Pneumonia & Shingles Vaccinations	100%	100%; Deductible waived
Routine Hearing Exam	100% after $30 Copay per exam	50% after Deductible
Calendar Year Maximum Benefit	1 exam	
Prosthetics (other than bras)	100% after $200 Copay per item	100% after $200 Copay per item; Deductible waived
Prosthetic Bras	100% after $50 Copay per bra	100% after $50 Copay per bra; Deductible waived
Calendar Year Maximum Benefit	2 bras	
Psychological and Neuropsychological Testing	50%	50% after Deductible

ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – COPAY GOLD 2016-2017

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Radiation Therapy (Outpatient)	100% after $50 Copay per visit	50% after Deductible
Rehabilitation Facility (does not apply to Mental Disorders or Substance Use Disorders)	100% after $250 Copay per admission	$300 Copay per admission, then 50% after Deductible
Calendar Year Maximum Benefit	60 days	
Skilled Nursing Facility	100% after $250 Copay per admission	$300 Copay per admission, then 50% after Deductible
Maximum Benefit per 12 Month Period	60 days	
Speech Therapy (Outpatient)	100% after $30 Copay per visit	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 Visits	
Surgery (Inpatient)		
Facility	100% after $250 Copay per admission	50% after Deductible
Professional Services	100% after $75 Copay*	50% after Deductible
*Copay applies per surgical session.		
Surgery (Outpatient) (does not include surgery in the Physician's office)		
Facility	100% after $75 Copay*	50% after Deductible
Professional Services	100% after $75 Copay*	50% after Deductible
*Copay applies per surgical session.		
Temporomandibular Joint Dysfunction (TMJ)	100% after $50 Copay per occurrence	$50 Copay per occurrence, then 50% after Deductible
Lifetime Maximum Benefit: Surgical Procedure Appliances Office Services	1 Surgical Procedure 1 appliance $1,000	
Transplants (Facility)	100% after $250 Copay per admission	Not Covered
Urgent Care Facility	100% after $50 Copay per visit	$50 Copay per visit, then 50% after Deductible
Wig (see Eligible Medical Expenses)	100% after $50 Copay per wig	100% after $50 Copay per wig; Deductible waived
Maximum Benefit per 24 Month Period	1 wig	
All Other Eligible Medical Expenses	100% after $50 Copay*	$50 Copay*, then 50% after Deductible
*Copay applies per eligible item, service or occurrence.		

ASBA Insurance Trust

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – COPAY GOLD 2016-2017

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 Deductible and Copays – combined with major medical) Single Family	 $6,350 $12,700
Retail Pharmacy: 30-day supply	
Generic Drug	$15 Copay
Preferred Drug	20% Copay ($25 minimum, $80 maximum)
Non-Preferred Drug	30% Copay ($40 minimum, $110 maximum)
Specialty Drug	20% Copay ($100 minimum, $150 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Medications Generic Brand Name (Covered Persons must enroll in the Catamaran Diabetic Sense Program to receive the Copay for their diabetic supplies)	 $5 Copay $10 Copay
Mail Order: 90-day supply	
Generic Drug	$30 Copay
Preferred Drug	20% Copay ($50 minimum, $175 maximum)
Non-Preferred Drug	30% Copay ($80 minimum, $225 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Medications Generic Brand Name (Covered Persons must enroll in the Catamaran Diabetic Sense Program to receive the Copay for their diabetic supplies)	 $10 Copay $30 Copay

Mandatory Generic Program
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Brand Name Drug in addition to the Brand Name Drug Copay, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Mandatory Mail Order Program
This plan will allow maintenance medications to be filled at retail in 30 day quantities only and will be subject to appropriate copay upon each 30 day refill. Member must choose mail order to receive a 90 day quantity on a maintenance drug and benefit from paying only 2 copays for a 3 month (90 day supply).

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 paper copy, please contact the Plan Administrator.

ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – CLASSIC SILVER 2016-2017

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE Single Family	 $500 $1,000	 $1,400 $4,200
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes medical Deductible, medical Coinsurance, medical Copays and Precertification Penalties – combined with Prescription Drug Card) Single Family	 $4,500 $9,000	 N/A N/A
MEDICAL BENEFITS		
Allergy Serum & Injections		
Injections (If no office visit charge)	100% after $5 Copay per visit; Deductible waived	50% after Deductible
Serum	100% after $40 Copay per visit; Deductible waived	50% after Deductible
Ambulance Services		
Ground	80% after Deductible	Paid at Participating Provider level of benefits
Air Ambulance	$200 Copay per trip, then 80% after Deductible	Paid at Participating Provider level of benefits
Ambulatory Surgical Center	80% after Deductible	50% after Deductible
Anesthesiologist	80% after Deductible	50% after Deductible
Anti-Embolism Garments (e.g. Jobst)	$50 Copay per pair, then 80%; Deductible waived	$50 Copay per pair, then 50% after Deductible
Calendar Year Maximum Benefit	3 pairs	
Cardiac Rehab (Outpatient)	100% after $30 Copay per visit; Deductible waived	50% after Deductible
Chemotherapy (Outpatient)	80% after Deductible	50% after Deductible
Chiropractic Care/Spinal Manipulation	100% after $30 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	20 Visits	
Diagnostic Testing, X-Ray and Lab Services (Outpatient)		
Any Single Service Costing Less Than $500	80% after Deductible	50% after Deductible
Any Single Service Costing $500 or More	80% after Deductible	50% after Deductible
Freestanding Laboratory	100% after $30 Copay; Deductible waived	50% after Deductible
Oncotype Diagnostic Testing	80% after Deductible	50% after Deductible

ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – CLASSIC SILVER 2016-2017

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Durable Medical Equipment (DME)	80% after Deductible	50% after Deductible
Emergency Services		
Emergency Medical Condition		
Facility Charges	80% after Deductible	Paid at Participating Provider level of benefits, unless otherwise required by law
Professional Fees and Ancillary Charges	80% after Deductible	Paid at Participating Provider level of benefits, unless otherwise required by law
Non-Emergency Medical Condition		
Facility Charges	80% after Deductible	50% after Deductible
Professional Fees and Ancillary Charges	80% after Deductible	50% after Deductible
Foot Orthotics	$50 Copay per orthotic, then 80%; Deductible waived	$50 Copay per orthotic, then 50% after Deductible
Maximum Benefit	Age 19 and over - 1 every 12 months; Under age 19 - 1 every 6 months	
Hearing Aids (including any office visit and any related services, includes cochlear Implants)	$50 Copay, then 80%; Deductible waived	$50 Copay, then 50% after Deductible
Maximum Benefit	1 aid per ear per 36-month period	
Hemodialysis (Outpatient)	80% after Deductible	50% after Deductible
Home Health Care	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits*	
*Home health care supplies are not subject to the Calendar Year Maximum.		
Hospice Care		
Inpatient	$250 Copay per admission, then 80%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Outpatient	80% after Deductible	50% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	$250 Copay per admission, then 80%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*
Outpatient	80% after Deductible	50% after Deductible
*Charges for a private room, that exceeds the cost of a semi-private room, are eligible only if prescribed by a Physician and the private room is Medically Necessary.		
Infusion Therapy in Facility or Physician's Office	80% after Deductible	50% after Deductible

ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – CLASSIC SILVER 2016-2017

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Maternity (Professional Fees)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	50% after Deductible
Breast Pumps	100%; Deductible waived	100%; Deductible waived
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	80% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Medical Supplies	80% after Deductible	50% after Deductible
Mental Disorders and Substance Use Disorders		
Inpatient		
Facility Charge	$250 Copay per admission, then 80%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Professional Fees	80% after Deductible	50% after Deductible
Outpatient Facility	80% after Deductible	50% after Deductible
Office Visits	100% after $30 Copay; Deductible waived	50% 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.		
Morbid Obesity (Surgical Treatment Only)		
Facility (Inpatient and outpatient)	$250 Copay, then 80%; Deductible waived	50% after Deductible
Professional Services	80% after Deductible	50% after Deductible
Lifetime Maximum Benefit	1 Surgical Procedure	
Nutritional Food Supplements	50% after Deductible	50% after Deductible
Occupational Therapy (Outpatient)	100% after $30 Copay per visit; Deductible waived	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 Visits	
Physical Therapy (Outpatient)	100% after $30 Copay per visit; Deductible waived	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 Visits	

ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – CLASSIC SILVER 2016-2017

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Physician's Services		
Inpatient/Outpatient Services		
Primary Care Physician	80% after Deductible	50% after Deductible
Specialist	80% after Deductible	50% after Deductible
Office Visits		
Primary Care Physician	100% after $30 Copay*; Deductible waived	50% after Deductible
Specialist	100% after $40 Copay*; Deductible waived	50% after Deductible
Physician Office Surgery		
Primary Care Physician	Under $1,000 - 100% after $30 Copay*; Deductible waived; $1,000 or more – 80% after Deductible	50% after Deductible
Specialist	Under $1,000 - 100% after $40 Copay*; Deductible waived; $1,000 or more – 80% after Deductible	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
Preventive Services and Routine Care		
Preventive Services (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	Not Covered
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100% up to $300 per Calendar Year, then 10%; Deductible waived	Not Covered
Flu Vaccinations/Pneumonia & Shingles Vaccinations	100%; Deductible waived	100%; Deductible waived
Routine Hearing Exam	100% after $30 Copay per exam; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	1 exam	
Prosthetics (other than bras)	80% after Deductible	50% after Deductible
Prosthetic Bras	80% after Deductible	80% after Deductible
Calendar Year Maximum Benefit	2 bras	
Psychological and Neuropsychological Testing	50% after Deductible	50% after Deductible
Radiation Therapy (Outpatient)	80% after Deductible	50% after Deductible
Rehabilitation Facility (does not apply to Mental Disorders or Substance Use Disorders)	$250 Copay per admission, then 80%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Calendar Year Maximum Benefit	60 days	

ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – CLASSIC SILVER 2016-2017

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Skilled Nursing Facility	$250 Copay per admission, then 80%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Maximum Benefit per 12 Month Period	60 days	
Speech Therapy (Outpatient)	100% after $30 Copay per visit; Deductible waived	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 Visits	
Surgery (Inpatient)		
Facility	$250 Copay per admission, then 80%; Deductible waived	50% after Deductible
Professional Services	80% after Deductible	50% after Deductible
Surgery (Outpatient) (does not include surgery in the Physician's office)		
Facility	80% after Deductible	50% after Deductible
Professional Services	80% after Deductible	50% after Deductible
Temporomandibular Joint Dysfunction (TMJ)	$50 Copay per occurrence, then 80%; Deductible waived	$50 Copay per occurrence, then 50% after Deductible
Lifetime Maximum Benefit: Surgical Procedure Appliances Office Services	1 Surgical Procedure 1 appliance $1,000	
Transplants(Facility)	$250 Copay per admission, then 80%; Deductible waived	Not Covered
Urgent Care Facility	$50 Copay per visit, then 80%; Deductible waived	$50 Copay per visit, then 50% after Deductible
Wig (see Eligible Medical Expenses)	$50 Copay per wig, then 80%; Deductible waived	$50 Copay per wig, then 80%; Deductible waived
Maximum Benefit per 24 Month Period	1 wig	
All Other Eligible Medical Expenses	$50 Copay*, then 80%; Deductible waived	$50 Copay*, then 50% after Deductible
*Copay applies per eligible item, service or occurrence.		

ASBA Insurance Trust

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – CLASSIC SILVER 2016-2017

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 Deductible and Copays – combined with major medical) Single Family	 $4,500 $9,000
Retail Pharmacy: 30-day supply	
Generic Drug	$15 Copay
Preferred Drug	20% Copay ($25 minimum, $80 maximum)
Non-Preferred Drug	30% Copay ($40 minimum, $110 maximum)
Specialty Drug	20% Copay ($100 minimum, $150 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Medications Generic Brand Name (Covered Persons must enroll in the Catamaran Diabetic Sense Program to receive the Copay for their diabetic supplies)	 $5 Copay $10 Copay
Mail Order: 90-day supply	
Generic Drug	$30 Copay
Preferred Drug	20% Copay ($50 minimum, $175 maximum)
Non-Preferred Drug	30% Copay ($80 minimum, $225 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Medications Generic Brand Name (Covered Persons must enroll in the Catamaran Diabetic Sense Program to receive the Copay for their diabetic supplies)	 $10 Copay $30 Copay

Mandatory Generic Program
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Brand Name Drug in addition to the Brand Name Drug Copay, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Mandatory Mail Order Program
This plan will allow maintenance medications to be filled at retail in 30 day quantities only and will be subject to appropriate copay upon each 30 day refill. Member must choose mail order to receive a 90 day quantity on a maintenance drug and benefit from paying only 2 copays for a 3 month (90 day supply).

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 paper copy, please contact the Plan Administrator.

ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – VALUE GOLD 2016-2017

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE Single Family	 $750 $1,500	 $3,000 $9,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes medical Deductible, medical Coinsurance, medical Copays and Precertification Penalties – combined with Prescription Drug Card) Single Family	 $5,000 $10,000	 N/A N/A
MEDICAL BENEFITS		
Allergy Serum & Injections		
Injections (If no office visit charge)	100% after $5 Copay per visit; Deductible waived	50% after Deductible
Serum	100% after $45 Copay per visit; Deductible waived	50% after Deductible
Ambulance Services		
Ground	75% after Deductible	Paid at Participating Provider level of benefits
Air Ambulance	$200 Copay per trip, then 75% after Deductible	Paid at Participating Provider level of benefits
Ambulatory Surgical Center	75% after Deductible	50% after Deductible
Anesthesiologist	75% after Deductible	50% after Deductible
Anti-Embolism Garments (e.g. Jobst)	$50 Copay per pair, then 75%; Deductible waived	$50 Copay per pair, then 50% after Deductible
Calendar Year Maximum Benefit	3 pairs	
Cardiac Rehab (Outpatient)	100% after $35 Copay per visit; Deductible waived	50% after Deductible
Chemotherapy (Outpatient)	75% after Deductible	50% after Deductible
Chiropractic Care/Spinal Manipulation	100% after $35 Copay per visit; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	20 Visits	
Diagnostic Testing, X-Ray and Lab Services (Outpatient)		
Any Single Service Costing Less Than $500	75% after Deductible	50% after Deductible
Any Single Service Costing $500 or More	75% after Deductible	50% after Deductible
Freestanding Laboratory	75%; Deductible waived	50% after Deductible
Oncotype Diagnostic Testing	75% after Deductible	50% after Deductible

ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – VALUE GOLD 2016-2017

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Durable Medical Equipment (DME)	75% after Deductible	50% after Deductible
Emergency Services		
Emergency Medical Condition		
Facility Charges	75% after Deductible	Paid at Participating Provider level of benefits, unless otherwise required by law
Professional Fees and Ancillary Charges	75% after Deductible	Paid at Participating Provider level of benefits, unless otherwise required by law
Non-Emergency Medical Condition		
Facility Charges	75% after Deductible	50% after Deductible
Professional Fees and Ancillary Charges	75% after Deductible	50% after Deductible
Foot Orthotics	$50 Copay per orthotic, then 75%; Deductible waived	$50 Copay per orthotic, then 50% after Deductible
Maximum Benefit	Age 19 and over - 1 every 12 months; Under age 19 - 1 every 6 months	
Hearing Aids (including any office visit and any related services, includes cochlear Implants)	75% after Deductible	50% after Deductible
Maximum Benefit	1 aid per ear per 36-month period	
Hemodialysis (Outpatient)	75% after Deductible	50% after Deductible
Home Health Care	75% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	60 visits*	
*Home health care supplies are not subject to the Calendar Year Maximum.		
Hospice Care		
Inpatient	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Outpatient	75% after Deductible	50% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*
Outpatient	75% after Deductible	50% after Deductible
*Charges for a private room, that exceeds the cost of a semi-private room, are eligible only if prescribed by a Physician and the private room is Medically Necessary.		
Infusion Therapy in Facility or Physician's Office	75% after Deductible	50% after Deductible

ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – VALUE GOLD 2016-2017

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Maternity (Professional Fees)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	50% after Deductible
Breast Pumps	100%; Deductible waived	100%; Deductible waived
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	75% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Medical Supplies	75% after Deductible	50% after Deductible
Mental Disorders and Substance Use Disorders		
Inpatient		
Facility Charge	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Professional Fees	75% after Deductible	50% after Deductible
Outpatient Facility	75% after Deductible	50% after Deductible
Office Visits	100% after $35 Copay; Deductible waived	50% 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.		
Morbid Obesity (Surgical Treatment Only)		
Facility (Inpatient and outpatient)	$250 Copay, then 75%; Deductible waived	50% after Deductible
Professional Services	75% after Deductible	50% after Deductible
Lifetime Maximum Benefit	1 Surgical Procedure	
Nutritional Food Supplements	50% after Deductible	50% after Deductible
Occupational Therapy (Outpatient)	100% after $35 Copay per visit; Deductible waived	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 Visits	
Physical Therapy (Outpatient)	100% after $35 Copay per visit; Deductible waived	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 Visits	
Physician's Services		
Inpatient/Outpatient Services		
Primary Care Physician	75% after Deductible	50% after Deductible
Specialist	75% after Deductible	50% after Deductible
Office Visits		
Primary Care Physician	100% after $35 Copay*; Deductible waived	50% after Deductible
Specialist	100% after $45 Copay*; Deductible waived	50% after Deductible

ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – VALUE GOLD 2016-2017

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Physician Office Surgery		
Primary Care Physician	Under $1,000 - 100% after $35 Copay*; Deductible waived; $1,000 or more – 75% after Deductible	50% after Deductible
Specialist	Under $1,000 - 100% after $45 Copay*; Deductible waived; $1,000 or more – 75% after Deductible	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
Preventive Services and Routine Care		
Preventive Services (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	Not Covered
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100% up to $300 per Calendar Year, then 10%; Deductible waived	Not Covered
Flu Vaccinations/Pneumonia & Shingles Vaccinations	100%; Deductible waived	100%; Deductible waived
Routine Hearing Exam	100% after $35 Copay per exam; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	1 exam	
Prosthetics (other than bras)	75% after Deductible	50% after Deductible
Prosthetic Bras	75% after Deductible	75% after Deductible
Calendar Year Maximum Benefit	2 bras	
Psychological and Neuropsychological Testing	50% after Deductible	50% after Deductible
Radiation Therapy (Outpatient)	75% after Deductible	50% after Deductible
Rehabilitation Facility (does not apply to Mental Disorders or Substance Use Disorders)	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Calendar Year Maximum Benefit	60 days	
Skilled Nursing Facility	$250 Copay per admission, then 75%; Deductible waived	$300 Copay per admission, then 50% after Deductible
Maximum Benefit per 12 Month Period	60 days	

ASBA Insurance Trust

MEDICAL SCHEDULE OF BENEFITS – VALUE GOLD 2016-2017

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Speech Therapy (Outpatient)	100% after $35 Copay per visit; Deductible waived	50% after Deductible
Maximum Benefit Payable per Calendar Year	60 Visits	
Surgery (Inpatient)		
Facility	$250 Copay per admission, then 75%; Deductible waived	50% after Deductible
Professional Services	75% after Deductible	50% after Deductible
Surgery (Outpatient) (does not include surgery in the Physician's office)		
Facility	75% after Deductible	50% after Deductible
Professional Services	75% after Deductible	50% after Deductible
Temporomandibular Joint Dysfunction (TMJ)	$50 Copay per occurrence, then 75%; Deductible waived	$50 Copay per occurrence, then 50% after Deductible
Lifetime Maximum Benefit: Surgical Procedure Appliances Office Services	1 Surgical Procedure 1 appliance $1,000	
Transplants(Facility)	$250 Copay per admission, then 75%; Deductible waived	Not Covered
Urgent Care Facility	$50 Copay per visit, then 75%; Deductible waived	$50 Copay per visit, then 50% after Deductible
Wig (see Eligible Medical Expenses)	$50 Copay per wig, then 75%; Deductible waived	$50 Copay per wig, then 75%; Deductible waived
Maximum Benefit per 24 Month Period	1 wig	
All Other Eligible Medical Expenses	$50 Copay*, then 75%; Deductible waived	$50 Copay*, then 50% after Deductible
*Copay applies per eligible item, service or occurrence.		

ASBA Insurance Trust

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – VALUE GOLD 2016-2017

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 Deductible and Copays – combined with major medical) Single Family	 $5,000 $10,000
Retail Pharmacy: 30-day supply	
Generic Drug	$15 Copay
Preferred Drug	20% Copay ($25 minimum, $80 maximum)
Non-Preferred Drug	30% Copay ($40 minimum, $110 maximum)
Specialty Drug	20% Copay ($100 minimum, $150 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Medications Generic Brand Name (Covered Persons must enroll in the Catamaran Diabetic Sense Program to receive the Copay for their diabetic supplies)	 $5 Copay $10 Copay
Mail Order: 90-day supply	
Generic Drug	$30 Copay
Preferred Drug	20% Copay ($50 minimum, $175 maximum)
Non-Preferred Drug	30% Copay ($80 minimum, $225 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Diabetic Medications Generic Brand Name (Covered Persons must enroll in the Catamaran Diabetic Sense Program to receive the Copay for their diabetic supplies)	 $10 Copay $30 Copay

Mandatory Generic Program
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Brand Name Drug in addition to the Brand Name Drug Copay, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Mandatory Mail Order Program
This plan will allow maintenance medications to be filled at retail in 30 day quantities only and will be subject to appropriate copay upon each 30 day refill. Member must choose mail order to receive a 90 day quantity on a maintenance drug and benefit from paying only 2 copays for a 3 month (90 day supply).

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 paper copy, please contact the Plan Administrator.

ASBA Insurance Trust

DENTAL SCHEDULE OF BENEFITS 2016-2017

BENEFIT	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
CALENDAR YEAR DEDUCTIBLE (combined Deductible for Participating and Non-Participating Providers)		
Single	$50	
Family	$150	
CLASS A, B, C AND D EXPENSES COMBINED CALENDAR YEAR MAXIMUM BENEFIT	$1,500 per Covered Person	
CLASS D ORTHODONTIC LIFETIME MAXIMUM BENEFIT (Coverage is provided only to age 19)	$1,500 per Covered Person	
DENTAL BENEFITS		
Class A-Preventive Services	100%; Deductible waived	100%; Deductible waived
Class B-Basic Services	80% after Deductible	80% after Deductible
Class C-Major Services	50% after Deductible	50% after Deductible
Class D-Orthodontic Services (Coverage is provided only to age 19)	50% after Deductible	50% after Deductible

Late Enrollment Restriction
If you and your eligible Dependent(s) fail to enroll for Employee or Dependent coverage during your original eligibility period or due to a Special Enrollment Event or Status Change Event, or later terminate coverage and subsequently re-enroll, coverage will be limited as follows:

(1) During the first 12 months, coverage will be limited to Class A-Preventive Services only (other than restorative and endodontic services – certain Class B – Basic Services).

(2) Coverage for certain Class B – Basic Services (restorative and endodontic services) is available after you have been covered under the Plan for 6 months. The 6 month waiting period may be waived if you provide a Certificate of Creditable Coverage from another dental plan.

NOTE: The dental benefits provided under this Plan are limited-scope benefits and are offered separately from any medical coverage offered under the Plan. You have a separate right to enroll in the dental benefits under the Plan. If you choose to enroll in such dental benefit, you may be charged an employee contribution amount that is separate from what you are charged for any other benefit offered under the Plan. The amount of a required employee contribution, if any, will be communicated to you by the Plan Administrator prior to the annual open enrollment period.

ELIGIBILITY FOR PARTICIPATION

Employee Eligibility
An Employee of the Trust or a Participating School who receives a paycheck from the Trust or Participating School they are employed by and any governing board member (if permitted by the Participating School) who satisfies the eligibility requirements (including any applicable waiting period) established by the Trust or Participating School (as applicable) will be eligible to enroll for coverage under this Plan as of the date he or she satisfied such eligibility requirements and/or applicable waiting period. If governing board members are permitted by the Participating School, such member will be considered employed by the Participating School on the date he/she is sworn in. Participation in the Plan will begin as of the next day following completion of the eligibility requirements and/or waiting period, as applicable; provided all required election and enrollment forms are properly submitted to the applicable Participating School and any required contributions have been authorized and paid.

You are not eligible to participate in the Plan if you are a 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).

Please note that this document describes benefits for Major Medical, Prescription Drug, Dental and Vision. Although this document contains a description of the aforementioned benefits, it does not mean that you and your Dependents are eligible for every benefit. Please refer to the Schedule of Benefits to determine what benefits you are eligible for.

For more information related to the eligibility provisions that would qualify or disqualify you for this Plan, please contact the Trust or Participating School. Information will be provided to you free of charge.

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

(1) Your Spouse.

(2) Your Domestic Partner (when offered by your District).

(3) Your Child until the end of the month he/she attains the limiting age of 26.

(4) Your Child, who is unable to be self supporting by reason of mental or physical handicap and is incapacitated, provided the child suffered such incapacity prior to the date he/she attained the applicable limiting age identified in (2) above. Your Child must be unmarried, primarily dependent upon you for support and reside with you for more than one-half of the Calendar Year. The Plan Sponsor may require subsequent proof of your Child's disability and dependency, including a Physician's statement certifying your Child's physical or mental incapacity.

(5) 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 your Participating School at no cost.

The below terms have the following meanings:

"Domestic Partner" means an unrelated individual of the same or opposite sex for which an Employee submits an Affidavit of Domestic Partnership to the Employer. The Affidavit must include the following statements:

(1) We share a permanent residence, and have resided with one another continuously for at least 12 consecutive months before filing an application for benefits and are expected to continue to reside with one another indefinitely as evidenced by this affidavit; AND

(2) Neither one of us has signed a declaration or affidavit of domestic partnership with any other person and have not had another domestic partner within the 12 months prior to filing an application for benefits; AND

(3) Neither one of us has any other domestic partner or spouse of the same or opposite sex; AND

(4) Neither one of us is currently married to anyone else or legally separated from anyone else; AND

(5) We are not blood relatives any closer than would prohibit marriage between us in Arizona; AND

(6) We were mentally competent to consent to a contract when the partnership began; AND

(7) Neither one of us is acting under fraud or duress in accepting benefits; AND

(8) We are both at least 18 years of age; AND

(9) We are financially interdependent in at least 3 of the following ways:

(a) Have a joint mortgage, joint property tax identification or joint tenancy on a residential lease;
(b) Hold one or more credit or bank accounts jointly, such as a checking account in both names;
(c) Assume joint liabilities (e.g. credit card(s), car loans, etc.);
(d) Have joint ownership of significant property (e.g. real estate .etc.);
(e) The employee/retiree names the partner as beneficiary of the employees life insurance, under the employees will or employees retirement annuities, and the partner names the employee/retiree as beneficiary of the partners life insurance, under the partners will or the partners retirement annuities;
(f) Each agree in writing to assume financial responsibility for the welfare of the other, such as durable power of attorney;
(g) Can offer other proof of financial responsibility for the welfare of the other, such as durable power of attorney.

The Plan Administrator reserves the right to require such evidence as it deems necessary that a Domestic Partner satisfies the above eligibility requirements.

"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). The term "Child" shall include a child of your Domestic Partner.

"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 has not attained the age of 18 as of the date of such placement for adoption. 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.

"Full-Time Student," means a Dependent Child who is enrolled in and regularly attending an educational institution such as high school, an accredited post-secondary school, an accredited college or university for the minimum number of credit hours required by that institution in order to maintain full-time student status. A Full-Time Student shall also include any Dependent Child who is on a church mission. During the final semester prior to graduation, the number of hours required to graduate will be allowed and considered as full time.

Other examples of post-secondary education institutions include an accredited business school, trade school, nursing school, business school, mortuary school, cosmetology school, community or junior college or other similar accredited educational institution that offers a full-time curriculum. The institution must be accredited in order to qualify the Dependent Child for Full-Time Student status.

(1) A full-time student will remain covered during any regular scheduled break in the educational institution's full-time curriculum (such as spring or summer break), as long as the Dependent Child was a Full-Time Student the quarter/semester before the break and is a Full-Time Student again the quarter/semester following the break. If the Dependent Child is not enrolled as a Full-Time Student in the next regular term or at any time drops below the minimum number of credit hours during a semester to maintain Full-Time Student status, coverage under the Plan will terminate retroactively to the last day of the month the child attended school full-time.

(2) If a Dependent Child loses dental and vision coverage under the Plan because he lost his/her status as a Full-Time Student, he will again become eligible for dental and vision coverage under the Plan, on the date he/she once again enrolls as a Full-Time Student.

(3) A Dependent Child covered by this Plan who graduates from high school will remain covered for dental and vision benefits; provided such child enrolls and begins attending classes full-time in an accredited post-secondary school, college or university in the next quarter/semester following the child's high school graduation date; or

(4) A Dependent Child who does not have dental and vision coverage under this Plan and who subsequently enrolls and begins attending classes as a Full-Time Student will also be eligible for coverage. The date such child begins attending full-time classes will be considered the date you acquire an eligible Dependent for Plan enrollment purposes. The Plan may require a completed application for the Dependent's coverage within a specified time frame.

"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 who is lawfully married to you under any state law, including persons of the same sex who were legally married in a state that recognizes such marriages, but who may reside in a state that does not recognize same sex marriages. Specifically excluded from this definition is a spouse by reason of common law marriage, whether or not permitted in your State. The Participating School may require documentation proving a legal marital relationship.

The Plan Administrator, in its sole discretion, shall have the right to require documentation necessary to establish an individual's status as an eligible Dependent.

When you and your Spouse are both Covered Employees
When both you and your Spouse are covered Employees of the same Participating School, each of you must choose coverage as either an Employee or as a Dependent. You may not be covered under this Plan as both an Employee and a Dependent. A Dependent Child may be covered under the Plan by either parent, but may not be covered under the Plan by both parents.

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.

Your Participating School 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 Participating School receives a QMCSO, the Participating School shall also enroll you for immediate coverage under this Plan; provided you satisfy the applicable eligibility requirements. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Plan Sponsor 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 Trust or your Participating School 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 Sponsor 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 your Participating School.

Retiree Eligibility
You are eligible for coverage under this Plan as a Retiree if you meet all of the following requirements:

(1) Your Participating School or the Trust offers Retiree coverage and you meet the terms and conditions of retirement eligibility established by the Trust or your Participating School (as applicable);

(2) You were covered under the Plan on the date of your retirement;

(3) You are under age 65 for medical, dental and vision benefits;

(4) If you are a governing board member, you have completed the length of service requirement under ARS 15-387 (4 years); and

(5) You have made any required contribution for coverage under the Plan.

This Plan offers more than one benefit option. If you retired on or after July 1, 2006 eligibility for coverage under this Plan is limited to Plan option B$25.

You may also elect to continue coverage for your Spouse and any eligible Dependents if such Spouse and Dependents are covered under the Plan as of the date of your retirement. Please contact the Trust or your Participating School for a detailed description of the eligibility requirements for Retiree coverage.

At the time of retirement you may elect to enroll in COBRA Continuation Coverage in lieu of Retiree coverage. If you elect COBRA Continuation Coverage in lieu of Retiree coverage for yourself and any eligible Dependents or if you fail to make any election under the Plan, you and/or your Dependents will not be eligible to enroll in the Retiree coverage under the Plan at a later time. If however, you elect Retiree coverage in lieu of COBRA Continuation Coverage, the Retiree coverage under the Plan will be treated as alternative coverage and you will not be eligible to continue coverage under COBRA once Retiree coverage under the Plan has ended; however your Dependents may elect to continue coverage under COBRA upon the occurrence of certain qualifying events. Please refer to the COBRA Continuation Coverage section of the Plan.

If you decide to enroll yourself and your eligible Dependents in Retiree coverage, you must enroll by completing all required election and enrollment forms and submitting them to your Participating School within 30 or 31 days after your retirement date, depending on the district's plan parameters. Participation in the Plan will begin for you and any eligible Dependents as of your date of retirement; provided all required election and enrollment forms are properly submitted to your Participating School.

If Retiree coverage terminates for you or your Dependents, it may be reinstated at a later date only if you meet the requirements for eligibility as a Retiree. A Retiree may return to work as an active employee for the district of which they retired from and then return to the Retiree program for said district. If the Retiree goes to work for another ASBAIT district the following applies:

(1) The district would have to offer the Retiree program.

(2) The Retiree would have to meet the district eligibility requirements for the Retiree program.

(3) The Retiree can not return to the Retiree program of the district originally Retired from.

You may be required to pay the entire cost or a portion of the cost of Retiree coverage for yourself and any eligible Dependents in accordance with the policies and procedures established by the Participating School. The amount of any required contribution will be communicated to you prior to the date of your retirement.

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 Participating School within 30 or 31 days after satisfaction of the eligibility requirements, depending on the district's plan parameters. If you are required to contribute towards the cost of coverage you must complete and submit a payroll deduction authorization for the Participating School to deduct the required contribution from your pay. 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 Participating School 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 decline enrollment for you and/or your Dependents, you must provide a written statement to your Participating School indicating that the reason you are declining enrollment is due to other health coverage. If you lose such other health coverage, it may constitute a Special Enrollment Event (described below) that gives you and/or your Dependents a right to enroll in the Plan mid-year due to such loss of coverage. However, if you failed to submit such written statement when initially eligible, you will lose your right to this special mid-year enrollment opportunity.

If you fail to complete and submit the appropriate election and enrollment forms within the 30 or 31-day period described above, depending on the district's plan parameters, you will not be eligible to enroll in the Plan until the next open enrollment period (if available) 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 open enrollment period (if available), 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 30 or 31 -day eligibility period, depending on the district's plan parameters, you may do so by making written application to the Participating School 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; provided, however, you submitted a written statement to your Participating School when you and/or your Dependents were initially eligible stating that other health coverage was the reason for declining enrollment under this Plan:

(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 your Participating School within 30 or 31 days after the date the other health coverage was lost, depending on the district's plan parameters. Coverage under the Plan will become effective on the date you submit the appropriate election and enrollment forms to your Participating School.

(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 or your Dependents are no longer eligible for Medicaid or SCHIP and your coverage terminates because you or your Dependents are no longer eligible for Medicaid or SCHIP 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 your 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 your Participating School 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 date you submit the appropriate election and enrollment forms to your Participating School.

(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 Participating School within 30 or 31 days after the date you acquire such Dependent, depending on the district's plan parameters.

(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 30 or 31 days after the child's birth, depending on the district's plan parameters. Failure to enroll in the Plan within this 30 or 31 day period, depending on the district's plan parameters- will result in no coverage under the Plan, other than routine newborn care (as outlined under the Eligible Medical Expenses section of the Plan). However, if you already have coverage for Dependents and are making the maximum required contribution for Dependent coverage under the Plan, the requirement to complete and submit election and enrollment forms is waived. Once a claim is received for the Dependent Child, the Employee will be required to submit an enrollment form in order to process the child's claim.

(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 (including a payroll deduction authorization, if applicable) within 30 or 31 days after your date of marriage, depending on the district's plan parameters. Failure to enroll in the Plan within the 30 or 31 day period described above, depending on the district's plan parameters- will result in no coverage under the Plan.

(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 (including a payroll deduction authorization, if applicable) within 30 or 31 days after adoption or placement in anticipation of adoption, as applicable, depending on the district's plan parameters. Failure to enroll in the Plan within the 30 or 31 day period described above, depending on the district's plan parameters- will result in no coverage under the Plan.

Note: If you did not enroll your Spouse when initially eligible and later acquire a new Dependent Child as a result of birth or adoption, you may also enroll your Spouse for coverage under the Plan; provided you submit the appropriate election and enrollment forms to your Participating School within 30 or 31 days after the date you acquire such Dependent, depending on the district's plan parameters.

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 employee 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 employee 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 if the change impairs your ability to access the services 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 is 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 your Participating School within 30 or 31 days after the Status Change Event, depending on the district's plan parameters. Coverage under the Plan will become effective on the date you submit the appropriate election and enrollment forms to your Participating School.

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 date you report to active 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 date a governing board member's term ends;

(7) The date a Participating School no longer participates in the Plan;

(8) The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud; and

(9) The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact.

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 date the Plan discontinues coverage for Dependents;

(3) The date your Dependent becomes covered as an Employee under the Plan;

(4) The date 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 date the Dependent Spouse reports to active military service;

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

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

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

Termination of Retiree Coverage
Coverage under the Plan will terminate for you and any Dependents on the earliest of the following dates:

(1) The date in which you attain age 65 for medical coverage only. Coverage for the Spouse of a Retiree will continue under the Plan until the first of the month in which he/she attains age 65 even though coverage for you, the Retiree, ends as of the date you attain age 65. Dental and vision coverage will not end at age 65 for Retirees or their Spouse.

(2) The date in which a required contribution has not been paid.

(3) The date the Plan terminates or no longer provides Retiree coverage.

(4) The date you or any eligible Dependent become eligible for Medicare. Coverage will terminate only for the Medicare eligible person.

(5) The date in which a Dependent no longer satisfies the eligibility requirements as a Dependent under the terms of the Plan.

(6) The date of a Retiree's death.

(7) The date your Dependent becomes eligible for coverage under another employer-sponsored group health plan.

(8) The date you or your Dependent (or any person seeking coverage on behalf of you or your Dependent) performs an act, practice or omission that constitutes fraud.

(9) The date 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 employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

Continuation of Plan Coverage due to Approved Leave of Absence.
Medical, dental and vision coverage will be continued for you and your Dependents in the event of an approved Leave of Absence for a period of 12 weeks.

If your leave qualifies under the Family and Medical Leave Act (FMLA), any continuation of coverage provided under this provision will run concurrent with FMLA.

Coverage under this provision will continue in accordance with the same terms and conditions of an active Employee and any period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under COBRA. Please refer to the COBRA Continuation Coverage section of the Plan.

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 Plan Sponsor 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 your covered Dependents if you return to work at the end of the FMLA leave.

Continuation of Coverage under State Family and Medical Leave Laws
To the extent this Plan is required to comply with a State family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such State family and medical leave law, as well as under FMLA.

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 to the Participating School 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. Your 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 or exclusionary period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

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 (including administration). The allowance for antigens will be based on a 3 month supply. Injections of food allergy antigens and sublingual immunotherapy are not covered under the Plan. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

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

(a) Ground ambulance to the nearest Hospital equipped to treat a specific Illness or Injury that occurred within 24 hours of an emergency situation; or

(b) Ground ambulance 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) Ground ambulance 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) Ground ambulance to and from the Hospital to the individual's home or to a convalescent facility when there is documentation the Covered Person required ambulance transportation.

(e) Transport by air ambulance is an eligible expense for (a) or (b) above if transport by air ambulance is Medically Necessary due to an Emergency Medical Condition.

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

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

(4) **Anesthetics:** Anesthetics and their professional administration, including 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) **Blood and Blood Derivatives:** Blood, blood plasma or blood components not donated or replaced.

(6) **BRCA Testing:** BRCA testing when Medically Necessary.

(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 twelve (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:** Skeletal adjustments, manipulation or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body and the necessary adjunctive modalities (hot, cold therapy, etc.), including x-rays regardless of where services for x-rays are rendered. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(10) **Contraceptives:** Contraceptive procedures and medications (other than oral medications), including, but not limited to: patches, injections, diaphragms, intrauterine devices (IUD), implants (other than those considered preventive services) and any related office visit. Oral contraceptives are available under the Prescription Drug Card program. The Plan does not cover contraceptive supplies or devices available without a Physician's prescription or contraceptives provided over-the-counter (unless the expense qualifies as a preventive service).

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

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

(b) Any other Medically Necessary Surgery related to an Illness or Injury.

(c) 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.

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

(12) **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) Emergency repair due to Injury to sound natural teeth, including the 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.

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.

(13) **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.

(14) **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 Card program.

(15) **Diagnostic Testing, X-ray and Laboratory Services:** Diagnostic testing, x-ray and laboratory services, including services of a professional radiologist or pathologist. Dental x-rays are not eligible expenses, except as specified under Dental Care.

Oncotype diagnostic testing to assess the necessity of adjuvant chemotherapy in females or males with recently diagnosed breast tumors, provided the following criteria is met:

(a) Breast cancer is non-metastatic; and

(b) Breast tumor is estrogen receptor positive; and

(c) Breast tumor is HER2 receptor negative or breast tumor is HER2 receptor positive and less than 1 cm in diameter; and

(d) Adjuvant chemotherapy is not precluded due to any other factor (e.g., advanced age and/or significant co-morbidities); and

(e) A Covered Person and Physician (prior to testing) have discussed the potential results of the test and agree to use the results to guide therapy.

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

(16) **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 if the Covered Person has rented the equipment for a minimum of 3 consecutive months. 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, 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.

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

The Plan does not pay for lost or stolen Durable Medical Equipment.

(17) **Emergency Services:** The Plan will pay the greater of the following amounts for Emergency Services received from Non-Participating Providers (as required by law):

(a) The amount negotiated with Participating Providers for Emergency Services provided, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider. If there is more than one amount negotiated with Participating Providers for the Emergency Services provided, the amount paid shall be the median of the negotiated amounts, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider; or

(b) The amount for the Emergency Services calculated using the same method the Plan generally uses to determine payments for services provided by a Non-Participating Provider (such as Usual and Customary Charge), excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider; or

(c) The amount that would be paid under Medicare (Part A or Part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Services, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider.

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

(18) **Foot Care:** 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; (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 and dispensed by a certified orthotics laboratory are covered by the Plan. Replacement of foot orthotics is limited to one every 12 months for a Covered Person age 19 or older and one every 6 months for a Covered Person under the age of 19. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(19) **Hearing Aids:** Hearing aids and cochlear implants and any related fittings. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(20) **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.

(21) **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 or speech therapy if provided by the Home Health Care Agency;

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

(f) Laboratory services;

(g) Nutritional counseling by a licensed dietician; and

(h) Mileage reimbursement may be eligible if a Covered Person resides in a remote area that does not have a local Home Health Care Agency. To determine whether or not mileage is reimbursable under the Plan, please contact the Claims Administrator.

For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each 4 hours of home health aide services shall be considered as one home health care visit.

In no event will the services of a Close Relative, transportation costs (other than mileage reimbursement as indicated above) housekeeping services and meals, etc., be considered an eligible expense.

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

(22) **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. The Hospice treatment plan must be renewed in writing by the attending Physician every 30 days.

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 the following:

(i) health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and

(ii) physical and speech therapy.

(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

(23) **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.

(24) **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.).

(25) **Iron Supplement Therapy:** Iron supplement therapy when supported by laboratory testing documenting clinical deficiency.

(26) **IV Infusion Therapy.**

(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 an Employee or a Dependent Spouse for:

(a) Pregnancy.

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

(c) Services provided by a Birthing Center.

(d) One amniocentesis test per Pregnancy if the amniocentesis is given for non-genetic reasons. Amniocentesis testing for genetic reasons is not eligible for coverage under the Plan.

(e) One epidural per Pregnancy.

(f) Up to 2 ultrasounds per Pregnancy (more than 2 only when it is determined to be Medically Necessary).

Complications of pregnancy or those services considered preventive services will be covered for dependent daughters.

Elective induced abortions only when carrying the fetus to full term would seriously endanger the life of the mother will be a Covered Expense for any Covered Person. If complications arise after the performance of any abortion for any covered Employee or Spouse, 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.

(30) **Mental Disorders/Substance Use Disorders:** Covered charges for care, supplies and treatment of a Mental Disorder and Substance Use Disorder, including coverage for the treatment of autism. Facility charges for inpatient or residential treatment of a Mental Disorder or Substance Use Disorder will be eligible when care is received at a licensed Hospital or a licensed treatment facility. Alternative outpatient facility/day programs may be eligible under the inpatient benefit when provided in lieu of inpatient care and approved by the Medical Management Program. Outpatient treatment (other than Home Health Care) for a Mental Disorder or a Substance Use Disorder will be eligible when rendered by a licensed Psychiatrist, a licensed Psychologist, a Licensed Professional Counselor (LPC), a Licensed Psychiatric Nurse Practitioner (PSYNP), Licensed Clinical Social Worker (LCSW), Licensed Independent Substance Abuse Counselor (LISAC) or when rendered by one of the following counselors, provided the counselor is employed by and working under the direct supervision of a Psychiatrist or Clinical Psychologist:

(a) Master Social Worker (MSW)

(b) Master Science Nurse (MSN)

(c) Master of Arts in Guidance and Counseling (MA)

(d) Master of Education in Guidance and Counseling (MED)

(e) Master in Counseling (MA)

(f) Certified Addiction Counselor (CAC)

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

(31) **Morbid Obesity:** Surgical treatment for Morbid Obesity is limited to one surgical procedure per Lifetime and will only be covered if all the following conditions are met:

(a) The Covered Person has been covered under the Plan for a minimum of 12 months prior to the date of the procedure.

(b) The Covered Person has either (1) a body mass index (BMI of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction.

(c) The Covered Person has at least a 24 month year history of Morbid Obesity as documented in such person's medical records.

(d) The Covered Person does not have an underlying diagnosed medical condition that would cause Morbid Obesity (e.g., an endocrine disorder) that can be corrected by means other than surgical treatment.

(e) The Covered Person has completed full growth (18 years old or supporting documentation of complete bone growth).

(f) The Covered Person has failed to achieve and maintain significant weight loss and such person has participated in a Physician-supervised nutrition and exercise program for at least 6 months (occurring within the 24-month period prior to the proposed surgical treatment) and such participation is documented in his or her medical records.

(g) The Covered Person must be evaluated by a licensed professional counselor, psychologist or psychiatrist within 12 months prior to the proposed surgical treatment. The evaluation should document the following:

(i) that there is no significant psychological problem that would limit the ability of the Covered Person to understand the procedure and comply with any medical and/or surgical recommendations;

(ii) any psychological co-morbidities that may be contributing to the Covered Person's inability to lose weight or a diagnosed eating disorder; and

(iii) the Covered Person's willingness to comply with the preoperative and postoperative treatment plans.

Includes coverage for one year of post-operative visits.

The following surgery will not be eligible as treatment of Morbid Obesity under the Plan:

(a) Loop gastric bypass;

(b) Gastroplasty, more commonly known as "stomach stapling" (not to be confused with vertical band gastroplasty); and

(c) Mini gastric bypass.

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

(32) **Nutritional Supplements:** Physician-prescribed nutritional supplements or other enteral supplementation necessary to sustain life, including rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation. Special dietary treatment for phenylketonuria (PKU) when prescribed by a Physician.

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

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

(33) **Occupational Therapy:** Rehabilitative occupational therapy rendered by a qualified Physician or a licensed occupational therapist under the recommendation of a Physician. 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) **Outpatient Pre-Admission Testing:** Outpatient pre-admission testing performed prior to a scheduled Inpatient hospitalization or Surgery.

(35) **Physical Therapy:** Physical therapy rendered by a qualified Physician or a licensed physical therapist under the recommendation of a Physician. Maintenance Therapy will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(36) **Physician Services:** Services of a Physician for medical care or Surgery.

(a) 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, 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. For BCBSAZ providers, BCBSAZ assigns the primary procedure based on the highest billed charge per unit. If multiple procedures have the highest billed charge per unit, then the first listed procedure is deemed to be the primary procedure. This applies to all Surgical Procedures, except as determined by the Plan.

(c) For surgical assistance by an Assistant Surgeon, the charge will be 25% (for M.D. and D.O. Participating and Non-Participating Providers other than BCBSAZ); 20% (for BCBSAZ providers); and 15% (for all other Participating and Non-Participating Providers) of the Usual and Customary Charge.

(d) Services provided by a medical student, intern or resident when under the supervision of a licensed Physician.

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

(37) **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 2002 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. A maximum of 5 screenings for gestational diabetes shall be covered in pregnant women.

(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-immune-deficiency 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 sterilization implant (Essure) and surgical sterilization (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:

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

(b) Purchase of a standard (non-Hospital grade) electric breast pump or manual breast pump if requested during pregnancy or during the duration of breastfeeding, provided the Covered Person has not received either a standard electric breast pump or a manual breast pump within the last 3 Calendar Years and provided the Covered Person remains continuously enrolled in the Plan.

(3) For women using a breast pump from a prior pregnancy, one 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: http://www.hrsa.gov/womensguidelines. 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 paper copy, please contact the Plan Administrator.

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

Routine care including, but not limited to, the office visit, lab tests, x-rays, routine testing, routine hearing exam, vaccinations or inoculations, flu vaccines, pneumonia and shingles vaccinations, well child care, pap smears, mammograms, colon exams, PSA testing, cancer screenings, bone density scans, and circumcisions performed in a Physician's office. If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other Illness.

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.

(38) **Prophylactic Mastectomy or Bilateral Oophorectomy:** A prophylactic mastectomy or prophylactic bilateral oophorectomy when Medically Necessary.

(39) **Prosthetic Bras:** Prosthesis bras and the related postmastectomy prosthetic devices. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(40) **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. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(41) **Pulmonary Therapy:** Pulmonary therapy under the recommendation of a Physician.

(42) **Qualified Clinical Trial Expenses:** Qualified Clinical Trial Expenses 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 of 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 provided in a Rehabilitation Facility will be payable as shown in the Medical Schedule of Benefits, 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. This benefit does not apply to Mental Disorders and Substance Use Disorders.

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) **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 until the mother is discharged from the Hospital.

A newborn will automatically be covered under the Plan until the mother is discharged from the Hospital. The newborn must be enrolled within 31 days of birth to continue coverage after the mother is discharged.

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.

(47) **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.

(48) **Skilled Nursing Facility:** Skilled nursing care provided in a Skilled Nursing Facility will be payable as shown in the Medical Schedule of Benefits, 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.

(49) **Speech Therapy:** Restorative or rehabilitative speech therapy rendered by a qualified Physician or a licensed speech 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, such as dysphasic or swallowing disorders. Speech therapy for 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.

(50) **Standby Physician:** Services of a standby surgeon will only be covered when a clear Medical Necessity exists and the standby surgeon is gowned, scrubbed and physically present in the surgical suite. Charges for services as a standby pediatrician during childbirth when a high risk factor was indicated during the covered pregnancy and during the delivery; provided the pediatrician was present during the delivery.

(51) **Sterilization:** Elective sterilization procedures for the covered Employee and Spouse (this does not include reversal of sterilization). When a vasectomy is elected, only the Physician and anesthesia charge for the surgery in his/her office will be covered. Facility charges for vasectomies will not be eligible.

(52) **Substance Use Disorders:** See the Mental Disorder/Substance Use Disorder benefit. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(53) **Temporomandibular Joint Dysfunction (TMJ):** Surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) when rendered by an MD, DO or DDS.

The treatment of jaw joint disorders (TMJ) includes conditions of structures linking the jawbone and skull and complex muscles, nerves and other tissues related to the temporomandibular joint. Treatment shall include, but is not limited to: orthodontics; physical therapy; and any appliance that is attached to or rests on the teeth.

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

(54) **Testosterone Injections:** Testosterone injections when supporting lab work is provided documenting clinical deficiency.

(55) **Transplants:** Services and supplies in connection with Medically Necessary non-Experimental and/or non-Investigational transplant procedures such as: kidney, cornea, liver, pancreas, heart, lung, heart/lung and bone marrow subject to the following conditions:

(a) The Covered Person is a likely candidate for a successful outcome of the procedure; and

(b) The procedure is performed at a Participating Provider facility known to have an effective program for doing such procedure. If there is not a Participating Provider facility that is equipped to perform the transplant, a Non-Participating Provider facility may be eligible if approved in advance by the Plan Sponsor.

Charges associated with 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 and charges associated with the donor for the removal of the organ and/or the procurement/acquisition/transportation of the organ will also be considered eligible.

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

Exclusions:

(a) Non-human and artificial organ transplants;

(b) Donor expenses for screening and testing;

(c) Lodging expenses, including meals;

(d) Expenses related to the Covered Person’s transportation;

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

(f) Transplants which are not medically recognized and are Experimental and/or Investigational in nature; and

(g) Transplants received from a Non-Participating Provider or if performed outside the state of Arizona, unless prior approval is received from the Plan.

(56) **Urgent Care Facility:** Services and supplies provided by an Urgent Care Facility. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(57) **Wigs:** Purchase of a scalp hair prosthesis when necessitated by hair loss due to radiation or chemotherapy. 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

No payment will be eligible under any portion of this Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. 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:** Expenses for acupuncture will not be considered eligible.

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

(4) **Against Medical Advice:** Expenses for services received if you leave against the medical advice of an attending Physician within 72 hours after admission will not be considered eligible.

(5) **Allergy Services:** Injections of food allergy antigens and sublingual immunotherapy will not be considered eligible. All other expenses for allergy services are covered as specified under Eligible Medical Expenses.

(6) **Autologous Blood Donations:** Expenses related to autologous blood donations, unless the blood is used during a scheduled surgery covered under this Plan, will not be considered eligible.

(7) **Autopsies:** Expenses related to an autopsy, unless required by the Plan.

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

(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 Close Relative will not be considered eligible.

(12) **Cognitive and Kinetic Therapy:** Expenses for cognitive therapy and kinetic therapy will not be considered eligible. Cognitive therapy is defined as therapy which embraces mental activities associated with thinking, learning and memory. Kinetic therapy is defined as therapy related to motion or movement (e.g., the study of motion, acceleration or rate of change). This exclusion will not apply to expenses related to a neurological brain impairment resulting from an acute major Illness.

(13) **Complications:** Expenses for care, services or treatment required as a result of complications from a treatment or procedure not covered under the Plan will not be considered eligible. This exclusion does not apply to complications from abortions or for complications of a Dependent Child's pregnancy as specified under Eligible Medical Expenses.

(14) **Contraceptives:** Expenses for oral contraceptives will not be considered eligible, except as specified under the Prescription Drug Card program or as a preventive service as specified under Eligible Medical Expenses.

(15) **Convenience Items:** Expenses for personal hygiene and convenience items including elevators, chairlifts or other modifications to your home, stairs or vehicles will not be considered eligible.

(16) **Cosmetic Procedures:** Expenses for Cosmetic and reconstructive procedures, including any expenses related to the removal of or conditions caused by, breast implants that were inserted for Cosmetic reasons (regardless of the reason for removal) will not be considered eligible, except as specified under Eligible Medical Expenses.

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

(18) **Court Ordered:** Expenses for court ordered treatment or hospitalization, unless a clear Medical Necessity exists, will not be considered eligible.

(19) **Custodial Care:** Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.

(20) **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.

(21) **Developmental Delays:** Expenses in connection with the treatment of developmental delays, including, but not limited to speech therapy, occupational therapy, physical therapy and any related diagnostic testing will not be considered eligible. This exclusion does not apply to Prescription Drugs covered under the Prescription Drug Card Program to treat a developmental delay or to office visits to monitor medications for a developmental delay. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism and to expenses covered as a preventive service under the Eligible Medical Expense section of the Plan.

(22) **Exercise Programs:** Exercise programs 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.

(23) **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 to the extent such expenses are Qualified Clinical Trial Expenses.

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

(25) **Genetic Testing/Counseling:** Expenses for genetic testing or genetic counseling will not be considered eligible, except non-genetic amniocentesis testing, BRCA testing and except as otherwise covered as a preventive service under the Eligible Medical Expense section of the Plan.

(26) **Governmental Agency:** Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. 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).

(27) **Hair Loss:** Expenses for hair loss or hair transplants will not be considered eligible, except as specified under Eligible Medical Expenses.

(28) **Home Health Care:** Home Health Care expenses for the treatment of a Mental Disorder or Substance Use Disorder will not be considered eligible.

(29) **Homeopathic Treatment:** Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.

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

(31) **Illegal Occupation/Felony:** Expenses for or in connection with an Injury or Illness sustained while incarcerated or sustained during the commission of an assault, 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.

(32) **Infertility:** Expenses for confinement, treatment or services related to infertility (the inability to conceive) or the promotion of conception 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).

(33) **Magnet Therapy:** Expenses related to magnet therapy will not be considered eligible.

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

(35) **Mandible Treatment:** Expenses for appliances, medical or surgical treatment for correction of a malocclusion or protrusion or recession of the mandible; maxillary or mandibular hyperplasia or maxillary or mandibular hypoplasia will not be considered eligible. (Malocclusion - teeth do not fit together properly, bite problem; mandible protrusion or recession: under bite, chin excessively large or overbite, chin abnormally small; maxillary/mandibular hyperplasia: overbite due to excess growth of upper/lower jaw; maxillary/mandibular hypoplasia: undergrowth of upper/lower jaw). This is considered dental Surgery, performed by dental surgeons. This is not considered a medical procedure. This exclusion does not apply to orthognathic surgery when there is a significant dysfunction that exists due to an extreme Congenital Anomaly.

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

(37) **Maternity:** Maternity expenses Incurred by a Dependent other than an Employee's Spouse will not be considered eligible, except when required as a result of Complications of Pregnancy and except as otherwise covered as a preventive service under the Eligible Medical Expense section of the Plan.

(38) **Medically Necessary:** Expenses which are determined not to be Medically Necessary will not be considered eligible.

(39) **Missed Appointments:** Expenses for completion of claim forms, medical/dental reports, itemized bills, missed appointments, telephone consultations, virtual office visits, internet consultations, photocopying fees, mailing or shipping or handling expenses will not be considered eligible.

(40) **Morbid Obesity:** Expenses for non-surgical treatment of Morbid Obesity will not be considered eligible. Expenses for surgical treatment of Morbid Obesity will not be considered eligible unless the Covered Persons meets the requirements under Eligible Medical Expenses. Expenses for the following procedures will not be considered eligible for treatment of Morbid Obesity:

(a) Loop gastric bypass;

(b) Gastroplasty, more commonly known as "stomach stapling" (not to be confused with vertical band gastroplasty);

(c) Mini gastric bypass.

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

(42) **Naturopathic:** Expenses related to naturopathic treatment rendered by a Naturopath will not be considered eligible.

(43) **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.

(44) **Non-Covered Procedure:** All expenses related to a non-covered Surgery or procedure, including Medically Necessary treatment of complications, will not be considered eligible regardless of when the Surgery or procedure was performed. This exclusion does not apply to complications of an abortion or of a Dependent child's pregnancy.

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

(46) **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.

(47) **Nutritional Counseling:** Expenses related to nutritional counseling will not be considered eligible, except if received as part of the Home Health Care benefit and except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(48) **Nutritional Supplements:** Expenses for nutritional supplements or other enteral supplementation will not be considered eligible, except as specified under Eligible Medical Expenses. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(49) **Obesity:** 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 under the Eligible Medical Expenses section of the Plan.

(50) **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.

(51) **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. This exclusion will not apply to covered dental expenses received in Mexico.

(52) **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 services under the Eligible Medical Expenses section of the Plan.

(53) **Plan Maximums:** Charges in excess of Plan maximums will not be considered eligible.

(54) **Prior to Effective Date:** Expenses which are Incurred prior to the effective date of your coverage under the Plan will not be considered eligible.

(55) **Private Duty Nursing:** Expenses for private duty nursing will not be considered eligible, except those nursing services which are considered eligible under the Home Health Care and Hospice Care benefits.

(56) **Prophylactic Surgery:** Expenses for prophylactic surgery of any kind will not be considered eligible. This exclusion does not apply to a Prophylactic Mastectomy as specified under the Eligible Medical Expenses section of the Plan.

(57) **Recreational and Educational Therapy:** Expenses for recreational and educational services; learning disabilities; behavior modification services; any form of non-medical self-care or self-help training, including any speech aides, any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies; will not be considered eligible.

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

(59) **Required by Law:** Expenses which would be eligible for payment under any plan or policy required by law, whether the Covered Person chose to be covered under such plan or not will not be considered eligible. Under required No-Fault auto coverage, the minimum required coverage or actual coverage elected, whichever is higher, will be treated as an additional Deductible.

(60) **Reversal Surgery:** Expenses related to the reversal of any surgery will not be considered eligible.

(61) **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.

(62) **Routine Care:** Expenses for routine care, including x-ray, laboratory tests, vaccinations and immunizations will not be considered eligible, except as specified under Eligible Medical Expenses.

(63) **Sex Transformation:** Expenses in connection with sex transformation will not be considered eligible.

(64) **Sexual Dysfunction:** Expenses for services, supplies or drugs related to sexual dysfunction not related to organic disease will not be considered eligible. Expenses for sex therapy will not be considered eligible.

(65) **Sleep Disorder:** Expenses for treatment, services and supplies for sleep disorders (other than sleep apnea) will not be considered eligible.

(66) **Smoking Cessation:** Expenses for smoking cessation programs, including smoking deterrents will not be considered eligible, unless otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(67) **Stand-by Physician:** Expenses for technical medical assistance or stand-by Physician services will not be considered eligible, except as specified under Eligible Medical Expenses.

(68) **Sterilization:** Expenses for reversal of elective sterilization will not be considered eligible. In addition, expenses for elective sterilization for anyone other than the covered Employee and eligible Spouse will not be considered eligible, unless otherwise covered as a preventive service as specified under the Eligible Medical Expenses section of the Plan..

(69) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan and for any Covered Person other than the Employee and Spouse will not be considered eligible, including but not limited to pre-pregnancy, conception, prenatal, childbirth and postnatal expenses. This exclusion does not apply to preventive services as described under the Eligible Medical Expenses section of the Plan.

(70) **Transplants:** The following expenses will not be considered eligible transplant expenses:

(a) Non-human and artificial organ transplants;

(b) Donor expenses for screening and testing;

(c) Lodging expenses, including meals;

(d) Expenses related to the Covered Person's transportation;

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

(f) Transplants which are not medically recognized and are Experimental and/or Investigational in nature; and

(g) Transplant expenses received from a Non-Participating Provider or performed outside of the state of Arizona.

(71) **Travel:** Expenses for travel will not be considered eligible, except as specified under Eligible Medical Expenses.

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

(73) **Vision Care:** Expenses for vision care, including routine eye exams, professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices, orthoptic or visual training, vision therapy, testing for visual acuity or field charting will not be considered eligible, except as specified under a vision plan offered by the Employer, if applicable. 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. This exclusion does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages.

(74) **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.

(75) **War:** Expenses for the treatment of Illness or Injury resulting from a war or any act of war or terrorism (whether declared or undeclared) or while in the armed forces of any country or international organization, invasion or aggression or any atomic explosion or release of nuclear energy (except when used solely for the purpose of medical treatment) will not be considered eligible.

(76) **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 CARD PROGRAM

Eligible expenses include Prescription Drugs and medicines prescribed in writing by a Physician and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an Illness or Injury including but not limited to: insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician, diabetic supplies and oral contraceptives.

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 below).

When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 30-day supply.

Maintenance drugs of more than a 30-day supply may be purchased through the mail order program. When using the mail order program, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

Expenses for injectables that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under this Plan subject to any applicable major medical Deductibles and Coinsurance as well as any coverage limitations and exclusions applicable to the major medical component of the Plan. Please refer to the Eligible Medical Expenses and the General Limitations and Exclusions section of the Plan.

Note: Coverage, limitations and exclusions for Prescription Drugs will be determined through the Prescription Drug Card Program elected by the Plan Sponsor and will not be subject to any limitations and exclusions under the major medical component of the Plan (except for injectables that are not covered under the Prescription Drug Card Program). For a complete listing of Prescription Drugs available under the Prescription Drug Card Program, as well as any exclusions or limitations that may apply, please contact the Prescription Drug Card Program Manager identified in the General Information section of this Plan and listed on the back of your Employee identification card.

Mandatory Mail Order Program
This plan will allow maintenance medications to be filled at retail in 30 day quantities only and will be subject to appropriate copay upon each 30 day refill. Member must choose mail order to receive a 90 day quantity on a maintenance drug.

Mandatory Generic Program
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Brand Name Drug in addition to the Brand Name Drug Copay (if applicable), even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Brand Name Drug: Means a trade name medication.

Preferred Drug: A list of Brand Name drugs that has been developed by a Pharmacy and Therapeutics Committee comprised of Physicians, Pharmacists and other health care professionals. The list of Brand Name drugs is subject to periodic review and modification based on a variety of factors such as, but not limited to, Generic Drug availability, Food and Drug Administration (FDA) changes, and clinical information. The Prescription Drug Card Program Manager will have a list of Preferred Drugs available.

Generic Drug: A Prescription Drug, which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Non-Preferred Drug: Any Brand Name drugs that do not appear on the list of Preferred Drugs.

Prescription Drug: 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 paper copy, please contact the Plan Administrator.

DENTAL EXPENSES

If a Covered Person incurs expenses for a service on the list of "Eligible Dental Expenses," such charges are covered to the extent that they meet all of the following conditions:

(1) Constitute Dentally Necessary treatment.

(2) Are Incurred while covered under this Plan.

(3) Are Usual and Customary Charges for Non-Participating Providers.

The Plan will pay for such eligible expenses as shown in the Schedule of Dental Benefits.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted.

Deductible
A Deductible is the total amount of eligible expenses as shown in the Dental Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan. 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.

Dental Participating Provider Network
The Claims Administrator has entered into an agreement with a network of Participating Providers (the “Network”). This Network offers you dental services at discounted rates. Using a Network provider will normally result in a lower cost to the Plan as well as a lower cost to you. There is no requirement for anyone to seek care from a provider who participates in the Network. The choice of provider is entirely up to you. The Network will apply to all family members regardless of where the individual family members may reside. The Claims Administrator will provide each Employee with information regarding his or her dental Network.

Date Expenses are Incurred
An expense is Incurred when the service is performed, except that it is deemed to be Incurred:

(1) When the impression is taken in the case of dentures or fixed bridgework;

(2) When preparation of the tooth is begun in the case of crown work;

(3) When the pulp chamber is opened in the case of root canal therapy.

(4) When the active course of treatment begins for orthodontic care.

Mexico
Covered services rendered in Mexico will be covered under the Plan. Services rendered in Mexico must be paid by the Covered Person and submitted to the Claims Administrator with services translated in English along with the cost of the services.

Eligible Dental Expenses
Class A-Preventive Services:

(1) Routine oral examinations, limited to 2 per Calendar Year.

(2) Prophylaxis/Cleanings, limited to 2 per Calendar Year (Periodontic cleanings can be substituted at the U&C rate payable for a routine cleaning).

(3) Topical fluoride treatments (to age 19), limited to one application per 12-month period.

(4) Full mouth or panorex x-rays, limited to one per 36-month period.

(5) Bitewing x-rays, limited to one set per Calendar Year.

(6) X-rays (other than bitewing, full mouth or panorex x-rays), unless other services are also rendered. If other services are also rendered, then x-rays are covered at the same rate as the other service.

(7) Sealants on permanent bicuspids and molars on children up to age 15.

(8) Palliative treatment / emergency care to relieve pain when no other dental treatment is given (If other treatment, other than x-rays, is given, the amount of benefits paid for the pain care will be based on the category of that treatment).

Class B-Basic Services:

(1) Fillings: amalgam, synthetic, porcelain, plastic or composite materials. No plan reductions for amalgam fillings.

(2) Pulp therapy and root canal treatment.

(3) Treatment for disease of gingival tissue or alveolar supporting structures of the mouth, including periodontal surgery. Periodontal surgery is limited to once in a 24-month period for each quadrant.

(4) Occlusal adjustments, only in connection with periodontal treatment.

(5) Full mouth debridement, once per 12-month period.

(6) Crown lengthening or single tooth gingivectomy, limited to once in conjunction with crown preparation.

(7) Periodontal prophylaxis, limited to 2 per Calendar Year.

(8) Non-surgical periodontal treatment, limited to once per quadrant every 24-month period.

(9) Oral surgery: Charges incurred for the necessary examinations and procedures for treatment by extraction or other oral surgery that provides the necessary procedures for extractions and other oral surgical procedure including impacted teeth and including pre- and postoperative care. Anesthesia in conjunction with a covered oral surgery procedure will also be covered; unless used for a simple extraction.

Class C-Major Services:

(1) Crowns: three-quarter, full and stainless steel.

(2) Charges for fixed bridges, Maryland bridges and full and partial dentures.

(3) Porcelain, composite or gold inlays and onlays.

(4) Space Maintainers that replace prematurely lost primary teeth for children under the age of 19.

(5) Charges for adjusting, relining, re-basing or repairing bridges or dentures and re-cementing inlays, onlays, crowns or bridges.

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

(a) Placement is due to the extraction of one or more natural, injured or diseased teeth; and

(b) Placement of bridge or denture includes replacement of extracted tooth; and

(c) Bridge or denture is placed within 12 months after the extraction.

(7) Replacement of an existing prosthodontic appliance is an Eligible Expense provided:

(a) Prosthetic appliance to be replaced was placed more than 5 years ago and cannot be made satisfactory and, the Covered Person was eligible under this Plan a minimum of 12 months; or

(b) Addition of teeth is needed to replace one or more natural teeth extracted while the Covered Person was eligible under this Plan and, the addition of teeth is completed within 12 months after the date of the extraction(s); or

(c) Replacement of existing fixed bridge or denture is due to an accidental injury requiring oral surgery and, the replacement is completed within 12 months after the event.

(8) Temporary partial dentures only when anterior teeth are missing.

(9) Implants are a Covered Expense and will be payable up to the benefit allowed for a comparable partial denture.

(10) Replacement or alteration of full or partial denture or fixed bridgework, if more than 5 years after the last installation, unless:

(a) Such replacement is necessary due to the initial placement of an opposing full denture or extractions of natural teeth;

(b) The denture is a stayplate or a similar temporary partial denture and is being replaced by a permanent denture; or

(c) The denture, while in the oral cavity, has been damaged beyond repair as a result of injury while the individual is a Covered Person.

Class D-Orthodontic Services
Charges incurred for the detection and active treatment and appliance for the correction of abnormalities of the teeth and malocclusion. Orthodontic services are subject to a separate orthodontic Lifetime Maximum and are only available when the Covered Person is banded by the age of 19.

(1) Active course of treatment shall mean any services for diagnostic casts, x-rays, records, tooth extraction or the placement of active orthodontic appliances. The active course of orthodontic treatment is the period which begins when the first orthodontic service is performed and ends when the last active appliance is removed.

(2) The initial banding will represent 25% of the total allowable charge for the orthodontic treatment. Payments for the balance of the active orthodontic treatment will be processed on a monthly basis prorated over the total period of the orthodontic treatment plan.

(3) The orthodontic benefit maximum for a Covered Person for any one course of treatment will include the charges incurred for diagnosis, evaluation, pre-care and x-rays.

DENTAL EXCLUSIONS AND LIMITATIONS

In addition to the General Exclusions and Limitations section of this Plan, no payment will be eligible under any portion of this Plan for Dental Expenses Incurred by a Covered Person for the expenses or circumstances listed below. 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) **Adjustments**: Adjustment of a denture or bridgework made within 6 months after installation by the same Dentist who installed it.

(2) **American Dental Association:** Expenses that do not meet the standards of dental practices accepted by the American Dental Association will not be considered eligible.

(3) **Analgesia:** Expenses for analgesia sedation or hypnosis for relief of anxiety or apprehension will not be considered eligible.

(4) **Anesthesia:** Expenses for anesthesia, except as specified for oral surgery under Eligible Dental Expenses will not be considered eligible.

(5) **Anterior Space Maintainer:** Expenses for anterior space maintainers will not be considered eligible.

(6) **Athletic Mouth Guards:** Expenses for athletic mouth guards will not be considered eligible.

(7) **Cosmetic:** Expenses for services or supplies partially or wholly Cosmetic in nature, including, but not limited to bleaching, whitening, altering or extracting and replacing sound natural teeth to change appearance will not be considered eligible.

(8) **Department Maintained by an Employer:** Expenses for services received from a Dentist or dental department maintained by an employer, labor union, etc., where the individual is eligible under any group insurance plan will not be considered eligible.

(9) **Duplicate Devices:** Expenses for duplicate prosthetic devices or appliances; expenses for a lost or stolen dental appliance; will not be considered eligible.

(10) **Extra oral Grafts**: Extra oral grafts (grafting of tissue or bone from outside the mouth to oral tissues) will not be considered eligible.

(11) **Harmful Habit Appliances:** Expenses for Harmful Habit appliances will not be considered eligible, except as specified in Eligible Dental Expenses.

(12) **Hospital Expenses:** Expenses for Hospital expenses will not be considered eligible.

(13) **Implants:** Removal of implants will not be considered eligible.

(14) **Installation or Replacement:** Expenses for installation, replacement or alteration of or addition to, dentures and fixed bridgework will not be considered eligible, except as shown in Eligible Dental Expenses.

(15) **Medical Plan:** Expenses covered under the medical portion of the Plan will not be considered eligible.

(16) **Not Performed By a Dentist:** Expenses for treatment by other than a Dentist (DDS or DMD) will not be considered eligible, except charges for treatment performed under the supervision and direction of a Dentist by any person duly licensed or certified to perform such treatment under applicable professional statutes and regulations. Services rendered by a M.D. or D.O. will be eligible in emergency situations.

(17) **Not Prescribed by a Dentist:** Expenses for services not prescribed as necessary by a Physician or Dentist will not be considered eligible.

(18) **Occlusion:** Appliances, restorations or procedures to splint, change vertical dimension, restore or alter occlusion for Cosmetic or non-Cosmetic purposes will not be considered eligible, except as shown in Eligible Dental Expenses.

(19) **Oral Hygiene:** Expenses for oral hygiene, dietary or plaque control programs or other educational programs will not be considered eligible.

(20) **Orthodontic Treatment:** The following expenses for Orthodontic Treatment will not be considered eligible:

(a) Orthodontic Treatment which commenced before the date the Covered Person became eligible under this Plan, except when the Participating School is new to this Plan and the Participating School had Orthodontic benefits with a prior carrier. The Covered Person's Orthodontia benefits will continue up to the lifetime maximum, less the amount paid by the prior dental plan. In addition, the following expenses related to Orthodontic Treatment will not be considered eligible:

(b) Orthodontic treatment that will occasion major restorative dental work not ordinarily performed in general dentistry.

(c) Orthodontic treatment for cases in which the desired results are unlikely to be obtained, such as those with severe periodontal problems, poor bone structure or extremely short roots.

(d) Orthodontic treatment for patients with severe medical disabilities which may prevent satisfactory orthodontic results.

(e) Orthodontic treatment plans, which, in the opinion of the Plan, are unlikely to produce professional accepted corrections of existing malocclusion.

(21) **Orthognathic Surgery:** Surgery to correct malposition in the bones of the jaw will not be considered eligible.

(22) **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. This exclusion will not apply to covered dental expenses received in Mexico.

(23) **Personalization:** Expenses for personalization of dentures will not be considered eligible.

(24) **Plan Design:** Expenses excluded or limited by the Plan design as stated in this document will not be considered eligible.

(25) **Prescription Drugs:** Expenses for Prescription Drugs, unless available under the Prescription Drug Card Program, will not be considered eligible.

(26) **Precision attachments:** Expenses for precision attachments, semi-precision attachments or stress-breakers will not be considered eligible.

(27) **Replacement:** Replacement of lost or stolen appliances will not be considered eligible. In addition, replacement of an existing bridge or denture that can be made satisfactory will not be considered eligible.

(28) **Take Home Items:** Expenses for take home items will not be considered eligible.

(29) **Temporary:** Temporary dental service will be considered an integral part of the final dental service rather than a separate service.

(30) **Temporary Prosthesis:** Expenses for a temporary full prosthesis will not be considered eligible.

(31) **Temporomandibular Joint Dysfunction (TMJ):** Expenses Incurred for appliances or restorations in connection with Temporomandibular Joint Dysfunction (TMJ) or myofunctional therapy will not be considered eligible.

(32) **Veneers:** Cosmetic veneers will not be considered eligible.

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".

A Domestic Partner of an Employee, generally is not entitled to continue coverage; however the Plan Sponsor has chosen to extend Continuation coverage to Domestic Partners and to the child of a Domestic Partner. Continuation Coverage is identical to a continuation of coverage offered to a Spouse and any Dependent Child of an Employee, except it is not available upon termination of a domestic partnership.

If the qualifying event is a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, a covered Retiree and his or her covered Spouse, surviving Spouse or Dependent Child of such Retiree will also be considered qualified beneficiaries provided the bankruptcy results in the loss of their coverage under the Plan.

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 either one of the following qualifying events happens:

(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 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 Participating School 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 such Dependent Child provides notice of the qualifying event to the Participating School and elects 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 COBRA Continuation 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 Participating School (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 (as designated by the Participating School) 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 Participating School, 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 Participating School at the address provided in this notice.

Notice must be sent to your Participating School.

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). However, a qualified beneficiary who becomes covered under a group health plan which has a Pre-Existing Condition limit that affects that individual; he/she will be allowed to continue COBRA continuation coverage for the length of the pre-existing condition or to the COBRA maximum time period, if less; 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 will be required to pay 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 your Participating School, who is identified on the General Information page of this Plan.

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

CLAIM PROCEDURES

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 the address listed below. You may obtain a claim form by contacting Claims Administrator.

Meritain Health, Inc.
18444 North 25 th Avenue, Suite #410
Phoenix, AZ 85023
(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 National Provider Identifier (NPI);

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

(4) The place where the services were rendered;

(5) The diagnosis and procedure codes, including a description of the services rendered;

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

(7) The name of the Plan;

(8) The name of the covered Employee; and

(9) 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 Claims 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 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 (acting on behalf of the Plan Sponsor) 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 (acting on behalf of the Plan Sponsor) 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 (acting on behalf of the Plan Sponsor) 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 (acting on behalf of the Plan Sponsor) 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 (acting on behalf of the Plan Sponsor) 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 (acting on behalf of the Plan Sponsor) 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 (acting on behalf of the Plan Sponsor) needs additional time to process a claim, the Plan Sponsor may extend the time in which the Claims Administrator can notify you of the Plan's benefit determination for up to 15 days, provided that the Claims Administrator (acting on behalf of the Plan Sponsor) notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Plan Sponsor 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 (acting on behalf of the Plan Sponsor) 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 (acting on behalf of the Plan Sponsor) needs additional time to process a claim, the Plan Sponsor 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 (acting on behalf of the Plan Sponsor) 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).

Manner and Content of Notice of Initial Adverse Determination
If a claim is denied, 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 Initially Denied Claims
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 following procedures listed below.

Health Benefit Claims
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 initially denied claims (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 41980
Plymouth, MN 55441-0970

Deadline for Internal Review of Initially Denied Claims

(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 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 Initially Denied Claims. 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; and

(8) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and, if your benefit is an insured benefit, your State insurance regulatory agency."

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 or a denied claim) 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 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.

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 Denied Claims
Note: This provision does not apply to dental and vision benefits.

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, effective after December 31, 2011, 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 not 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, for any claim for which an external review request is not initiated before September 20, 2011, 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; and

(2) A rescission of coverage.

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:

Meritain Health, Inc.
Appeals Department
P. O. Box 41980
Plymouth, MN 55441-0970

(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 Employee Benefits Security Administration.

(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 ten 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
Note: This provision does not apply to dental and vision benefits.

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 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 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 Sponsor has been rendered (or deemed rendered).

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 Claims Administrator. However, in connection with a claim involving urgent care, 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 Sponsor, Participating School or Claims 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 (acting on behalf of the Plan Sponsor) may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

COORDINATION OF BENEFITS

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

Excess Insurance
If at the time of injury, sickness, disease or disability there is available or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlements), the benefits under 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) 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 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.

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 (or as that employee’s dependent) determines its benefits before the Plan which covers a person as a laid-off or retired employee (or as that employee’s dependent). 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) Dependent children of separated or divorced parents or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:

   (a) The plan of the parent with custody pays first;

   (b) The plan of the spouse of the parent with custody (the step-parent) pays next;

   (c) The plan of the parent without custody pays next; and

   (d) The plan of the spouse of the non-custodial parent pays last.

   Notwithstanding the above provisions, if there is a court decree that would otherwise establish financial responsibility for the child’s health care expenses, the benefits of the plan that covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.

(6) If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information
For the purpose of determining the applicability of and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other plan, this Plan may, without notice to any person, release to or obtain from any insurance company or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan is deemed to consent to the release and receipt of such information and agrees to furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment
Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the Plan Sponsor may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of Recovery
Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this Plan.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions or should otherwise not have been paid by the Plan. This Plan may also inadvertently pay benefits that are later found to be greater than the maximum allowable charge. In this case, this Plan may recover the amount of the overpayment from the person or entity to which it was paid, primary payers or from the party on whose behalf the charge(s) were paid. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Sponsor has the right to recover any such erroneous payment.

A Covered Person, provider, another benefit plan, insurer or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Sponsor shall have discretion in deciding whether to obtain payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Sponsor shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Sponsor shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for any other Injury or Illness) under the Plan by the amount due as reimbursement to the Plan. The Plan Sponsor may also, in its sole discretion, deny or reduce future benefits (including future benefits for any other Injury or Illness) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, most recent edition of the ICD or CPT standards, Medicare guidelines, HCPCS standards or other standards approved by the Plan Sponsor or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, a Covered Person and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns ("Plan Participants") shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s) or damages arising from another party's act or omission for which the Plan has not already been reimbursed.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

(1) In error;

(2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act;

(3) Pursuant to a misstatement made to obtain coverage under this Plan within 2 years after the date such coverage commences;

(4) With respect to an ineligible person;

(5) In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Subrogation, Third Party Recovery and Reimbursement provisions; or

(6) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to the Covered Person.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

Medicaid Coverage
You or your Dependent's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of you or your Dependent. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of such person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

Coordination of Benefits with Medicaid
In all cases, benefits available through a state or federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

Coordination of Benefits with Medicare
When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare. If you did not elect coverage under Medicare Parts A and/or B when eligible, the Plan will be secondary and coordinate with benefits that would have been provided by Medicare.

When you, your Spouse or Dependents (as applicable) are eligible for or entitled to Medicare and covered by the Plan, the Plan at all times will be operated in accordance with any applicable Medicare secondary payer and non-discrimination rules. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active employees age 65 or over and rules concerning working disabled individuals (as discussed below).

When Medicare is the primary payor, the Plan will pay secondary to the extent the benefit is a Covered Expense under the Plan (meaning that 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"), for a period not to exceed 30 months generally beginning the first day of the month of eligibility 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.

Medicare and COBRA
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.

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 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 insurance 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 any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees 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 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 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 such rights or action.

(2) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable 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 it 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) 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 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 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 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, express 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.

Covered Person 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 Covered Person understands that he/she is required to:

(a) Notify the Plan or it 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 Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person 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 Covered Person, 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 otherwise provided for under the Plan's "Coordination of Benefits" section.

The Plan's benefits shall be excess to any of the following:

(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(s) 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 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 Covered Person may have against any responsible party or coverage;

(h) To instruct his/her attorney to ensure that the Plan 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 Covered Person 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 Covered Person 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 Covered Person'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.

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.

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 or 2 Assistant Surgeons. 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.

Claims Administrator means Meritain Health, Inc., 18444 N. 25th Avenue, Suite #410, Phoenix, Arizona 85023.

Close Relative means a Covered Person's spouse, parent (including step-parents), sibling, child, grandparent or in-law.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time.

Coinsurance has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

Complications of Pregnancy means condition(s) (when the Pregnancy is not terminated) whose diagnosis is distinct from Pregnancy but which is adversely affected by Pregnancy or caused by Pregnancy; such as, acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity.

Complications of Pregnancy also include an ectopic Pregnancy which is terminated or spontaneous termination of Pregnancy which occurs during a period of gestation when a viable birth is not possible; and, pernicious vomiting (hyperemesis gravidarum) and toxemia with convulsions (eclampsia of Pregnancy).

Complications of Pregnancy do not include false labor, occasional spotting, Physician prescribed rest during the period of Pregnancy, morning sickness and similar conditions, which, although associated with the management of a difficult Pregnancy, are not medically classified as distinct Complications of Pregnancy.

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 has the same meaning as set forth in the section of this Plan entitled “General Overview of the Plan”.

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 Card Program.

(3) For dental expenses, an item or service listed in the Plan as an eligible dental expense for which the Plan provides coverage.

(4) For vision expenses, an item or service listed in the Plan as an eligible vision expense for which the Plan provides coverage.

Covered Person means, individually, a covered Employee or Retiree 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, 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.

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.

Dentally Necessary means services or supplies, which are determined by the Plan Sponsor to be:

(1) Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the dental condition, Injury or Illness;

(2) Provided for the diagnosis or direct care and treatment of the dental condition, Injury or Illness;

(3) Within standards of good dental practice within the organized dental community;

(4) Not primarily for the convenience of the Covered Person, the Covered Person’s Dentist or another provider; and

(5) The most appropriate supply or level of service which can safely be provided.

Dependent is a Covered Person, other than the Employee or Retiree**,** who is covered by the Plan pursuant to the terms and conditions set forth in the "Eligibility for Participation" section of the Plan.

Domestic Partner is defined 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 manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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:

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

(1) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

(2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to Stabilize the individual.

Employee is defined in the "Eligibility for Participation" section of the Plan.

Employer means the Trust and each Participating School, as applicable**.**

Endodontic Treatment means procedures for the prevention and treatment of diseases of the dental pulp, pulp chamber, root canal and surrounding periapical structures.

ERISA means the Employee Retirement Income Security Act of 1974, as may be amended from time to time.

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 Sponsor as set forth below.

The Plan Sponsor must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Plan Sponsor 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 Sponsor will be final and binding on the Plan. In addition to the above, the Plan Sponsor 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 in the United States (U.S.) or is the subject of the research, Experimental, study, Investigational or other arm of on-going Phase III clinical trials in the U.S. 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. However, if the claimant is participating in the standard arm of any phase of a clinical trial in the U.S., that will not exclude the charges as 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 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:

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

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

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

(4) 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.

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 Sponsor.

FMLA means the Family and Medical Leave Act of 1993, as may be amended from time to time.

Genetic 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. Genetic 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.

Harmful Habit means the acquired habit of thumb sucking, tongue thrusting or bruxism, which causes damage to the teeth and/or periodontal support.

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.

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.

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 31-day eligibility period. A Special Enrollee is not considered a Late Enrollee.

Leave of Absence means a Leave of Absence of an Employee that has been approved by the as provided for in the Trust and/or Participating School’s rules, policies, procedures and practices.

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; (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.

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.

Morbid Obesity Morbid obesity is defined as (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy or musculoskeletal dysfunction.

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.

Orthodontic Treatment means the corrective movement of teeth to treat a handicapping malocclusion of the mouth.

Participating School means any school district that has, with the consent of the Plan Sponsor, adopted this Plan pursuant to a participation agreement by and between the Plan Sponsor and the school district for the exclusive benefit of its Employees and their eligible Dependents.

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 who is acting within the scope of their license and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. 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 Therapist, Speech Pathologist and Licensed Midwife. An employee of a Physician 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 Arizona School Boards Association Insurance Trust Employee Benefit Plan.

Plan Sponsor means Arizona School Boards Association Insurance Trust (ASBAIT).

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.

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; or (4) pediatrics.

Qualified Clinical Trial is defined as 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 though 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.

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.

Retiree means a former Employee of the Trust and/or Participating School, as applicable, who meets the eligibility requirements for Retiree coverage under the Plan. Eligibility requirements for a Retiree are established by the Trust and each Participating School, as applicable.

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 as an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 31-day 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.).

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of 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 and (1) there is inadequate time to effect a safe transfer to another Hospital before delivery or (2) transfer may pose a threat to the health or safety of the woman or her unborn child; to deliver (including the placenta).

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;

(7) Biopsy;

(8) To puncture or aspirate; or

(9) Use of a laser.

Urgent Care Facility means a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. 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 Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

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 will be subject to a Usual and Customary determination. Usual and Customary allowances are based on what is usually and customarily accepted as payment for the same service within a geographical area. In determining whether charges are Usual and Customary, consideration will be given to the nature and severity of the condition and any medical or dental complications or unusual circumstances which require additional time, skill or experience. Limitations for Usual and Customary Charges are not applicable to Participating Providers.

MISCELLANEOUS INFORMATION

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.

The Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate by operation of law, as a result of changes in law which are required to affect provisions in the Plan.

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.

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 Sponsor 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.

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 Dependents.

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 Trust or any Participating School 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 Trust or any Participating School or to interfere with the right of the Trust or any Participating School 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 Sponsor 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 Sponsor shall be free from any liability that may arise with regard to such action; however, the Plan Sponsor at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Sponsor 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 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 Genetic 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 genetic information, including information about genetic 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 genetic 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); (3) the application of any preexisting condition exclusion under the Plan; and (4) 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.

GENERAL PLAN INFORMATION

Name of Plan:	Arizona School Boards Association Insurance Trust Employee Benefit Plan
Plan Sponsor: (Named Fiduciary)	Arizona School Boards Association Insurance Trust (ASBAIT)
Plan Sponsor EIN:	86-0726505
Plan Year:	July 1 - June 30
Plan Type:	Welfare benefit plan providing medical, dental, vision and prescription drug benefits.
Plan Funding:	All benefits are either paid through a trust that has been established by the Plan Sponsor or through the general assets of your Participating School.
Contributions:	The cost of coverage under the Plan is funded in part by Employee contributions and in part by contributions from the Plan Sponsor and each Participating School.
Claims Administrator:	Meritain Health, Inc. 18444 North 25th Avenue, Suite #410 Phoenix, AZ 85023 (866) 300-8449
COBRA Administrator:	Please contact the Participating School for information with respect to the COBRA Administrator.
Medical Management Program Administrator:	ASBAIT Medical Management 10 West Old Wilson Road, 3rd Floor Worthington, OH 43085 (855) 527-2248 or (855) 5-ASBAIT
Prescription Drug Card Program Administrator:	CatamaranRx Customer Care Center: (855) 312-6103 www.mycatamaranrx.com
Participating School:	A list of all Participating Schools may be obtained, upon request and free of charge, by contacting the Plan Sponsor.
Agent for Service of Legal Process:	Arizona School Boards Association Insurance Trust

Trustee(s):

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Director of Business
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Indian Wells, AZ 86301
lindayazzie@holbrook.k12.az.us

The Plan shall take effect for each Participating School as of the Effective Date, unless a different date is set forth in the list of Participating Schools that is available upon request and free of charge to the Plan Sponsor.

The Plan is a legal entity. Legal notice may be filed with and legal process served upon, the Plan Sponsor.