PLAN DOCUMENT
SUMMARY PLAN DESCRIPTION

Benefits discussed in this document include:

Medical/Prescription Drug Plan Options	**Basic Life Insurance and AD&D Insurance**	**Short Term Disability (STD)**
Dental Plan Options	**Supplemental Life Insurance**	**Long Term Disability (LTD)**
Vision Plan Options	**Business Travel Accident/Commuter Travel**	**COBRA**
Employee Assistance Program (EAP)		**Flexible Spending Accounts – Health and Dependent Care (FSA)**

Amended, Restated and Effective January 1, 2016

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INTRODUCTION

The City of Mesa offers a variety of health care and other benefits to eligible participants. This Plan Document describes the wide variety of benefits available including: Medical/Prescription Drug, Dental, Vision Care, Employee Assistance Program (EAP), Life insurance, Accidental Death and Dismemberment, Short and Long Term disability, Business Travel Accident/Commuter insurance and Flexible Spending Accounts.

The City self-insures and contracts with various third-party administrators and other vendors to administer the Medical/Prescription Drug and Dental Plans as well as the Flexible Spending Accounts program (including Health and Dependent Care Accounts). The City contracts with various insurers and organizations to provide the following services: Employee Assistance Program (EAP), Vision Care Plans, Basic Life Insurance/AD&D, Supplemental (Voluntary) Life Insurance, Business Travel Accident/Commuter insurance and Short and Long Term Disability coverage.

The Plan described in this document is effective January 1, 2016 except for those provisions that specifically indicate other effective dates, and replaces all other Plan Document/Summary Plan Descriptions previously provided to you. If you are not eligible for certain benefits then the chapters and sections pertaining to those Plans/benefits do not apply to you. This Plan is **not** subject to the provisions of the Employee Retirement Income Security Act, commonly called ERISA. This Plan is a non-grandfathered plan under the requirements of the Patient Protection and Affordable Care Act (PPACA).

This document will help you understand, make enrollment decisions and use the benefits provided by the City of Mesa. Please review it and share it with those members of your family who are or will be covered by the Plan. This Plan Document explains:

- the coverage provided;
- Plans that are automatic enrollment;
- Plans that require you to actively enroll in a timely manner;
- the procedures to follow in obtaining services and submitting claims; and
- member responsibilities to provide necessary information to the Plan Administrator (and Appropriate Claims Administrators).

Remember, not every expense you incur for health care is covered by the Plan, even if the expense is otherwise medically necessary. The City of Mesa reserves the right to amend, modify, add or delete benefits to this Plan Document.

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

Be sure to keep this document (or retain any links to online access), along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

Questions You May Have:

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Employee Benefits Administration Office or any of the Appropriate Claims Administrators listed, at the web sites, phone numbers and addresses located in the Quick Reference Chart in this document. As a courtesy to you, the benefits service staff may respond informally to oral questions; however, oral/verbal communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits.

Spanish Language Assistance:

Este documento contiene una breve descripción sobre sus derechos de beneficios del Plan, en Ingles. Si usted tiene dificultad en comprender cualquier parte de este documento, por favor de ponerse en contactó con el Benefits Plan Administration a la dirección y teléfono en el (Quick Reference Chart) de este documento.

QUICK REFERENCE CHART	
Information Needed About:	**Contact the following:**
City of Mesa Health Plan – Plan Administrator/Employee Benefits Administration • Plan Sponsor and Plan Administrator • Eligibility and enrollment – active employees and retirees • eBenMesa Online Application • Medicare Part D Notice of Creditable Coverage • COBRA Eligibility and Billing • Retiree Eligibility and Billing • HIPAA Privacy & Security Officer (Plan Administrator)	**Employee Benefits Administration Office** 20 E Main Street, Suite 600, Mesa AZ 85201 Mailing address: P O Box 1466, Mesa AZ 85211-1466 Phone #: 480-644-2299 Hours: M-Thurs 7:00 am to 6:00 pm MST (except holidays) E-mail Address: Benefits.Info@mesaaz.gov Website Benefits Information: www.mesaaz.gov/benefits Website online enrollment: ebenmesa.mesaaz.gov (also a link in benefits website)
Medical Plans/Benefits - Third Party Claims Administration/Member Services Utilization Management & Disease Management (In-State AZ) • Group #: CM001 • Medical Claims and Utilization/Disease Management Administrator • Eligibility verification and benefits information • Medical/Prescription Drug ID Cards – combo card • Website member portal • Health and Wellness Information and Links • Appeals Administration • Pre-certification/Case Management • Disease Management Programs	**AmeriBen:** Member Customer Care Center: 1-855-258-6467 Pre-certification phone #: 1-800-388-3193 Hours: M-Fri 7:00 am to 6:00 pm MST (except holidays) Member Portal/Website: www.myameriben.com AZ In-network providers submit electronic claims to: BCBSAZ with EDI# 53589 Submit Out-of-Network and paper claims to: AmeriBen P O Box 7186 Boise ID 83707 Submit Appeals to: AmeriBen P O Box 7186 Boise ID 83707
Medical Network Provider for In-State (AZ) Medical Plan Participants • PPO Network Providers	**Blue Cross and Blue Shield of Arizona (BCBSAZ)** can be accessed from www.azblue.com/CHSNetwork or by phone through AmeriBen Member Customer Care Center 1-855-258-6467
Nurse Help Line (In-State and OOS Medical Plan Participants) • 24/7 access to a Professional Nurse to discuss symptoms and possible next-steps regarding your health care needs	**Provided by Blue Cross and Blue Shield of Arizona (BCBSAZ)** 1-866-422-2729

QUICK REFERENCE CHART	
Information Needed About:	**Contact the following:**
Out-of-State Medical Plan/Benefits - Third Party Claims Administration, Member Services, Network Access, Utilization Management and Disease Management (OOS) – effective 1/1/16, all members of the same covered family unit, who have at least one family member residing out-of-state of Arizona, may be enrolled in the OOS medical plan • Group #: 29231 • Medical Claims and Utilization Management Administrator – for Plan participants who live outside AZ and participate in the OOS Plan • **Blue Card** PPO Network Access with BCBS Association licensees nationally • Eligibility verification and benefits information • Medical ID Cards • Website member portal • Mobile App • Health and Wellness Information and Links • Appeals Administration • Pre-certification/Case Management • Disease Management	**Blue Cross and Blue Shield of Arizona - BCBSAZ (independent licensee of Blue Cross and Blue Shield Association)** Member Services: 1-866-288-5788 Pre-certification phone #: 602-864-4320 or 1-800-232-2345 ext. 4320 Hours: M–Fri 6:00 am to 6:00 pm MST (except holidays) Member Portal/Website: www.azblue.com Mobile App: Google Play Store or App Store – search for "AZBlue" Submit Claims to: Blue Cross Blue Shield of AZ P O Box 2924, Phoenix AZ 85062-2924 EDI#: 53589 Submit Appeals to: Blue Cross Blue Shield of AZ Mail Stop A116 P O Box 13466 Phoenix AZ 85002-3466 Fax: 602-544-5601 Phone: 602-544-4938; 866-595-5998
Prescription Drug Benefits/Program and Member Services for In-State and OOS Medical Plan Participants • ID Cards for OOS Rx participants • Online Temp Rx ID cards all participants • In-Network Retail Pharmacy locations • Home Delivery (Mail Order) and CVS Retail up-to 90 day supply services • Non-network outpatient retail pharmacy claims • Preauthorization, step-therapy and quantity limits of certain prescription drugs • Formulary Management • Specialty Drug Pharmacy • Website member portal • Mobile App	**CVS/Caremark** www.caremark.com Mobile App: Google Play Store or App Store – search for "CVS Caremark" Member Services: 1-855-264-5048 Home Delivery (Mail Order) Services: Doctor's fax instructions: 1-800-378-0323 Doctor's phone refills: 1-800-378-5697 Option 2 Member's mail order phone refill requests: 1-855-264-5048 Submit non-network outpatient retail pharmacy claims to: CVS/Caremark P.O. Box 52136, Phoenix, AZ 85072-2136 Request Rx Claim Reimbursement Form (Paper Claim Form) from Member Services or www.caremark.com

QUICK REFERENCE CHART	
Information Needed About:	**Contact the following:**
Dental Plan/Benefits Third Party Claims Administration/Member Services and Dental PPO Network Access • Group #: 04760 • Delta Dental PPO Network access • Eligibility verification and benefits information • Dental ID Cards • Website member portal • Mobile App • Dental and Wellness Information and Links • Dental claims administration • Appeals Administration • Pre-estimation services	**Delta Dental of Arizona** Member Customer Service: 602-588-3981 or 1-888-611-6711 (English or Spanish) Hearing Impaired: 602-588-3903 (English); 602-588-3920 (Spanish) Hours: M-Thurs 7:30 am to 5:00 pm MST; Fri 7:30 am to 4:30 pm MST (except holidays) Member Portal/Website: www.deltadentalaz.com Mobile App: Google Play Store or App Store – search for "Delta Dental" E-mail Address: customerservice@deltadentalaz.com Provider Customer Service: 602-588-3982 or 1-866-746-1834 Submit claims and appeals to: Delta Dental of Arizona P O Box 43026 Phoenix, AZ 85080-3026 EDI #: 86027
Vision Care Plan - Routine Exams & Materials • Group #: 300167772 • VSP Preferred Provider Network • Website member portal • Routine vision care claims and appeals • Copays, Discounts and Allowances for covered services and materials • TruHearing Hearing Aid Discount Program • Diabetic Eye Exam benefit	**Vision Service Plan (VSP)** Member Services: 1-800-877-7195 Hours: M – F 5am to 7pm PST Member portal/website: www.vsp.com or access from Smart Phone Submit claims and appeals to: Automatic processing for network and affiliate vendor services; non-network claims to: VSP Attn: Out-of-network Claims P. O. Box 997105, Sacramento, CA 95899-7105
Employee Assistance Program (EAP) • Up to eight (8) free counseling visits (in-person or telephonic) per patient per problem per calendar year • Eldercare and Childcare Referrals/Services • Legal Services • Resource materials • Website member portal • Mobile App	**ComPsych Guidance Resources** Phone #: 1-866-519-7415 (TDD: 1-800-697-0353) Member portal/website: www.guidanceresources.com Web ID: MESA Mobile App: Google Play Store or App Store – search for "GuidanceResources Now"

QUICK REFERENCE CHART	
Information Needed About:	**Contact the following:**
Flexible Spending Accounts (FSA) Third Party Administration • Health FSA claims processing • Health FSA Debit Cards • Dependent Care FSA claims processing • Direct Deposit payments • Account balances (including applicable rollover balances) • Website member portal • Mobile App • Health and Wellness Information and Links	**ConnectYourCare** IVR/Customer Service: 1-844-226-1872 Hours: 24 x 7 x 365 E-mail Address: service@connectyourcare.com Member Portal/Website: www.connectyourcare.com Mobile App: Google Play Store or App Store – search for "CYC Mobile" Fax #: 1-866-879-0812 Address: P O Box 622337, Orlando FL 32862-2337 (Claims may be auto submitted and adjudicated by CYC; participant claims submission or verification/substantiation by mail, fax, website/email, mobile app)
Basic Life, Accidental Death & Dismemberment Insurance (AD&D) Policy #: GL 151846; VAR 206004	**Reliance Standard Life Insurance Company** Contact Employee Benefits Administration Office for questions, certificates/policy information, beneficiary designations or claims regarding this coverage at 480-644-2299
Supplemental (Voluntary) Life Insurance Policy #: GL 1511846	**Reliance Standard Life Insurance Company** Contact Employee Benefits Administration Office for questions, certificates/policy information, beneficiary designations or claims regarding this coverage at 480-644-2299
Business Travel Accident/Commuter Travel Insurance Policy #: ETB-147012	**The Hartford Life Insurance** Contact Employee Benefits Administration Office for questions, certificates/policy information, beneficiary designations or claims regarding this coverage at 480-644-2299
Short Term Disability (STD) Insurance Policy #: 402870	**The Hartford (Hartford Life and Accident Insurance Company)** Member Services/Claims: 1-800-549-6514 Fax: 1-866-411-5613 Hours: 6 am to 6pm PST (except holidays) Address: P.O. Box 14302, Lexington, KY 40512-4302
Long Term Disability Insurance Policy #: LTD 124669	• Public Safety Personnel Retirement System and Elected Official employees – insured and administered by **Reliance Standard Life Insurance Company.** • Arizona State Retirement System covered employees - administered by **Sedgwick CMS.** • For questions and to file a claim contact Employee Benefits Administration Office at 480-644-2299.

IMPORTANT NOTICE

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

FAILURE TO DO SO MAY CAUSE YOU OR YOUR DEPENDENTS TO LOSE CERTAIN RIGHTS UNDER THE PLAN OR MAY RESULT IN YOUR LIABILITY TO THE PLAN IF ANY BENEFITS ARE PAID ON BEHALF OF AN INELIGIBLE PERSON.

ELIGIBILITY AND ENROLLMENT

OVERVIEW OF ELIGIBILITY FOR COVERAGE/ENROLLMENT IN PLAN BENEFITS					
Benefit Options	**Full-time Employees**	**Benefit Eligible Part-time Employees**	**Elected Officials**	**Retirees**	**Retirees with Disability**
Medical/Prescription Drug Plans	X	X	X	X	X
Dental Plans	X	X	X	X	X
Vision Plans	X	X	X	X	X
EAP	X	X	X	Automatically provided during the first 18 months of participation in Retiree Medical/Prescription Drug coverage	Automatically provided during the first 18 months of participation in Retiree Medical/Prescription Drug coverage
Long Term Disability (LTD)	X	X	X		
Voluntary Short Term Disability (STD)	X				
Basic Life Insurance	X		X	May port or convert to an individual policy at time of retirement from full-time status	May continue through Waiver of Premium privilege (if disabled prior to medical retirement or port/convert if not eligible for Premium Waiver at time of retirement from full-time status
Basic AD&D Insurance	X		X	May convert to an individual policy at time of retirement from full-time status	May convert to an individual policy at time of medical retirement from full-time status
Supplemental Life Insurance	X	X	X	May port or convert to an individual policy at time of retirement	May continue through Waiver of Premium privilege or port/convert if not eligible for Premium Waiver at time of medical retirement
Business Travel Accident/Commuter Death Insurance	X		X		
Flexible Spending Accounts (FSA)	X	X	X	May continue Health FSA through COBRA for remainder of calendar year after last day worked, with post-tax contributions	May continue Health FSA through COBRA for remainder of calendar year after last day worked, with post-tax contributions

1. **Full time employees** (regularly scheduled to work at least 40 hours or more each week) and **Part time employees** (working at least 20 hours but less than 40 hours per week on a regular, year-round basis in a benefits-eligible part time position), of the City of Mesa, who receive a bi-weekly paycheck directly from the City of Mesa (unless otherwise on an authorized unpaid leave of absence), are eligible for the benefits listed on the chart describing the Overview of Eligibility for Plan Benefits, as of the first day of the month coincident to or following your date of hire. All employees are required

to have medical coverage either through the City (if eligible) or another health plan including Medicare, Medicaid, AHCCCS, Exchange/Marketplace coverage or another employer or qualified individual health plan. For Medical/Prescription Drug, Dental, Vision and FSA benefits **only,** full-time and part-time benefit eligible employees may voluntarily choose the benefit effective date to be the date of hire, instead of the standard City eligibility default already described. Note however, to select this date of hire option, employees must complete enrollment processes and submit enrollment paperwork (including any required verification documentation) on or before the date of hire.

Benefit Effective Date	**Comments**
Option 1: First of the month following or coincident to the date of hire	• Enrollment processes/forms and any required documentation such as marriage/birth certificate, divorce decree, etc. must be uploaded to the online enrollment system or physically in the Employee Benefits Administration Office as soon as administratively practical but no later than 31 days from the hire date. If this deadline is missed or if opt-out procedures have not been completed, the employee's coverage will be automatically defaulted to the City's Basic Medical/Prescription Drug Plan with employee only coverage and a required wait until annual Open Enrollment or a qualified family status change to make changes, drop coverage, add dependents or optional benefits.
Option 2: Date of hire (for medical/prescription drug, dental, vision and FSA coverage only)	• Enrollment processes/forms and any required documentation such as marriage/birth certificate, divorce decree, etc. must be uploaded or physically in the Employee Benefits Administration Office on or before the benefit effective date (hire date). If this deadline is missed, coverage will be effective on the first of the month following or coincident to the date of hire, provided that enrollment processes/forms and documentation have been uploaded/received timely. Please note the Employee Benefits Office hours of operation and plan accordingly.

The benefits enrollment process includes completion of online enrollment processes and upload/submission of forms and verification documentation to the Employee Benefits Administration Office and any required premium contributions are paid.

LTD coverage under the Public Safety Personnel Retirement System (PSPRS) or the Arizona State Retirement System (ASRS) is effective on the date of hire for eligible employees (see Long Term Disability section of this Plan Document for additional information).

2. **Elected Officials of the City of Mesa** (Mayor and City Council members) are eligible for the benefits listed on the chart describing the Overview of Eligibility for Plan Benefits. Coverage for these benefits starts on the day on which the elected official is sworn into office, as long as the online enrollment process/forms have been completed and submitted to the Employee Benefits Administration Office (within 31 days of swearing into office) and any required premium contributions are paid.
3. **Retired employees (retirees) of the City of Mesa** who meet the eligibility requirements as stated in the Definitions section of this Plan Document, and begin receiving and continue to receive retirement benefits either from the Arizona State Retirement System (ASRS) or Public Safety Personnel Retirement System (PSPRS) on the first of the month following retirement with the City of Mesa, are eligible for the benefits listed in the chart describing the Overview of Eligibility for Plan Benefits. The monthly premium paid by the retiree depends upon the employee's most recent date of hire, coverage chosen, and the number of years of eligible service with the City of Mesa. Coverage begins on the first day of the month following the employee's retirement date, as long as any required contributions are paid. Retired employees and their eligible dependents must enroll in Medicare Parts A and B upon becoming eligible. Note that employees hired on or after 1-1-09, who meet the eligibility requirements for retirement described in this section and the Definitions section of this Plan Document, are eligible for City retiree Health Plan coverage but are not eligible for City contributions or City subsidies towards the cost of that coverage.
4. **Retired employees (retirees) with a Disability:** Retired employees other than those described above, who have medically retired from employment due solely to a Total Disability **and** are receiving an LTD benefit **and** who continue to meet the requirements of Total Disability as defined in the Definitions chapter of this document, are also eligible for the same Health Plan coverage as retired employees without a disability. See the benefits described in the chart above describing the Overview of Eligibility for Plan Benefits. Employees hired on or after 1/1/09 may be eligible for retiree Health Plan coverage during a period of Total Disability, but without any City contributions or subsidies towards the cost of this coverage (may be eligible for ASRS or PSPRS subsidies). An employee will be eligible to retire under this provision if totally disabled for a period of at least six months, and the Total Disability continues thereafter. Coverage begins on the first day of the month following

the medical retirement date, and will continue as long as the medical retiree is receiving LTD benefits and any required contributions are paid. Individuals who retire due to a disability must enroll in Medicare Parts A and B upon becoming eligible. When LTD benefits end, the medical retiree may be eligible to continue coverage as a retired employee IF the eligibility requirements stated in 3. above, are met i.e. (City service requirements related to hire date and length of service). City service does not continue to accrue while medically retired and receiving LTD benefits. Note, when LTD benefits end, employees hired on or after 1-1-09 are eligible for the same Plan coverage as retired employees without a disability, but without any City contributions or subsidies towards the cost of this coverage (may be eligible for ASRS or PSPRS subsidies).

5. ***Independent contractors, temporary agency workers, employees of staffing firms, leased employees* and any other contingent workers and their dependents are not eligible for benefits provided under this Plan Document. This exclusion shall apply even if a court or other authority deems the contingent workers to be common law employees.**

DEPENDENTS' ELIGIBILITY FOR COVERAGE

If you elect coverage for yourself, you are also eligible for the same benefit coverage for your Eligible Dependents in the medical, dental, vision and supplemental life insurance Plans, on the later of the day you become eligible for your own coverage or the day you acquire an Eligible Dependent, either by marriage, birth, adoption or placement for adoption **and** if benefit coverage is in effect for you on that day. You must complete any online enrollment processes as may apply **and** pay any required contributions for covered Dependents.

1. Your Eligible Dependents include your lawful Spouse (as defined by Arizona state law) and your Dependent Child (ren) as those terms are defined in the Definition chapter of this document.
2. Anyone who does not qualify as a Dependent Child or Spouse as those terms are defined by this Plan has no right to any coverage for Plan Benefits or services under this Plan (except as described in the Committed Partner eligibility section).

SURVIVING LAWFUL SPOUSE AND SURVIVING DEPENDENT(S) OF LAW ENFORCEMENT OFFICER EMPLOYEES – Harrolle's Law

The surviving lawful spouse and surviving dependent(s) of a deceased City law enforcement officer are entitled to continue health coverage under the Plan. Effective April 5, 2013, the following terms apply:

1. "Law Enforcement Officer" means a peace/police officer, detention officer, corrections officer, probation officer, surveillance officer or a Fire Fighter employed by the City of Mesa
2. dependent coverage means coverage for an unmarried child of a deceased law enforcement officer who is under 18 years of age, or if over age 18 and under age 23, is a full-time student
3. disabled Adult Child dependent is also eligible for coverage providing the disability began before age 23 and Adult Child remains a dependent of the surviving spouse or guardian
4. the law enforcement officer: (1) must have been killed in the line of duty; or (2) must have died from injuries/illnesses suffered in the line of duty; and
5. the law enforcement officer must have been enrolled in a City-sponsored Medical Plan at the time of death; and
6. the surviving lawful spouse and surviving dependents must have been covered by a City-sponsored Medical Plan at the time of the officer's death; and
7. premiums for coverage must be paid by the surviving lawful spouse and surviving dependents at the same employee-contribution rate that applies to active employees and their families; and
8. continued health coverage at active rates will be discontinued if the surviving lawful spouse remarries, becomes Medicare eligible or dies, or if a dependent otherwise becomes ineligible for coverage
9. upon termination of coverage, the surviving lawful spouse and surviving dependent(s) will have the opportunity to elect temporary COBRA continuation of coverage at full cost.

COMMITTED PARTNER ELIGIBILITY An employee/retiree who is eligible for medical/prescription drug, dental, vision care or supplemental life insurance coverage under this Plan, has the option of enrolling an eligible Committed Partner and Committed Partner children, as of April 1, 2014 or during a subsequent Open Enrollment period.

Committed Partner eligibility requires:

1. Both the employee/retiree and the Committed Partner are at least age 18 and mentally competent to consent to a Declaration of Committed Partnership.
2. Employee/retiree and Committed Partner have lived together in a common household for at least twelve months prior to the effective date of the enrollment and will continue to do so throughout the entire period of benefits coverage (except for temporary separations connected to employment, education or military service).
3. Both parties are each other's sole Committed Partner.
4. The employee/retiree and the Committed Partner are not legally married to each other.

5. The employee/retiree and the Committed Partner are not related in any way that would prohibit legal marriage if they could otherwise be married under applicable law.
6. The employee/retiree and the Committed Partner are not legally married to, or legally separated from, or a Committed Partner to any other person(s).

Enrolling a Committed Partner

An employee/retiree who wishes to enroll a Committed Partner and Committed Partner children must complete any online enrollment processes as may apply and upload/submit the following information to Employee Benefits Administration during the designated enrollment period (either when first eligible to enroll or, during an Open Enrollment period):

1. A Declaration of Committed Partnership form, completed, signed by both the employee and the Committed Partner and notarized by a Notary Public
2. Verification of Committed Partner children relationship to Committed Partner (birth/adoption/legal guardianship/foster documentation), if applicable to the enrollment
3. Documented verification of the Committed Partnership financial inter-dependence, including at least **two** (2) of the following documents:
   - Joint ownership or lease of primary residence (mortgage, deed or lease agreement)
   - Joint bank or credit card account (redacted bank/credit statement or blank voided check with both names printed on the check or statement of account)
   - Life Insurance or Last Will and Testament naming employee or Committed Partner as each other's primary beneficiary
   - Designation of employee/retiree and Committed Partner to act on each other's behalf for all purposes under a Power of Attorney
   - Joint utility billing notice(s), showing both parties, same address/location
   - Other original documentation that verifies financial inter-dependence and Committed Partnership

Note, at least one of the above documents must have an effective date twelve (12) months or more prior to the intended benefit coverage effective date. Failure to produce the above requested documentation will render a Committed Partner and Committed Partner children ineligible for coverage/benefits under the Plan. Committed Partner children are not eligible for coverage if the Committed Partner is not also eligible and enrolled for coverage.

Tax Implications of Enrolling a Committed Partner

The Plan will automatically default a Committed Partner and his or her children to non-qualified tax dependent status for purposes of Committed Partner benefit plan coverage. This means that premiums paid by the employee for medical, dental or vision coverage (as applicable), will be on a post-tax basis and the value of the coverage provided to a Committed Partner and Committed Partner children, will result in taxable imputed income to the employee. The employee (or retiree) is responsible for seeking tax advice and making a determination of qualified tax dependent status of their Committed Partner or Committed Partner children, for purposes of adjusting their annual federal and/or state income tax returns if applicable.

- **Post-Tax Elections Only**

Health Plan premium deductions for employees who enroll a Committed Partner/Committed Partner children will be allowed on a post-tax deduction basis only.

- **Imputed Income Attribution**

The **value of the City (employer) contribution** for medical, dental or vision Plan coverage for the tier in which the Committed Partner (and Committed Partner children) are enrolled, **minus the value of the City contribution for the employee only tier of that coverage**, will be considered imputed income to the employee, subject to additional federal, state and FICA tax withholding and may result in a reduction in the employee's net pay amount. The Plan reserves the right to change post-tax and imputed income processing as may be required by regulatory guidelines.

Dropping Committed Partner Coverage

If a Committed Partner or Committed Partner children are no longer eligible for coverage as defined above, the employee/retiree must immediately advise Employee Benefits Administration (within 31 days of an event) and coverage must be terminated. Additionally, an employee/retiree can **voluntarily** drop Committed Partner and Committed Partner children from coverage at any time, even if the Committed Partner or Committed Partner children otherwise remain eligible for coverage.

Committed Partner and Committed Partner child(ren) are not eligible for COBRA continuation privileges. Re-enrollment after a drop of coverage is subject to satisfaction of eligibility and enrollment provisions during Open Enrollment period.

Primary/Secondary Committed Partner Coverage
If a Committed Partner is eligible for Medicare (based on age or social security disability award), Medicare is primary and the Plan will pay secondary. Similarly, if a Committed Partner and/or Committed Partner child(ren) has other health plan coverage of any type, that coverage will be primary and the City of Mesa Health Plan will pay secondary (unless otherwise prohibited by regulatory provisions).

PROOF OF DEPENDENT STATUS
Specific documentation to substantiate Dependent status will be required by the Plan and may include any of the following:

- **Marriage:** copy of the certified marriage certificate.
- **Birth:** copy of the certified birth certificate or hospital issued birth notification (if parent names are included).
- **Natural son or daughter:** birth certificate listing employee/retiree as parent, child's marriage certificate (if child is married and has had a name change).
- **Adoption or placement for adoption**: birth certificate; adoption or placement documentation listing employee/retiree or spouse as adoptive parent; if child is married and has had a name change, child's marriage certificate.
- **Stepchildren**: birth certificate showing the employee's/retiree's spouse as the parent; if child is married and has had a name change, child's marriage certificate; employee's/retiree's marriage certificate documenting marriage to stepchild's parent.
- **Foster Children:** birth certificate; if child is married and has had a name change, child's marriage certificate; foster care license & placement documentation listing employee/retiree or spouse.
- **Grandchildren:** birth certificate; if child is married and has had a name change, child's marriage certificate; legal guardianship documentation listing employee/retiree or spouse as legal guardian.
- **Legal Guardianship:** a copy of your legal guardianship documents and a copy of the certified birth certificate.
- **Involuntary loss of Dependent coverage:** Certificate of loss of coverage from previous employer and marriage certificate if applicable to the event and not already on file.
- **Disabled Dependent Child:** The plan requires Social Security Disability award documentation as proof of disability status (or medical and dependency documentation with proof of Social Security Disability application if Social Security Disability award documentation is still pending).
- **Qualified Medical Child Support Order** (QMCSO): Valid QMCSO document or National Medical Support Notice.

COORDINATION OF BENEFITS WITH MEDICARE

To comply with federal Medicare coordination of benefit regulations, you must promptly provide the **Social Security Number (SSN)** of your Eligible Dependents for which you have elected, or are electing Plan coverage, along with information on whether you or any of such dependents are currently enrolled in Medicare or have dis-enrolled from Medicare, to the Plan Administrator or its designee. This information will be requested when you first enroll for Plan coverage, but may also be requested at a later date. Failure to provide this information will result in claims processing delays.

As a reminder, retired employees and/or their dependents MUST enroll in Medicare Parts A and B upon becoming eligible. Disabled Dependents (including children) must also apply for Medicare upon becoming eligible and must provide proof of Medicare coverage when received.

Enrollment in Medicare Part D is optional; however, when a retired employee or dependent elects Medicare Part D through a Prescription Drug Plan (PDP), that plan will become the only payer for your prescription coverage. Enrollment in Medicare or disenrollment from a Medicare Part D Prescription Drug Plan must be reported to the Plan Administrator or its designee.

EMPLOYEE ASSISTANCE PROGRAM (EAP) ELIGIBILITY
All employees and their family/household members are eligible to use the EAP program sponsored by the City of Mesa. You do not have to be eligible for or enrolled in one of the City-sponsored medical plans to use the services available through the EAP while you are actively employed. Eligible Retirees who elect medical plan coverage and terminated employees who are eligible for and elect COBRA continuation medical plan coverage, may also continue to use the EAP at no charge for up to 18 months after the commencement of either retiree medical plan or COBRA continuation medical plan coverage. The EAP is described in the EAP chapter of this document.

ENROLLMENT FOR AND START OF COVERAGE
There are three opportunities to enroll for coverage under this Plan: Initial Enrollment, Special/Qualifying Event Enrollment, and Open Enrollment. These opportunities are described further in this chapter.

Procedure to Request Enrollment:
Generally an individual must enroll in the Plan using online enrollment processes or call, fax, e-mail or visit the Employee Benefits Office.

T**he steps to enroll** include all of the following:

1. online enrollment selections, and
2. upload/submit proof of Dependent status (as requested), and
3. pay any required contributions for coverage, and
4. perform steps a. through c. above, in a timely manner according to the timeframes noted under the Initial, Special/Qualifying Event, or Open Enrollment provisions of this Plan.

Enrollment Is Required for Coverage:
You and your Eligible Dependents may become covered under the benefits of this Plan that require an enrollment selection, **only** upon completion of online enrollment processes including upload/submission of any required documentation such as birth or marriage certificate, and by paying any required contributions for coverage. A person who is not duly enrolled by completing these required processes and paying any required contributions has no right to any coverage for Plan Benefits or services under this Plan.

Declining (Opting Out or Waiving) Medical, Dental, Vision and/or Other Coverage:
As an employee, you may decline (opt-out or waive) medical, dental and/or vision coverage under this Plan and opt-out or waive any voluntary benefit plan. To do so, you must opt-out in the online enrollment processes for each of the plans you wish to waive coverage.

Note that no additional compensation is paid to you if you opt-out of any benefit coverage. If you decline coverage for yourself, you will **not** be allowed to enroll your spouse or dependent children in the coverage you decline (does not apply to supplemental life insurance coverage).

If, at a later date, you want to reinstate the coverage you declined you may enroll yourself and any eligible dependents **only** under the Special/Qualifying Event Enrollment provisions (when applicable) or the Open Enrollment provisions described later in this chapter.

Eligible retirees may also decline/opt-out of medical, dental and/or vision coverage at any time, by completing and submitting an enrollment form to the Employee Benefits Administration Office with the opt-out provisions elected, (or using online enrollment/change processes as may apply). If you decline coverage for yourself, you will **not** be allowed to enroll your spouse or dependent children under the coverage you declined. **Once a retiree opts-out of a coverage option under this Plan, the retiree may never re-enroll in any such City-sponsored program again (even during a subsequent Open Enrollment period).** For example, if the retiree opts out of medical coverage and keeps dental coverage, the retiree may never re-enroll in any City-sponsored medical plan but may continue with the dental plan from year to year. Note that no compensation is made to a retiree if the retiree waives/declines/opts out of benefit coverage.

INITIAL ENROLLMENT

1. **Initial Enrollment Period and Procedure:** You must enroll no later than 31 days after the latest date on which you are eligible for coverage by completing online enrollment processes. If you want Dependent coverage, you must enroll your Eligible Dependents at the same time. This Plan **does not** apply a pre-existing condition limitation on medical plan benefits.
2. **Rehired/Reinstated Individuals:**
   - **If you cease to be covered under this Plan and then within thirty 30 days return to work with the City in a benefits-eligible position**, you will be required to take the same benefit election for the remaining portion of the Plan year as you had before you terminated. Participation will be effective the first of the month following such election.
   - **If you cease to be covered under this Plan and return to work with the City in a benefits-eligible position more than 30 days** following the termination you will be considered a new hire and must follow the Initial Enrollment provisions of this Plan.
   - **Special rules pertaining to Reduction in Work Force (RIWF**): Employees who are officially laid off from the City of Mesa (on or after January 1, 2009) OR who, as a result of a position being targeted for lay-off, elected to take an early retirement in lieu of being laid off (on or after January 1, 2009) AND who are reinstated as employees within two years from their last day worked, will have the following apply for purposes of determining retiree health insurance eligibility, upon a subsequent eligible retirement from the City:
     - the employee's last prior employment effective date with the City of Mesa will be reinstated to determine the number of years of service required for that employee to qualify for retiree benefits with the City and
     - the employee's prior years of service with the City of Mesa (including partial years) will be reinstated and used as credit toward the City's years of service requirement for determining eligibility and family premium amount.

These provisions will not apply to City of Mesa employees who voluntarily separate from the City of Mesa (or separate for any other reason than RIWF).

3. **Start of Coverage Following Initial Enrollment:**
   - **For Full-time employees and Part-time benefit eligible employees,** your coverage starts on your "benefit effective date". The definition of "benefit effective date" is outlined at the front of this chapter under Full-time employees. Coverage of your enrolled Spouse and/or Dependent Child(ren) begins on the date your coverage begins.
   - **For Elected Officials,** your coverage starts on the day on which you are sworn into office. Coverage of your enrolled Spouse and/or Dependent Child(ren) begins on the day your coverage begins.
   - **For Retired employees and retirees with a disability,** your coverage starts on the first day of the month following the employee's retirement date. Coverage of your enrolled Spouse and/or Dependent Child(ren) begins on the date your coverage begins.
4. **Failure to Enroll Eligible Dependents During Initial Enrollment**: If you do not enroll your Eligible Dependents during the Initial Enrollment period, (unless your Eligible Dependent(s) qualify for the Special/Qualifying Event Enrollment described in the following sections), you will **not** be able to enroll them until the next Open Enrollment period.

SPECIAL ENROLLMENT

1. **Newly Acquired Spouse and/or Dependent Child(ren) (as these terms are defined under this Plan)**:
   - If you are enrolled for individual coverage and if you acquire a Spouse by marriage, or if you acquire any Dependent Children by birth, adoption or placement for adoption, you may request enrollment for your newly acquired Spouse and/or any Dependent Child(ren), **no later than 31 days** after the date of marriage, birth, adoption or placement for adoption.
   - If you did not enroll your Spouse for coverage within 31 days of the date on which he or she became eligible for coverage, and if you subsequently acquire a Dependent Child by birth, adoption or placement for adoption, you may request enrollment for your Spouse together with your newly acquired Dependent Child (and any other Dependent Children that are not already enrolled) no later than 31 days after the date of your newly acquired Dependent Child's birth, adoption or placement for adoption.
   - To request Special Enrollment follow the Enrollment procedures described earlier in this chapter. Supporting documentation, including birth/marriage certificates for your newly acquired dependents must be uploaded/submitted. If verification documentation is not available within 31 days after the date of marriage, birth adoption or placement for adoption, do not delay the submission of your change enrollment and notify Employee Benefits Administration of the documentation circumstances. To obtain more information about Special Enrollment, contact the Employee Benefits Administration Office.
   - Special Enrollment provisions do not apply to a Committed Partner or his/her children.
2. **Loss of Other Coverage**:

   If you did not request enrollment under this Plan for yourself, your Spouse and/or any Dependent Child(ren) within 31 days after the date on which coverage under the Plan was previously offered because you or they had health care coverage under any other health insurance policy or program or employer plan, including COBRA Continuation Coverage, individual insurance, Medicare, or other public program; **and** you, your Spouse and/or any Dependent Child(ren) cease to be covered by that other health insurance policy or plan; you may request enrollment for yourself, that Spouse and/or Dependent Child(ren) within 31 days after the termination of their coverage under that other health insurance policy or plan if that other coverage terminated because:
   - of loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause); or
   - of termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
   - the health insurance was provided under COBRA Continuation Coverage, and COBRA coverage was "exhausted"; or
   - of moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
   - of the other plan ceases to offer coverage to a group of similarly situated individuals; or
   - of the loss of dependent status under the other plan's terms; or
   - of the termination of a benefit package option under the other plan, unless substitute coverage offered

   See also the Enrollment Procedures section of this chapter for more information. Proof of loss of coverage is required by this Plan. Loss of coverage provisions do not apply to Retirees and their dependents (or a Committed Partner and his/her children).

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

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

3. You and your dependents may also enroll in this Plan if you (or your eligible dependents):
   a. have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment in this Plan **within 60 days** after the Medicaid or CHIP coverage ends; or
   b. become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment in this Plan **within 60 days** after you (or your dependents) are determined to be eligible for such premium assistance.
4. **Start of Coverage Following Special Enrollment**: if a request for enrollment has been submitted on a timely basis, and:
   - Coverage of a new spouse who is enrolled within 31 days of the marriage date will become effective as of the first of the month following the marriage date (default) or you may request the effective date to be the marriage date (your choice – please indicate in the Special Enrollment process/forms).
   - Requests for Special Enrollment **within 60 days** of the date of the Special Enrollment opportunity related to **Medicaid or a State Children's Health Insurance Program (CHIP),** will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity.
   - Coverage of a newborn or newly adopted Dependent Child who is enrolled within 31 days after birth will become effective as of the date of the child's birth.
   - Coverage of a newly adopted Dependent Child who is enrolled more than 31 days after birth (but within 31 days of adoption or placement for adoption) will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.
   - Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options (when such options exist) as are available to similarly-situated employees at Initial Enrollment. This also means that for individuals enrolled during a Special Enrollment opportunity, the employee will be permitted to change benefit plan options if desired.
5. **Failure to Enroll During Special Enrollment:** If you fail to request enrollment for any of your Eligible Dependents within 31 days (or as applicable, 60 days) after the date on which they first become eligible for Special Enrollment, you will not be able to enroll them until the next Open Enrollment period (or during a subsequent Qualifying Event, also known as a mid-year status change).

OPEN ENROLLMENT

1. Open Enrollment is the period of time during the fall (October) of each year (designated by the City and subject to change from year to year) during which eligible employees, retirees and COBRA participants may add or drop certain benefits, add or drop dependents or switch between different plan options offered by the City. The Employee Benefits Administration Office will notify eligible participants of the choices and options available during an Open Enrollment period.
2. **Restrictions on Elections During Open Enrollment**:
   - No Dependent may be covered unless you are covered.
   - You and all your covered Eligible Dependents must be enrolled for the same medical/dental/vision coverage. For example, you must all be covered in the same Medical Plan option.
   - All relevant parts of the enrollment process must be completed and submitted **before the end of the Open Enrollment period**.
   - All required Proof of Dependent Status documentation (including birth/marriage certificates if not previously submitted, etc.) must be uploaded/submitted to the Employee Benefits Administration Office on or before the close of the Open Enrollment period. Failure to upload/submit such documentation will result in the dependent NOT being enrolled.
   - Retirees who have opted out of a particular coverage will not be able to re-enroll during any Open Enrollment period or at any other time.
3. **Start of or Changes to Coverage Following Open Enrollment:** If you or your Spouse or Dependent Child(ren) are enrolled for the first time during an Open Enrollment period, that person's coverage will begin on the first day of the Plan Year following Open Enrollment. All other changes in or discontinuance of coverage will become effective on the first day of the Plan Year following Open Enrollment.

4. **Failure to Make a New Election During Open Enrollment:** All Active Employees, Retirees and COBRA participants who are enrolled for medical, dental, vision, voluntary life or STD coverage, and who choose NOT to make a new coverage election during Open Enrollment will be enrolled in the same coverage in which they are currently enrolled for the new plan year if that coverage remains otherwise available. This provision does not apply to Flexible Spending Account elections, which must be designated every year.
5. **Failure to Enroll during Open Enrollment:** If you fail to enroll any of your Eligible Dependents within the Open Enrollment time period, unless your Eligible Dependents qualify for Special/Qualifying Event Enrollment described in previous/later sections, you will not be able to enroll them until the next Open Enrollment period.

LATE ENROLLMENT

There are **no late enrollment provisions under this Plan**. The Plan offers an annual Open Enrollment period as described earlier in this text.

NEWBORN DEPENDENT CHILDREN (Special Rule for Coverage)

Your newborn Dependent Child(ren) will be covered from the date of birth, **provided** you complete enrollment processes for that newborn Dependent Child **within 31 days** after the child's date of birth and you show proof of dependent status (as requested) **and** you pay any required contributions for that Dependent Child's coverage.

Remember that you may not enroll a newborn Dependent Child for coverage unless you, the employee, are also enrolled for coverage. Submitting a claim to the Plan for maternity care/delivery or for care of a newborn child (or social media/personal communications to/by other City employees) is not considered proper enrollment of that child for coverage under this Plan.

ADOPTED DEPENDENT CHILDREN (Special Rule for Coverage)

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

- A Newborn Child who is Placed for Adoption with you within 31 days after the child was born will be covered from the date the child was born if you comply with the Plan's requirements for obtaining coverage for a Newborn Dependent Child, described above in this chapter.
- A Dependent Child adopted more than 31 days after the child's date of birth will be covered from the date that child is adopted or "Placed for Adoption" with you, whichever is earlier, provided you complete enrollment processes and provide proof of Dependent status (as requested) **and** pay any required contributions for that Dependent Child's coverage, within 31 days of the child's adoption or placement for adoption.

If the adopted Dependent child is not properly enrolled in a timely manner, you must wait until the next Open Enrollment period or Special/Qualifying Enrollment period, if applicable. However, if a child is Placed for Adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child. Remember that you may not enroll an adopted Child or a Child Placed for Adoption for coverage unless you, the employee, are also enrolled for coverage. See also the Special Enrollment provisions and Enrollment Procedure in this chapter.

WHEN YOU AND ANY OF YOUR DEPENDENTS BOTH WORK FOR THE CITY (Special Rule for Enrollment)

1. **If both you and your Spouse are eligible employees of the City**, you may either elect your own individual (single) plan coverage, or elect one family plan for both you and your spouse and your eligible dependent children. The employee enrolled as the spouse of another employee may opt out of coverage. If both you and your Spouse are eligible employees of the City and each elect different plan coverage and one of you has a reduction in hours causing you to lose eligibility for coverage you should immediately contact the Employee Benefits Administration Office. An employee cannot be enrolled in any of the City's benefit plans as both an employee and as a spouse/dependent, at the same time. Dependent children cannot be enrolled in more than one employee's coverage with the City, at the same time.
2. If, while your family coverage is in effect, any of your **Dependent Children becomes an employee of the City** and becomes eligible for coverage as an employee, that child may enroll for coverage as an employee, in which case coverage as a Dependent Child will terminate as of the date of coverage as an employee begins. If the employee-child terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, and still qualifies as a Dependent Child, the employee-child can be covered under the parent's coverage **ONLY if** a new enrollment process is completed along with any required contributions, within 31 days of the status change event.
3. **If both you and your spouse were employed by and retired from the City of Mesa**, you may either elect your own individual (single) plan coverage or one family plan as described in #1 above. If the individual designated as the retiree precedes the spouse in death, the spouse may enroll in his/her own single coverage retiree plan (or family if other dependents are to be covered as well).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs) (Special Rule for Enrollment)

1. This Plan will provide benefits in accordance with a National Medical Support Notice. In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the plan recognize the child as a dependent even though the child may not meet the plan's definition of dependent.
2. A QMCSO usually results from a divorce or legal separation and typically:
   - Designates one parent to pay for a child's health plan coverage;
   - Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
   - Contains a reasonable description of the type of coverage to be provided under the designated parent's health care Plan or the manner in which such type of coverage is to be determined;
   - States the period for which the QMCSO applies; and
   - Identifies each health care plan to which the QMCSO applies.
3. An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an employee who is not covered by the plan to provide coverage for a Dependent Child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.
4. If a court or state administrative agency has issued an order with respect to health care coverage for any of the employee's Dependent Children, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law, and that determination will be binding on the employee, the other parent, the child and any other party acting on behalf of the child. If an order is determined to be a QMCSO, and if the employee is covered by the Plan, the Plan Administrator or its designee will so notify the parents and each child, and advise them of the Plan's procedures that must be followed to provide coverage of the Dependent Child(ren).
5. If the employee is a participant in the Plan, the QMCSO may require the Plan to provide coverage for the employee's Dependent Child(ren) and to accept contributions for that coverage from a parent who is not a Plan participant. The Plan will accept a Special Enrollment of the Dependent Child(ren) specified by the QMCSO from either the employee, retiree or the custodial parent. Coverage of the Dependent Child(ren) will become effective as of the date the enrollment is received by the Plan, and will be subject to all terms and provisions of the Plan, insofar as is permitted by applicable law.
6. If the employee is **not** a participant in the Plan at the time the QMCSO is received **and** the QMCSO orders the employee to provide coverage for the Dependent Child(ren) of the employee, the Plan will accept a Special Enrollment of the employee and the Dependent Child(ren) specified by the QMCSO. Coverage of the employee and the Dependent Child(ren) will become effective as of the first day of the month following the date the enrollment is received by the Plan along with any required contributions, at the Employee Benefits Administration Office.
7. No coverage will be provided for any Dependent Child under a QMCSO unless the applicable employee contributions for that Dependent Child's coverage are paid, and all of the Plan's requirements for coverage of that Dependent Child have been satisfied.
8. Coverage of a Dependent Child under a QMCSO will terminate when coverage of the employee-parent terminates for any reason, including failure to pay any required contributions, subject to the Dependent Child's right to elect COBRA Continuation Coverage if that right applies. For additional information regarding the procedures for payment of claims under QMCSOs, see the Claims Information chapter of this document or contact the Employee Benefits Administration Office.

PAYMENT FOR YOUR COVERAGE

Your contributions pay part of the cost of coverage for yourself and your dependents. The City pays the rest. The amount that you and the other employees and retirees pay for this coverage is based on the cost of the Plan for all of the people that it covers with variations for the types of coverage chosen and whether you cover your dependents. (Note: beginning 1/1/13, premiums for coverage are collected concurrently during the month for which the premium is being paid; e.g. Premiums for January are collected in January, etc.)

CHANGING YOUR COVERAGE DURING THE YEAR (Qualifying Event or Mid-Year Change in Status)

Government regulations generally require that your Plan coverage remain in effect throughout the Plan Year (from January 1 through December 31), but you may be able to make some changes during the year if the Plan Administrator or its designee determines that you have a qualifying change in your status **affecting your benefit needs**. The following qualifying changes are **the only ones** permitted under the Plan:

1. Change in employee's legal marital status, including marriage, divorce, legal separation, annulment or death of a Spouse;

2. Change in number of employee's Dependents, including birth, adoption, placement for adoption, or death of a Dependent Child;
3. Change in employment status or work schedule IF it impairs your, your Spouse's or your Dependent Children's eligibility for benefits, including the start or termination of employment by you, your Spouse or any Dependent Child, or an increase or decrease in hours of employment by you, your Spouse or any Dependent Child, including a switch between part-time and full-time employment, a strike or lock-out, or the start of or return from an unpaid leave of absence that is either required by law (such as FMLA and military leave or, other leave permitted by your employer), or a change of work-site;
4. Change in Dependent status under the terms of this Plan that satisfies or ceases to satisfy the Plan's eligibility requirements, including changes due to attainment of age or any other reason provided under the definition of Dependent in the Definitions chapter of this document;
5. Change of residence or worksite that allows or impairs your, your Spouse or any Dependent Child's ability to continue benefits under the coverage you have chosen;
6. Change required under the terms of a Qualified Medical Child Support Order (QMCSO), including a change in your election to provide coverage for the child specified in the order, or to cancel coverage for the child if the order requires your former spouse to provide coverage;
7. Change consistent with your right to Special Enrollment as described in the paragraph on Loss of Other Coverage in the section dealing with Special Enrollment.
8. Change consistent with entitlement to (or loss of eligibility for) Medicare or Medicaid affecting you, your Spouse or Dependent Child (except for coverage solely under the program for distribution of pediatric vaccines), including prospective cancellation of coverage of the person entitled to Medicare/Medicaid following such entitlement or prospective reinstatement or election of coverage following loss of eligibility for Medicare/Medicaid.
9. Change in cost of coverage.
   a. **Automatic increase or decrease in your contributions for coverage** under any of your employer's Health Care Plan options as a result of a change in the cost of coverage for all Plan participants, or as a result of a change in the number of your covered Dependents or a permitted mid-year change to another of your employer's Health Care Plan options, if the increase or decrease in contributions is or would be required from all similarly-situated employees. The Plan may automatically increase or decrease contributions on a reasonable and consistent basis.
   b. **Significant increase or decrease in your contributions for coverage** under your employer's Health Care Plan options or your Spouse's employer's health care plans or programs. In such a case you may start coverage in the plan option with the decreased cost; or, revoke coverage in the plan option with an increased cost and elect, on a prospective basis, coverage under another plan option providing similar coverage, if one is available, or drop the coverage if no other such plan option is available.
10. **Significant changes in coverage.**
    a. **Significant curtailment**. If the coverage under the Plan is significantly curtailed or ceases during a Plan Year, you may revoke your elections under the Plan. In that case, you may make a new election on a prospective basis for coverage under another benefit package providing similar coverage. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to participants under the Plan so as to constitute reduced coverage to participants generally.
    b. **Addition or elimination of a benefit package option providing similar coverage.** If during a Plan Year the Plan adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option) you may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.
11. **Changes in Spouse's, Former Spouse's or Dependent's coverage.** You may make a change in coverage if it is on account of and corresponds with a change made under a plan of your Spouse, Former Spouse or Dependent for one of the following reasons:
    a. If the change is permitted under federal cafeteria plan regulations; or
    b. If the plan of the Spouse, Former Spouse, or Dependent's employer permits participants to make an election for a period of coverage that is different from the Plan Year under this Plan.
12. **Addition or significant improvement of any Plan option** under the employer's Health Care Programs or your Spouse's employer's health care plans or programs. In such a case you may revoke coverage in the current plan and either elect, on a prospective basis, coverage under a new or improved plan option.

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

1. Any change you make to your benefits must be determined by the Plan Administrator or its designee to <u>be necessary, appropriate to and consistent with the change in status</u> (for example, if mid-year, the employee and spouse deliver a newborn child they can add that child to this Plan but it would be inconsistent with a birth event to drop the spouse from coverage at this time); and

2. You must notify the Plan in writing within 31 days of the qualifying change in status, otherwise, the request will not be considered to be made on account of your change of status and you will have to wait until the next Open Enrollment period to make your changes in coverage; and
3. If you have a qualifying change in status, you are only allowed to make changes to your coverage that are consistent with the change of status event. Generally only coverage for the individual who has lost eligibility as a result of a change of status (or who has gained eligibility elsewhere and enrolled for that coverage) can be dropped mid-year from this Plan; and
4. Coverage changes associated with a mid-year qualifying change of status opportunity **must be prospective** and therefore are effective the first day of the month following the qualifying change provided you complete enrollment processes, except for:
   - Newborns, who are effective on the date of birth;
   - Children adopted or placed for adoption, who are effective on the date of adoption or placement for adoption whichever is earlier.
5. Except in situations where there is a change in plan costs, or a Special Enrollment opportunity, employees cannot change from one plan option to another plan option mid-year and must wait until Open Enrollment to change plans.

Brief Summary of Common Qualifying Events and Mid-Year Change in Status Enrollments/ Changes Allowed Under the Plan

Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code. This chart is only a summary of some of permitted plan changes and is not all inclusive.

This chart should NOT be referenced for Health FSA or Dependent Care FSA Accounts.

If you experience the following Event...	You may make the following change(s)* within 31 days (where applicable 60 days) of the Event…	YOU MAY NOT make these types of changes...
Family Events		
Marriage	• Enroll yourself, if applicable • Enroll your new Spouse and other eligible dependents • Drop health coverage (to enroll in your Spouse's plan) • Change health plans, when options are available	• May not drop health coverage and not enroll in Spouse's plan
Divorce	• Remove your Spouse from your health coverage • Enroll yourself (and your children) if you or they were previously enrolled in your Spouse's plan	• May not change health plans • May not drop health coverage for yourself or any other covered individuals
Gain a child due to birth or adoption	• Enroll yourself, if applicable • Enroll the eligible child and eligible spouse • Change health plans, when options are available	• May not drop health coverage for yourself or any other covered individuals
Child requires coverage due to a QMCSO	• Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled) • Change health plans, when options are available, to accommodate the child named on the QMCSO	• May not make any other changes, except as required by the QMCSO
Loss of child eligibility(*e.g.,* child reaches maximum age for coverage)	• Must remove the child from your health coverage • Child will be offered COBRA (unless child of a Committed Partner).	• May not change health plans • May not drop health coverage for yourself or any other covered individuals
Death of a dependent (Spouse or child)	• Remove the dependent from your health coverage • Change health plans, when options are available	• May no drop health coverage for yourself or any other covered individuals
Covered person receives or loses Medicare or Medicaid entitlement	• Drop coverage for the person who became entitled to Medicare or Medicaid. • Add the person who lost Medicare/Medicaid entitlement.	• May not drop health coverage for yourself or any other covered individuals

Employment Status Events		
Spouse becomes eligible for health benefits in another group health plan	• Remove your Spouse from your health coverage, with proof of other plan coverage • Remove your children from your health coverage, with proof of other plan coverage • Drop coverage for yourself only with proof that Spouse added you to the Spouse's new group health plan	• May not change health plans • May not add any other eligible dependents to your health coverage
Spouse loses employment or otherwise becomes ineligible for health benefits in another plan	• Enroll your Spouse and, if applicable, eligible children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under your Spouse's plan • Change health plans, when options are available	• May not drop health coverage for yourself or any other covered dependents
You lose employment or otherwise become ineligible for health benefits	• Enroll in your Spouse's plan, if available • Elect temporary COBRA coverage for the Qualified Beneficiaries (you and your covered dependents)	
Proof of a status change is required to make a corresponding change in coverage/enrollment.		

If your coverage terminates because you have a qualifying change in status resulting from loss of your job or switching to a job position which is not eligible for benefits**, and** if you do not elect to have COBRA continuation coverage described in the COBRA chapter, **and** your position status subsequently becomes benefit-eligible, you must re-enroll for coverage under this Plan by following the Initial Enrollment provisions discussed in this chapter.

Special rules, discussed in the section of this chapter on Special Circumstances, apply if you let your coverage lapse while you are on Family or Medical Leave or on Leave for Military Service.

WHEN COVERAGE ENDS (Events Causing Coverage to End):

1. **Employee coverage** ends on the earliest of the **last day of the month** in which:
   - your employment ends; or
   - you are no longer eligible to participate in the Plan; or
   - you cease to make any contributions required for your coverage; or the City terminates the Plan
2. **Dependent coverage** ends on the earliest of the **last day of the month** in which:
   - your own coverage ends; or
   - your covered Spouse or Dependent Child(ren) no longer meet the definition of Spouse or Dependent Child(ren); or
   - you cease to make any contributions required for their coverage; or the City terminates the Plan

   NOTE: For the first 6 months following the death of an employee, dependents who were covered under any health Plan offered by the City may elect COBRA and the first six months of COBRA coverage will be provided by the City at the same employee-contribution rate for either single or family coverage as the Plan in place when the employee was covered (excludes Harrolle's Law).
3. **Retiree coverage** ends on the earliest of the **last day of the month** in which:
   - The retiree is no longer eligible as defined in this plan (i.e. no longer receiving either an LTD benefit or a benefit from the Arizona State Retirement System (ASRS) or Public Safety Personnel Retirement System (PSPRS); or
   - you cease to make contributions required for coverage; or
   - the City terminates the Plan.

   NOTE: For the first 6 months following the death of a retiree, dependents who were covered under any health Plan offered by the City may elect COBRA and the first six months of COBRA coverage will be provided by the City at the same contribution rate for either single or family coverage as the Plan in place when the retiree was covered (excludes Harrolle's Law).
4. **Surviving Lawful Spouse and Surviving Dependents coverage ends on the earliest of the last day of the month** in which:
   - the surviving lawful spouse and dependents are no longer eligible to participate in the Plan; or
   - the surviving lawful spouse and surviving dependents cease to make the contributions required for coverage; or
   - the City terminates the Plan.

COVERAGE ELECTIONS FOR RETIREES

Regular Retirement: If an active employee is planning to retire from the City, the active employee coverage will terminate and the individual will be offered the opportunity to elect COBRA coverage **or** the City's retiree coverage, under the same type of health plan coverage that they had as an active employee (if the employee meets retiree eligibility requirements as described in the section called Eligibility and Enrollment).

Medical Retirement: An active employee who is unable to work because of a Total Disability and who loses their eligibility under the active health plan will have the following options: 1) to elect COBRA coverage **or** 2) if the individual takes a Medical Retirement from the City and is approved for Long Term Disability (LTD) benefits and is currently enrolled in one of the City's health plans, that individual may elect the City's retiree coverage under the same type of health plan coverage that they had as an active employee. However, if that active employee opted out of health plan coverage as an active employee, there will be no opportunity to elect COBRA and instead the individual can elect to enroll in one of the health plans as a medical retiree. Employees hired on or after 1/1/09 may be eligible for retiree Health Plan coverage during a period of Total Disability, but without any City contributions or subsidies towards the cost of this coverage (may be eligible for ASRS or PSPRS subsidies).

There is no later opportunity to elect the City's retiree coverage or COBRA coverage if either of this coverage is declined when first offered.

REQUIRED PLAN NOTIFICATION

You, your Spouse, or any of your Dependent Children must notify the Plan **preferably within 31 days but no later than 60 days** after the date of:

- a divorce; or
- a Dependent Child becomes physically or mentally disabled; or ceases to have any physical or mental Disability.

Failure to notify the Plan of the above noted events may jeopardize future COBRA rights. See the section on Information You or Your Dependents Must Furnish to the Plan in the Other Information chapter of this document for information regarding other notices you must furnish to the Plan.

WHEN THE PLAN CAN END YOUR COVERAGE FOR CAUSE

1. The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause 30 days after it gives you written notice of its finding that you or your covered Dependent:
   a. **engage in an act, practice or omission that constitutes fraud or an intentional misrepresentation of a fact** in any enrollment, claim or other form in order to obtain coverage, services or benefits under the Plan; or
   b. **allow anyone else to use the identification card** that entitles you or your covered Dependent to coverage, services or benefits under the Plan; or
   c. **change any prescription** furnished by a Physician or other Health Care Practitioner.

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

LEAVES OF ABSENCE

Family and/or Medical Leave (FMLA):

1. If you are authorized for up to 12 weeks of unpaid Family or Medical Leave for specified family or medical purposes, such as the birth or adoption of a child, or to provide care of a spouse, child or parent who is seriously ill, or for your own serious illness, you can continue your health care coverage (and other coverage as applicable) while you are out on FMLA leave. The City will continue plan contributions for the employee on the same basis as prior to the beginning of the leave. The employee will be responsible for making any required monthly employee or dependent contributions.
2. Since you **may not be paid** while you are on Family or Medical Leave, you may pay your contributions as they come due on the dates you would have been paid or on at least a monthly basis; in either case your contributions will be made on an after-tax basis.
3. Whether or not you keep your coverage while you are on Family or Medical Leave, if you return to work promptly at the end of that Leave, your benefit coverage will be reinstated without any additional limits or restrictions imposed on account of your Leave. This is also true for any of your Dependents who were covered by the Plan at the time you took your Leave. Of course, any changes in the Plan's terms, rules or practices that went into effect while you were away on that Leave will apply to you and your Dependents in the same way they apply to all other employees and their Dependents.
4. To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact Human Resources.

Leave for Military Service:
If you go into Active Duty military service (Active Duty leave), you can continue your health care coverage under this Plan for yourself and your eligible family members during that leave period for a maximum of 24 months. The City will continue plan contributions for the employee and eligible family members on the same basis as prior to the beginning of the leave. You must also continue to pay your portion of contributions for that coverage during the Active Duty leave (either by payroll deduction if you are continuing to receive paychecks from the City, or in response to monthly invoice billing that you may receive). You may also receive military health care coverage at no cost; in which case, the City's health plan coverage would become secondary to any military health care coverage you receive.

If your Active Duty leave extends beyond 24 months, you and your eligible dependents may also have COBRA continuation rights for a period of time thereafter at your full expense. See the COBRA chapter of this document.

Questions regarding your entitlement to USERRA leave, continuation coverage during that leave and general information on COBRA and USERRA continuation of health care coverage should be referred to the Employee Benefits Administration Office or to Management Policy #338 Military Leave.

Medical or Special Leave While Receiving Short Term Disability Benefits
If you participate in the voluntary Short Term Disability insurance program offered by the City of Mesa and are approved to receive Short Term Disability benefits from the carrier, and you are also on an authorized Medical or Special Leave, you will be responsible for paying your health insurance and other premiums for coverage that you continue during your leave, as indicated in the City of Mesa Personnel Rules.

REINSTATEMENT OF COVERAGE AFTER LEAVES OF ABSENCE
If your coverage ends at the beginning of, or while you are on an approved leave of absence of any type, your coverage will be reinstated on the day you return to active service, if you return immediately after your authorized leave of absence ends.

CONTINUATION OF CERTAIN BENEFIT COVERAGES
If you become ineligible for benefit coverage there is no extension of benefits provision under this Plan, except to the extent that you may be eligible for COBRA continuation rights. See the chapter describing COBRA for an explanation of when and how you may continue your coverage.

MEDICAL PLANS

MEDICAL PLAN OPTIONS

The City offers three Medical Plan options, described below. You and all your family members who are enrolled for medical coverage must all be enrolled in the same plan option.

- **Choice PPO Plan:** This plan option is a deductible and coinsurance plan allowing you to use either in-network or out-of-network providers. The in-network providers are Preferred (PPO) providers as defined by the network provider listed in the Quick Reference Chart found at the beginning of this Plan Document.
- **Basic Choice PPO Plan**: This plan option is a deductible and coinsurance plan (with limited copayments as well) allowing you to use either in-network or out-of-network providers. Coverage is limited and certain types of services are not covered under this Plan. The in-network providers are Preferred (PPO) providers defined by the network provider listed in the Quick Reference Chart found at the beginning of this Plan Document.
- **Copay Choice Plan**: This plan option uses copayments for many services provided by in-network providers and deductibles and coinsurance for out-of-network providers. The in-network providers are Preferred (PPO) providers as defined by the network provider listed in the Quick Reference Chart found at the beginning of this Plan Document.

ELIGIBLE MEDICAL EXPENSES

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called Eligible Medical Expenses, and they are limited to those that are:

1. determined by the Plan Administrator or its designee (e.g. the City's contracted Utilization Management services providers) to be "Medically Necessary" and "Contracted Charges" or "Allowed Charges**"** as determined by the Appropriate Claims Administrator and as those terms are defined in the Definitions chapter of this document; **and**
2. not services or supplies excluded from coverage as provided in the Exclusions chapter of this document; **and**
3. not in excess of any applicable General Overall or Limited Overall Plan Benefits that are shown in the Schedule of Medical Benefits.

NON-ELIGIBLE MEDICAL EXPENSES EXPLAINED

The Plan will **not reimburse you** for any expenses that are not Eligible Medical Expenses as defined above. That means you are responsible for paying the full cost of all Non-Eligible Medical Expenses that even if they are considered Medically Necessary; that are determined to be in excess of the Allowed or Contracted Charges; that are not covered by the Plan; or that are determined to be in excess of any applicable General Overall or Limited Overall Plan Benefits. Plan exclusions apply whether or not services are medically necessary.

NETWORK PREFERRED PROVIDER ORGANIZATION (PPO) SERVICES

If you receive medical services or supplies from a Health Care Provider that is a member of the Plan's Preferred Provider Organization's (medical and dental PPO networks) you will be responsible for paying less money out of your pocket.

In Arizona, Preferred Health Care Providers are members of the Blue Cross Blue Shield of Arizona PPO Network who have agreed to accept the amounts the Plan actually pays for covered services, plus any additional amounts you must pay (i.e. deductible, copay, coinsurance), as described in the Schedule of Medical Benefits or in the Medical Network chapter of this document. In states other than Arizona, Preferred Health Care Providers are members of the Blue Cross Blue Shield of Arizona Out-of- State PPO Networks with affiliated BCBS networks. These providers have also agreed to accept the amounts the Plan actually pays for covered services plus applicable deductibles, copays, and coinsurance amounts as described in the Schedule of Medical Benefits.

ELIGIBLE MEDICAL EXPENSES <u>NOT</u> PAYABLE BY THE PLAN

Generally, **the Plan will not reimburse you for all Eligible Medical Expenses**. Usually, you will have to satisfy some Deductibles and pay some Coinsurance or Copayments toward the amounts you incur that are Eligible Medical Expenses. However, once you have incurred a maximum Out-of-Pocket cost, no further Coinsurance or copayments will be applied.

In addition, there is a Limited Overall Maximum Plan Benefits and Annual Maximum Plan Benefits applicable to each Plan Participant with respect to certain Eligible Medical Expenses. These features are described in the following sections of this chapter.

DEDUCTIBLES

The deductible is the amount you must pay each calendar year before the Plan pays benefits. The amount applied to the deductible is the lesser of billed charges or the amount considered to be Contracted or Allowed Charges under this Plan. In most cases, each year, you (and **not** the Plan) are responsible for paying all of your Eligible Medical Expenses until you satisfy the annual Deductible. Then, the Plan begins to pay benefits. Deductibles are accumulated on a **calendar** year basis and include:

- The **Individual Deductible** is the maximum amount **one** covered person has to pay before Plan benefits begin. The Plan's Individual Deductible varies depending on the plan selected and the use of network or non–network providers.

- The **Family Deductible** is the maximum amount that a family of **three** or more is responsible for paying before Plan Benefits begin. The Plan's Family Deductible also varies depending on the plan selected and the use of network or non-network providers.
- There is a separate per person prescription drug deductible outlined under Drugs in the Schedule of Medical Benefits for some of the medical plan options.
- There may be separate, specific service deductibles that vary depending on the plan selected and the service provided

Only eligible medical expenses can be used to satisfy the Plan's deductible. As a result, non-eligible medical expenses, do not apply to the deductible. Services paid with a copay are not subject to the deductible, unless otherwise specified in the Schedule of Medical Benefits. Deductibles are applied to eligible medical expenses **in the order in which the claims are received by the Plan.**

- **Note that the Individual and Family In-Network and Out-of-Network deductibles are NOT interchangeable, meaning you may not use any portion of an In-Network deductible to meet an Out-of-Network deductible and vice versa**.

Expenses Not Subject to Deductibles: Certain Eligible Medical Expenses are not subject to Deductibles. These expenses may be covered 100% by the Plan, or they may be subject to Copayments (explained below). See the Schedule of Medical Benefits chapter of this document to determine when Eligible Medical Expenses are not subject to Deductibles.

COINSURANCE

Once you've met your Annual Deductible, the Plan generally pays a percentage of the Eligible Medical Expenses, and you (**not** the Plan) are responsible for paying the rest. The part you pay is called the Coinsurance. Unless the Schedule of Medical Benefits indicates otherwise, this Plan generally pays a greater percentage of the Eligible Medical Expenses after the Deductible is satisfied, and you are responsible for the remaining lesser percentage.

Coinsurance When You Use Network Health Care Providers: The plan pays a greater percentage of benefits when you use network providers for the Plan you selected.

Coinsurance When You Don't Comply with Utilization Management Programs: If you fail to follow certain requirements within the Plan's Utilization Management Program, the Plan will not pay the cost of those services, and you will have to pay for all of those costs. The amount you'll have to pay **will not** count towards the Plan's Deductible that you may otherwise have to satisfy or towards Out-of-Pocket maximums. See also the Utilization Management chapter of this document.

COPAYMENT

A Copayment (or Copay, as it is sometimes called) is a set dollar amount you (and **not** the Plan) are responsible for paying when you incur an Eligible Medical Expense. The Plan pays the balance of allowable charges. When Copayments apply, generally there are no Deductibles or Coinsurance unless the Plan specifically provides otherwise. The Plan's Copayments are indicated in the Schedule of Medical Benefits. Copayments do not accumulate to meet the Plan's deductible but Copayments do accumulate to meet the Plan's In-Network Out-of-Pocket Maximum amounts.

OUT-OF-POCKET MAXIMUM EXPENSES (also called Coinsurance Stop Loss)

Out-of-Pocket Explained: Out-of-pocket costs are the in-network eligible expenses which must be paid by the plan participant **before** this Plan will pay in-network benefits at 100% of Allowed or Contracted Charges. Each calendar year, after an individual incurs a maximum Out-of-Pocket cost for eligible in-network services as described in the Schedule of Medical Benefits for any individual, no further coinsurance or copays will apply to covered Eligible In-Network Medical Expenses for the rest of that calendar year for that individual. As a result, the Plan will pay 100% of coinsurance and copays for all covered Eligible In-Network Medical Expenses that are incurred during the remainder of the Calendar Year after the Out-of-Pocket Maximum has been reached. **However, you will still be responsible for paying all of the expenses described in the section below.**

Expenses Not Included In the Out-of-Pocket Maximum: You are always responsible for paying for certain expenses for medical services and supplies yourself. Under this Plan, each year, you will be responsible for paying the following expenses out of your own pocket and not included in any applicable Out-of-Pocket Maximum:

1. All expenses for medical services or supplies that are not covered by the Plan.
2. All charges in excess of the Allowed or Contracted Charge for out-of-network expenses as determined by the Plan.
3. All charges in excess of the Plan's Limited Overall and/or in excess of any other limitation of the Plan.
4. Coinsurance, copays or expenses associated with outpatient retail, specialty pharmacy or mail order prescription drugs (although these expenses will contribute towards separate Prescription Drug Maximum Out-of-Pocket expenses).
5. All expenses incurred because of failure to follow the Utilization Management provisions of this Plan.

ANNUAL MAXIMUM PLAN BENEFITS

General Overall ("Annual") Maximum Plan Benefit: there is no General Overall ("Annual") Maximum Plan Benefit.

Limited Overall ("Annual") Maximum Plan Benefits: Plan Benefits for certain medical expenses are subject to Limited Overall ("Annual") Maximums for each Covered Individual. Once the Plan has paid the Limited Overall Maximum Plan Benefits for any of those services or supplies on behalf of any Covered Individual, it will not pay any further Plan Benefits for those services or supplies on account of that individual. The services or supplies that are subject to Limited Overall Maximum Plan Benefits and the amounts of the Limited Overall Maximum Plan Benefits are identified in the Schedule of Medical Benefits. This **does not** mean, nor should it be construed to mean, that the Plan has any obligation to pay any Benefits during the calendar year for the Plan Participant after coverage terminates.

Specific Annual Maximum or Lifetime Plan Benefits: Plan Benefits for certain medical expenses are subject to Annual Maximums per Covered Individual or family during each calendar year or lifetime. These limits may be dollar, units, days, frequency or quantity limitations. Once the Plan has paid the Annual Maximum Plan Benefits on behalf of any Covered Individual or family, it will not pay any further Plan Benefits for those services or supplies on account of that individual or family for the balance of the Calendar Year. The services or supplies that are subject to Specific Annual Maximum Plan Benefits are identified in the Schedule of Medical Benefits.

PRESCRIPTION DRUG PROGRAM

The Prescription Drug Program (part of Medical Plan coverage) is administered by the Appropriate Claims Administrator (and pharmacy network) shown in the Quick Reference section of this Plan Document (CVS/Caremark). For pharmacy locations or information on formulary drugs, contact the Prescription Drug Program listed in the Quick Reference Chart. Covered Prescription Drugs may be purchased at participating retail pharmacies or the Prescription Drug Plan's Home Delivery (Mail Order) Service. Use mail order or purchase mail order quantities at CVS/Caremark retail pharmacies, to receive up to a 90-day supply of non-emergency, maintenance, generic and brand medications. Note: mail order quantities (up to 90-day supply) are only available from CVS retail pharmacies or through CVS/Caremark Mail Order Pharmacies. Specialty drugs are only available through CVS/Caremark Specialty Pharmacy.

Coverage for prescription drugs is provided only for pharmaceuticals approved by the US Food & Drug Administration (FDA), requiring a prescription, approved for the condition, dose, route, duration and frequency, and if prescribed by a Physician or other Health Care Practitioner authorized by law to prescribe them. Drugs not yet approved by the FDA are not covered.

Retail Pharmacy: Use the Retail Pharmacy to fill prescriptions for up to a 30-day supply. To fill a prescription at a Retail Network pharmacy, obtain a prescription for up to a 30-day supply from your physician and present it, along with your ID card to any participating retail pharmacy. The price of the prescription will be discounted to you.

You may also choose to use CVS/Caremark Retail Pharmacies exclusively, to receive up to a 90-day supply of generic and brand name maintenance medications (at the same copay/coinsurance as by mail order).

Home Delivery/Mail Order Pharmacy: Use the Home Delivery/Mail Order Pharmacy to receive up to a 90-day supply of non-emergency, maintenance medications (both generic and brand). Mail order is the easiest and least expensive way to obtain many medications mailed directly to your home. Have your doctor write a prescription for a 90-day supply, with refills. Mail the prescription along with your copay/coinsurance to the Prescription Drug Program Mail Order service listed in the Quick Reference section of this Plan Document. Allow up to 14 days to receive your order by mail.

Non-Network (Non-PPO) Retail Pharmacy: There is no discount for prescriptions purchased at Non-Network pharmacies. If you fill a prescription at an out-of-network pharmacy, you will pay the entire cost of the drug at the time of purchase. Send a fully itemized drug receipt and a claim form (including patient name, prescription number, medicine NDC number, date of fill, metric quantity, days' supply, total charge, pharmacy name and address or NABP number, signature and date) to the Prescription Drug Program at the address indicated in the Quick Reference Chart. You will be reimbursed based upon the amount that would have been charged by a participating pharmacy, less the applicable retail deductible and coinsurance. Claim forms are available at the Prescription Drug Program's website or by calling Member Services.

Certain drugs and medications are subject to Utilization Management requirements and may be subject to any or all of:

- Step therapy
- Quantity limitations
- Prior authorization (PA) requirements
- Specialty Drug PA and Preferred Drug requirements
- New-to-Market Drug Exclusions and Limitations

Note: formularies (the list of drugs that may be covered under the Plan) and whether or not a brand name drug is a preferred or non-preferred brand name drug, are subject to change without notice at any time. Additionally, drug classifications and specific drug names that are subject to Utilization Management requirements may also change without notice at any time, as formularies change, patents end, new drugs are introduced, clinical guidelines change and FDA recommendations/indications change etc. For information about Utilization Management requirements for any particular drug or medication, and whether or not a brand

name drug is a preferred or non-preferred brand name drug, contact the Prescription Drug Program listed in the Quick Reference Chart.

Note: deductibles, coinsurance, copays or expenses associated with outpatient prescription drugs do not accumulate to the medical plan deductibles or out-of-pocket maximums, but **do contribute** to separate, non-integrated out-of-pocket maximums for outpatient prescription drugs delivered under the Prescription Drug Program.

See Drugs and Medicines section of the Schedule of Medical Benefits for more information and limitations on the Prescription Drug Program, deductibles, coinsurance, copays and out-of-pocket maximums.

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

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

Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Prescription Drug Plan during Medicare's annual enrollment period each year.

This Plan **does not coordinate benefits with Medicare Part** D. If you enroll in Medicare Part D prescription drug plan you may not enroll in or keep prescription drug coverage under this Plan. You will be dis-enrolled from the prescription drug coverage under this Plan as long as you are enrolled in a Medicare Part D prescription drug plan.

For more information about creditable coverage or Medicare Part D coverage see the Plan's Notice of Creditable Coverage (a copy is available from the Employee Benefits Administration Office. See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

The Medicare program has arranged to let employer-sponsored Plans, who have applied for a subsidy, know if their participants have tried to enroll in a Medicare Prescription Drug Plan. This is because many people with Medicare may not understand that they are able to keep their current employment based prescription drug coverage and do not need the Medicare Part D prescription drug coverage. If we are advised that you have tried to enroll in a Medicare Prescription Drug Plan, we will contact you to see if that is your final decision or just an error.

SCHEDULE OF MEDICAL BENEFITS

A chart describing the Plan's medical benefits, with explanations and limitations of those benefits appears on the following pages. Each of the Plan's medical benefits is described in the first column, with Hospital Services (Inpatient) and Physician and Health Care Practitioner Services appearing first. These two categories cover most (but not all) health care services covered by the Plan. They are followed by descriptions of all other benefits for specific health care services and supplies that are listed in **alphabetical** order.

Explanations and limitations that apply to all Benefits are shown in the second column of the Schedule of Medical Benefits. Specific differences in the Benefits when they are provided In-Network (when you use PPO Network Providers) and Out-of-Network (when you use providers who are not contracted with the PPO) are shown in the subsequent columns.

Payment of out-of-network claims is according to the Allowed or Contracted Charge reimbursement as defined in this Plan.

The following Schedule of Medical Benefits outlines this Plan's Deductibles, Coinsurance, Copayments and the Annual Out-of-Pocket Maximum.

SERVICES PROVIDED OUTSIDE THE UNITED STATES

There is no in-network coverage for services provided outside the United States, although there may be out-of-network coverage for non-emergency services and in-network benefit levels for emergency services outside the United States. **An out-of-network international claim or a claim for expenses for emergency medical services or supplies provided outside the United States** will be covered to the extent allowed by Federal or State Law and according to the Schedule of Medical Benefits. In order for outside the United States claims to be processed, you must generally pay for services directly and submit a claim to the Appropriate Claims Administrator for reimbursement/coverage:

1. in English (or translated into English if submitted in a foreign language), with Standardized Diagnosis and Procedure codes
2. with charges expressed in US dollars (or converted into US dollars if submitted in foreign currency)

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
General Overall ("Annual") Maximum Plan Benefit, also called the Plan Year Maximum • The most this Plan will pay for all covered expenses for one person who is enrolled in any Plan option		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Out-of-Pocket Maximums Medical OOP: • Out-of-pocket costs are the in-network expenses you must pay **before** this Plan will pay benefits at 100% of Allowed or Contracted Charges. After you pay the maximum annual in-network Out-of-Pocket cost in deductibles, coinsurance and copays, no further deductibles, coinsurance or copays will apply to eligible in-network medical expenses for the rest of that calendar year. • **Prescription Drug OOP**	• Some expenses do not accumulate to meet annual out-of-pocket maximum including: expenses not covered by the Plan, charges in excess of the Allowed or Contracted Charge, any amounts above Plan benefit maximums, penalties for failure to follow UM procedures, out-of-network expenses or expenses associated with outpatient retail or mail order prescription drugs (except these do contribute to separate Prescription Drug out-of-pocket maximums)	**Medical**: $2,450 per person $7,200 per family **Prescription Drug**: $4,400 per person $6,500 per family	Not applicable	**Medical**: $4,500 per person $9,000 per family **Prescription Drug**: $2,350 per person $4,700 per family	Not applicable	**Medical**: $3,425 per person $6,850 per family **Prescription Drug**: $3,425 per person $6,850 per family	Not applicable

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Deductible • The medical plan deductible is the amount of money you must pay each calendar year before the Plan pays benefits	• Note that In-Network and Out-of-Network deductibles are NOT interchangeable or commingled, meaning you may not use any portion of an In-Network deductible to meet an Out-of-Network deductible and vice versa. • See Drugs and Medicines for separate prescription drug deductibles that may apply	$300 per person $900 per family	$1,000 per person $3,000 per family	$550 per person $1,650 per family	$1,000 per person $3,000 per family	None	$1,000 per person $3,000 per family
Hospital Services (Inpatient) • Room & board in semiprivate room with general nursing services. Specialty care units (e.g., intensive care, cardiac care unit) • Lab/x-ray/diagnostic services • Related Medically Necessary ancillary services (e.g. prescriptions, supplies). • Newborn care; male circumcision (child must be enrolled in the plan – not automatic)	• **Elective Hospitalization subject to pre-certification; all Hospitalizations subject to concurrent review;** see Utilization Management chapter for details • Private room covered only if Medically Necessary or if semi-private room not available • Hospitalization for dental services **not** payable under medical plan • Observations up to 72 hours, without in-patient admission, covered under emergency room copay/co-insurance; after 72 hours, inpatient copay/coinsurance applies • Newborn hospital charges: both mother & baby incur separate deductibles, coinsurances or copays as applicable	80% after deductible	60% after deductible	50% after deductible	25% after deductible	$200 copay per admission then plan pays 100% (Note: Newborn hospital charges are subject to $200 copay, separate from mother)	60% after deductible

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Physician and Health Care Practitioner Services • Office, Hospital, emergency room, & other health care facility visits of Physicians & Health Care Practitioners • Surgeon fees • Assistant surgeon (if Medically Necessary) • Anesthesia fees for Physicians and Certified Registered Nurse Anesthetists (CRNA) • Audiology/Hearing Exams. • Certified Perfusionist for heart-lung surgical procedures • Pathologist and Radiologist fees • Physician Assistant, Nurse Practitioner and Nurse Midwife fees • Retail Medical Clinics (see Definitions chapter) • Psych and neuropsychiatric testing by a Physician or Psychologist (see also the Behavioral Health row of this Schedule)	• **Some surgical services subject to pre-certification; see Utilization Management chapter** • The Appropriate Claims Administrator will determine if multiple surgical or other medical procedures are covered as separate procedures or as a single procedure based on factors in the definition of "Surgery" in the Definitions chapter • **Assistant Surgeon fees** reimbursed for services to **maximum** of 25% of allowed or contracted expenses payable to primary Surgeon • Medical plan do not require selection or designation of a primary care provider (PCP); visit any network or non-network health care provider • Payment may be less for non-network providers • Do not need prior authorization to access obstetrical or gynecological care or any other specialist care from a specialized health care professional; health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making other referrals	80% after deductible	60% after deductible	Office Visits: 100% after $20 copay per visit All other services: 50% after deductible Prenatal visits are subject to the office visit copay to max of 15 copays ($300)	25% after deductible	Office Visits: 100% after $20 copay per visit All other services: 100% Prenatal visits are subject to the office visit copay to max of 15 copays ($300)	60% after deductible

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Allergy Services • Allergy sensitivity testing, including skin patch or Rast/Mast blood tests • Desensitization and hypo-sensitization (allergy shots given at periodic intervals) • Allergy antigen solution	• Covered only when ordered by a Physician • No coverage for allergy services considered to be experimental, such as sublingual allergy treatment, rhino-phototherapy, repository emulsion therapy, etc. (see Allergy in the Exclusions chapter)	80% after deductible	60% after deductible	50% after deductible	25% after deductible	Physician services: 100% after $20 copay/visit Allergy shots only: 100% after $5 copay Antigen: 100% no copay	60% after deductible
Alternative Health Care Services • Acupuncture services • Office visit with a Homeopathy or Naturopathy provider	• Services covered only if Appropriate Claims Administrator determines the practitioner is licensed or duly authorized to practice in the jurisdiction in which services & supplies are provided • General office visits with acupuncturist not covered • **Homeopathic and Naturopathic supplies, medication and treatments are not covered**	80% after deductible to maximum $1,000 per person per calendar year (in or out-of-network)	Covered as in-network benefit	Not covered	Not covered	Not covered	Not covered
Ambulance	• See the Emergency services row						
Ambulatory Surgery Facility	• See the Specialized Health Care Facility row						
Audiology/Hearing Services • Audiology/hearing exams • Hearing aids, devices, batteries, hearing aid repairs and implantable hearing aids	• For audiology/hearing exams, see the Physician and Health Care Practitioner Services row • For hearing aids, devices, batteries, hearing aid repairs and implantable hearing aids see Corrective Appliances row						

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Behavioral Health Services **Employee Assistance Program (EAP):** • See section titled "Employee Assistance Program (EAP) Benefits" **Mental Health and Substance Abuse:** • **Outpatient Visits: In-office therapy sessions,** Intensive outpatient, day treatment and partial day care • **Outpatient Visits: in-office or other outpatient Applied Behavioral Analysis (ABA) therapy** for Autism Spectrum Disorders (ASD) – effective 4/1/14, pre-certification required • **In-Patient Admission:** Hospital and residential treatment center services	• Coverage for both outpatient and inpatient behavioral health services available through the medical plan • In-office therapy sessions (i.e. office visits) do not require pre-certification • Neuropsychological testing covered • Behavioral health hospitalization, day treatment, partial day treatment, intensive outpatient and residential treatment center services **require pre-certification;** see Utilization Management chapter • See specific exclusions related to Behavioral Health Services, including mental retardation, in the Exclusions chapter • Benefits are payable only for services of Behavioral Health Care Providers listed in the Definitions chapter • **Outpatient Prescription drugs ordered by Behavioral Health Providers:** refer to Drugs and Medicines row	Outpatient and Inpatient Services: 80% after deductible	Outpatient and Inpatient Services: 60% after deductible	Outpatient: 100% after a $20 copay per visit Inpatient Services: 50% after deductible All other outpatient services: 50% after deductible	Outpatient and Inpatient Services: 25% after deductible	Outpatient including Intensive outpatient, partial day a& day treatment care 100% after $20 copay/visit Inpatient: $200 copay/ admission, then plan pays 100%	Outpatient and Inpatient Services: 60% after deductible
Birthing Center	• See the Specialized Health Care Facility row.						
Blood Transfusions • Blood transfusions and blood products and equipment for administration	• Covered only when ordered by a Physician. • Autologous (patient's own) blood transfusion expenses are not payable under this plan.	80% after deductible	60% after deductible	50% after deductible	25% after deductible	100%, no copay	60% after deductible

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Chemotherapy • Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, Specialized Health Care Facility, Physician's office or at home	• A single wig or toupee payable to $500 max once per lifetime (in-network or out-of-network) if required to replace hair lost as a result of chemotherapy • See also the exclusion of Hair Replacement Procedures in Exclusions chapter	80% after deductible	60% after deductible	50% after deductible	25% after deductible	100%, no copay	60% after deductible
Chiropractic Services	• Limited to 25 visits/person/year: including Office Visit, Manipulations(s), Modalities and Physical Therapy (PT) • Additional chiropractic visits above 25 visits, subject to medical necessity review through pre-certification process (see Utilization Management chapter) • PT performed by Chiropractor provider during 25 visit limitation does **not** require pre-certification (see Utilization Management chapter) • PT visits above 25 visits are not covered with Chiropractic provider - must be referred and pre-certified with Licensed Physical Therapist for coverage; see Rehabilitation Services row for coverage and limitations • Patient financially responsible for services rendered over and above those allowed	80% after deductible	60% after deductible	50% after deductible	25% after deductible	100% after $20 copay	60% after deductible

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Corrective Appliances (Prosthetic & Orthotic Devices, Other Than Dental) • See Reconstructive Services, Breast Reconstruction after Mastectomy and Chemotherapy sections • Coverage provided for rental (up to Allowed/Contracted purchase price) or purchase of standard model; medically necessary repair, adjustment or servicing of device; replacement of device due to change in covered person's physical condition or if device cannot be satisfactorily repaired • Colostomy, ostomy or compression supplies • **Hearing aids/devices**: one standard set per adult per lifetime; (every three years for children under age 18) for **in-network providers only** • See Vision chapter for additional discount Hearing Aid benefits and coverage for eyeglasses following certain types of eye surgery • Audiology exams payable under Physician & Health Care Practitioner Services • **Foot Orthotics** payable to one pair/person/ year for **in-network providers only**	• See specific exclusions for Corrective Appliances in Exclusions chapter • For Appliances coverage see definitions of "Prosthetics" and "Orthotics" in Definitions chapter • Corrective Appliances covered only when ordered by a Physician or Health Care Practitioner • Occupational therapy (orthotic) supplies needed to assist person in performing activities of daily living **not** covered • **Implantable Hearing Devices** such as cochlear implants - up to 2 implants/events per member per lifetime, and **all** of the following criteria: a) covered under a City medical plan for at least two years b) Pre-certification required - see Utilization Management section c) In-network providers only d) $2,000 copayment per implant/event (in addition to any applicable deductible or coinsurance) e) Complications related to Implantable Hearing Devices payable like any other medical expense	80% after deductible Batteries and repairs for hearing aids covered 100% no deductible to $500 max per person/ year in or out-of-network	60% after deductible No coverage for hearing aids, Implantable Hearing Devices or foot orthotics	50% after deductible Batteries and repairs for hearing aids, covered 100% no deductible to $500 max per person/year in or out-of-network	25% after deductible No coverage for hearing aids, Implantable Hearing Devices or foot orthotics	100% after $20 copay; $200 copay for hearing aids $2,000 copay for Implantable Hearing Devices/event Additional $20 copay applies to supplies added to corrective appliances Batteries and repairs for hearing aids covered 100% to $500 max per person/year in or out-of-network 100%, no copay Colostomy/ ostomy supplies	60% after deductible No coverage for hearing aids, Implantable Hearing Devices or foot orthotics

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Diagnostic Procedures • Procedures performed for making medical diagnoses • Non-invasive diagnostic procedures include exams, x-rays, scans (including CAT, MRI, MRA, and PET), observation, body fluid tests, etc. • Invasive diagnostic procedures include needle biopsy, endoscopy, etc.		80% after deductible	60% after deductible	50% after deductible	25% after deductible	No copay unless combined with Office Visit, then office visit copay applies	60% after deductible
Dialysis • Hemodialysis or peritoneal dialysis and supplies	• Covered only when ordered by a Physician and administered under the direction of a Physician in a Hospital, Specialized Health Care Facility, Physician's office or at home	80% after deductible	60% after deductible	50% after deductible	25% after deductible	100%, no copay	60% after deductible

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Disease Management Services (for Obesity/Morbid Obesity Diagnosis) • Out-patient Disease Management services in-network or out-of-network at a licensed facility (or with a licensed Nutritionist) related to Weight Loss Surgery or with diagnosis of Obesity or Morbid Obesity; covered only when authorized by Physician, to a maximum $500 per person per lifetime • **See the chapter on Disease Management (DM) programs for large number of other diseases/disorders, available at no charge through Appropriate Claims Administrators**	• Out-patient Disease Management services at licensed facility or for Nutritionist, in connection with Weight Loss Surgery or diagnosis of Obesity or Morbid Obesity, up to $500 lifetime benefit per person • Participant must submit receipts showing: cost; name, address & telephone number of licensed facility/provider; dates/times classes/visits; and proof of participant attendance • If participant attended 80% or more of scheduled classes/visits, full reimbursement will be made, subject to the applicable maximum benefit; if participant attended less than 80% of scheduled classes/visits, not eligible for any reimbursement	100%, no deductible to maximum $500 per person per lifetime	100%, no deductible to maximum $500 per person per lifetime	100%, no deductible to maximum $500 per person per lifetime	100%, no deductible to maximum $500 per person per lifetime	100%, to maximum $500 per person per lifetime	100%, no deductible to maximum $500 per person per lifetime

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Drugs and Medicines • See earlier chapter on Prescription Drugs • See **Out-of-Pocket Maximums** for in-network Prescription Drugs, in this Schedule of Medical Benefits • Fertility drugs are only payable if prescribed for non-fertility therapy • Preventive vaccinations covered 100% in-network only at broader vaccination network pharmacies (travel related vaccinations not covered); preventive bowel preparation medications covered 100% in–network only, for adults age 50 through 74 years • Prenatal vitamins requiring a prescription; diabetic supplies including insulin, syringes, blood glucose monitors, lancets, alcohol swabs, test strips & test tape; emergency contraceptives (2 kits/30 days) are payable under the plan • Generic and single source brand name contraceptive drugs, devices and OTC contraceptives for women, requiring a prescription, covered at 100%. • Breast cancer risk reducing drugs for women 35 years or older at low risk of adverse medication effects covered at 100% • **Some drug classifications are subject to step therapy, quantity limitations or prior authorization requirements; these clinical management guidelines are subject to change as new drugs enter the market, safety and efficacy guidelines change and other factors**	• See drug exclusions in Exclusions chapter; no coverage for over-the-counter (OTC) drugs (except preventive Aspirin – see Preventive Care Program – Adults section), drugs to treat infertility, certain dental drugs, non-prescription contraceptives • For all plan options if you fill a drug with a brand name when a generic is available, you pay the difference in price between the brand & generic drug plus the applicable copay or coinsurance (DAW penalty) • Specialty Drug classifications including but not limited to those that treat rheumatoid arthritis (RA), multiple sclerosis (MS) and growth hormone treatments (GH) are subject to Specialty Step Therapy/Preferred Drug guidelines • Specialty Drugs for new users after 1/1/14 may be purchased in up to 30-day supplies through CVS/Caremark Specialty Pharmacy • Compound medications subject to prior authorization/medical necessity review above $500 per script effective 11/1/14 • **Copay Choice Plan in-network only**: insulin and diabetic supplies paid under Generic copay rules for retail or mail order quantities; no copay for covered diabetic supplies in-network • **Non-Network (Out-of-Network Provider) Retail Pharmacy Provisions for all Plan Options:** coverage limited to 30-day supply only. (90-day supplies not covered out-of-network); no discounts apply; coverage limited to amount Plan would have paid if a participating pharmacy was used (you pay the balance including applicable deductibles, copays or co-insurance).	**Deductible:** applies to Retail Brand Drugs up to 30-day supply only: $50/person/year **Retail Pharmacy & CVS/Caremark Specialty Pharmacy:** (up to a 30-day supply) *Generic:* Greater of $5 copay or 20% (max $50) *Formulary Brand*: Greater of $30 copay or 25% (max $100) *Non-Formulary Brand*: Greater of $50 copay or 40% (max $150) **CVS/Caremark Retail Pharmacy - Maintenance or Long-Term Use Medications: (**up to a 90-day supply) - see Mail Order benefits below **Mail Order:** (up to 90-day supply) *Generic: G*reater of $12.50 copay or 20% (max $100) *Formulary Brand: G*reater of $75 copay or 25% (max $200) *Non-Formulary Brand*: Greater of $125 copay or 40% (max $300) **See Exclusions and Limitations column for Out-of-Network Provider benefits**		**Deductible:** $250/ person/year (applies to Retail & Mail Drugs combined) **Retail Pharmacy & CVS/Caremark Specialty Pharmacy:** (up to a 30-day supply) *Generic***:** Greater of $5 copay or 20% (max $50) *Formulary Brand***:** Greater of $30 copay or 25% (max $100) *Non-Formulary Brand:* Greater of $50 copay or 40% (max $200) **CVS/Caremark Retail Pharmacy - Maintenance or Long-Term Use Medications** (up to 90-day supply) – see Mail Order benefits below **Mail Order:** (up to a 90-day supply) *Generic:* Greater of $10 copay or 20% (max $100) *Formulary Brand*: Greater of $50 copay or 25% (max $200) *Non-Formulary Brand*: Greater of $80 copay or 40% (max $300) **See Exclusions and Limitations column for Out-of-Network Provider benefits**		**No deductible applies** **Retail Pharmacy & CVS/Caremark Specialty Pharmacy:** (up to a 30-day supply) *Generic***:** $10 copay *Formulary Brand:* $40 copay *Non-Formulary Brand:* $75 copay **CVS/Caremark Retail Pharmacy - Maintenance or Long-Term Use Medications:** (up to a 90-day supply) – see Mail Order benefits below **Mail Order**: (up to 90-day supply) *Generic***:** $20 copay *Formulary Brand*: $80 copay *Non-Formulary Brand:* $150 copay **See Exclusions and Limitations column for Out-of-Network Provider benefits**	

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Durable Medical Equipment (DME) (including Oxygen) Coverage provided for: • Rental (up to allowed/contracted purchase price); • Purchase of standard models • Medically Necessary repair, adjustment or servicing • Medically Necessary replacement due to change in covered person's physical condition or if equipment cannot be satisfactorily repaired • FDA approved manual or electric breast pump & related supplies purchased from in-network DME provider covered at 100% for breastfeeding women; limit one pump per calendar year per person	• **Pre-certification required for all DME with a cost over $1,000** • See specific exclusions related to DME in Exclusions chapter • To help determine DME coverage see definition of "Durable Medical Equipment" in Definitions chapter • DME covered only when Medically Necessary, ordered by Physician or Health Care Practitioner, and purchased through DME provider or supplier; items purchased online not covered • Coverage provided for Medically Necessary Oxygen, along with Medically Necessary equipment & supplies required for administration	80% after deductible	60% after deductible	50% after deductible	25% after deductible	100% after a $20 copay per piece of equipment purchased or per month for rental; necessary supplies purchased at the same time as the covered DME are payable at 100%, no copay (otherwise $20 copay per supply)	60% after deductible

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	**Out-of-Network Providers**	**In-Network PPO Providers**	**Out-of-Network Providers**	**In-Network PPO Providers**	**Out-of-Network Providers**
Emergency Services • Hospital **Emergency Room** facility for a medical emergency • **Urgent Care** facility • **Physician Office** for a medical emergency • **Ambulance**: ground vehicle transportation to nearest appropriate facility as Medically Necessary for treatment of medical emergency, acute illness or inter-health care facility transfer; air transportation only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the health status of the patient	• Expenses for use of Hospital emergency room and/or Ambulance covered only when services are for Emergency Services • Observations up to 72 hours, without inpatient admission, covered under emergency room copay/coinsurance; if inpatient admitted after 72 hours, inpatient copay/ coinsurance applies • See definition of "Emergency Services" in Definitions chapter • The Utilization Management Company must be **notified** of emergency in-patient hospital admission within 48 hours after admission; see Utilization Management chapter	**ER, Urgent Care facility, Physician Office and Ambulance**: 80% after deductible	**ER and Ambulance**: 80% after in-network deductible **Physician Office and Urgent Care facility**: 60% after out-of-network deductible for acute care (if for emergency care, 80% after in-network deductible)	**ER, Urgent Care facility, Physician Office and Ambulance**: 50% after deductible	**ER and Ambulance**: 50% after in-network deductible **Physician Office and Urgent Care facility**: 25% after out-of-network deductible for acute care (if for emergency care, 50% after in-network deductible)	**ER**: 100% after $100 copay/visit Waived if inpatient admitted but $200 inpatient copay applies **Physician Office**: 100% after $20 copay/visit **Urgent Care facility**: 100% after $50 copay/visit **Ambulance**: 100%, no copay	**ER:** 100% after $100 copay/visit Copay waived if admitted but $200 inpatient copay applies **Physician Office and Urgent Care facility**: 60% after out-of-network deductible for acute care (if for emergency care, no deductible, 100% after $20 copay/visit for Physician Office and $50 copay/visit for Urgent Care facility) **Ambulance**: 100%, no copay
Endoscopy Services (outpatient) • Technical and professional fees associated with outpatient endoscopic procedures such as colonoscopy, gastroscopy, bronchoscopy	• Covered only when medically necessary & ordered by Physician or Health Care Practitioner. • See Preventive Benefits described in Schedule of Medical Benefits for coverage of screening colonoscopy	80% after deductible	60% after deductible	50% after deductible	25% after deductible	$100 copay for outpatient facility; 100%, no copay for professional services	60% after deductible

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Fertility, Genetic, Reproductive, Family Planning, Sexual Dysfunction Services • Prescription contraceptive devices (such as diaphragm, intrauterine devices) and voluntary surgical sterilization (e.g. vasectomy, tubal ligation, Essure) • Prescription oral contraceptives covered under Drugs and Medicines section of this Schedule • Fertility and infertility services include evaluation and diagnostic lab services for hormonal evaluation and associated infectious diseases • Family Planning counseling services for women covered at 100% (in-network physicians only)	• Voluntary Sterilization services performed outside a physician's office require Pre-certification • See specific exclusions related to Fertility, Genetic, Reproductive and Sexual Dysfunction Services • Birth control devices, injectable drugs (e.g. Depo-Provera), intrauterine devices (IUD), diaphragms and implantable birth control devices/services (e.g. Norplant) covered under this Schedule of Medical Benefits • No coverage for surgical treatment of sexual dysfunction • No coverage for fertility/infertility diagnostics/treatment • No coverage for genetic services, tests and/or procedures except when performed for detecting, evaluating or treating chromosomal abnormalities or genetically transmitted characteristics in pregnant women & high-risk individuals, subject to medical necessity; requires Pre-certification • See Preventive Services section for BRCA testing and counseling coverage	**Voluntary Sterilization** Vasectomy: 100% no deductible Tubal Ligation: 100% no deductible **Fertility diagnosis** Not covered **Prescription Oral Contraceptives** See Drugs & Medicines Birth control devices and injectable drugs for women covered 100%	**Voluntary Sterilization** Not covered **Fertility diagnosis** Not covered **Prescription Oral Contraceptives** See Drugs & Medicines Birth control devices and injectable drugs Not covered	**Voluntary Sterilization** Vasectomy: 100% no deductible Tubal Ligation: 100% no deductible **Fertility diagnosis** Not covered **Prescription Oral contra-ceptives** See Drugs & Medicines Birth control devices and injectable drugs for women covered 100%	**Voluntary Sterilization** Not covered **Fertility diagnosis** Not covered **Prescription Oral contra-ceptives** See Drugs & Medicines Birth control devices and injectable drugs Not covered	**Voluntary Sterilization** Vasectomy: 100% no deductible Tubal Ligation: 100% no deductible **Fertility diagnosis** Not covered **Prescription Oral Contraceptives** See Drugs & Medicines Birth control devices and injectable drugs for women covered 100%	**Voluntary Sterilization** Not covered **Fertility diagnosis** Not covered **Prescription Oral Contraceptives** See Drugs & Medicines Birth control devices and injectable drugs Not covered

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Home Health Care and Home Infusion Services • Part-time, intermittent **Skilled Nursing Care** services and medically necessary supplies to provide Home Health Care or Home Infusion services • Home services other than Skilled Nursing Care are not covered	• **Home Health/Home Infusion Services require pre-certification – covered to a maximum 60 visits/person/calendar year;** see Utilization Management chapter of this document • See Exclusions related to Home Health Care and Custodial Care (including personal care and childcare) • Covered only when ordered by Physician • Home Hospice payable as described below under Hospice benefits • Home Physical Therapy payable as described below under Rehabilitation Services benefits • Outpatient prescription drugs payable as described above under Drug and Medicine benefits	80% after deductible	60% after deductible	50% after deductible	25% after deductible	100%, no copay	60% after deductible
Hospice Services	• **Hospice Services require pre-certification.** • Length of coverage based on medical necessity. • Applies to facility or home hospice care	80% after deductible	60% after deductible	50% after deductible	25% after deductible	100%, no copay	60% after deductible
Laboratory Services (Outpatient) • Technical and professional fees. • See Hospital Services section of this schedule for inpatient laboratory services.	• Covered only when ordered by a Physician or Health Care Practitioner. • Laboratory services for gestational diabetes screenings in pregnant women between 24-28 weeks and at first prenatal visit covered at 100% in-network, all plans.	80% after deductible	60% after deductible	50% after deductible	25% after deductible	100% no deductible	60% after deductible

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Maternity Services • Hospital, Birthing Center, Physician & Nurse Midwife fees for Medically Necessary maternity services. • **Preventive Care Screening for gestational diabetes** in pregnant women between 24-28 weeks gestation & at first prenatal visit (and thereafter for high risk patients) covered 100% in-network, all plans • **Preventive Care** FDA approved manual or electric breast feeding pump, supplies, & lactation counseling covered 100%, in-network only, up to one breast pump per calendar year (see DME section) • **IMPORTANT**: For a newborn to be covered by this Plan, you must follow the Newborn Eligibility requirements in the Eligibility chapter of this document • **Charges for baby and mother are billed separately to the Plan.**	• See Fertility & Reproductive Care in Exclusions. • Recommended but not required that pregnant women notify Utilization Management Company when pregnancy confirmed • Pre-certification requirements (see Utilization management section) for hospital stays **greater** than 48 hours for vaginal delivery or greater than 96 hours for cesarean delivery • Expenses for elective induced abortion are excluded unless the attending physician certifies that the health of the woman would be endangered if the fetus were carried to term or medical complications arising from an abortion • For newborn hospital charges, both mother & baby are responsible for separate coinsurances or copays (as applicable to the plan option)	Maternity Services: 80% after deductible Breast Pump, supplies, and lactation counseling 100%, no deductible	60% after deductible	See the Hospital and Physician services row of this Schedule Prenatal visits: $20 office visit copay to maximum of 15 copays ($300) Breast Pump, supplies, and lactation counseling 100%, no deductible	25% after deductible	See Hospital and Physician services row of this Schedule; Separate Inpatient copays for mother and newborn Prenatal visits: $20 office visit copay to maximum of 15 copays ($300) Breast Pump, supplies, and lactation counseling 100%	60% after deductible

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Nondurable Supplies • Sterile surgical supplies used immediately after surgery • Supplies needed to operate or use covered DME or Corrective Appliances • Supplies needed for use by skilled home health or home infusion staff during course of their required services • Diabetic Supplies – available under both this Nondurable Supplies section and Drugs and Medicines section • Supplies needed to operate breast feeding pump for women covered at 100% in-network	• Pre-certification is not required for Nondurable Supplies when used in conjunction with DME or Corrective Appliances • See the definition of "Nondurable Supplies" in the Definitions chapter	80% after deductible	60% after deductible	50% after deductible	25% after deductible	100%, no copay	60% after deductible

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers

Oral and Craniofacial Services
• **Treatment of Accidental Injuries to the Teeth:** medical plan will cover treatment of certain accidental injuries to teeth & jaws if all the following conditions are met:
  • Accidental injury caused by an extrinsic (external) and not intrinsic force (such as the force of chewing or biting); and
  • Dental treatment is most cost-effective option that meets acceptable standards of professional dental practice; and
  • Dental treatment will return the person's teeth to their pre-injury level of health and function
  • See definition of Injury to Teeth in the Definitions chapter
• Oral and Craniofacial Surgery
	• See exclusions related to Dental Services in the Exclusions chapter
	• **No coverage in medical plan for procedures, services or supplies related to TMJ syndrome or dysfunction** (as defined in Definitions chapter)
	• Medically necessary treatment of TMJ problems e.g. due to arthritis or fracture is covered
	• **Oral, maxillofacial or craniofacial surgery limited** to medically necessary cutting procedures to remove tumors or cysts, treat abscesses or acute injury of gums, cheek, lip, tongue, hard or soft palate or, due to arthritic deterioration
	• No coverage under this plan for treatment/removal of impacted teeth, root canal, gingivectomy or dental abscess
	• Orthognathic procedures payable only when Medically Necessary according to the Plan – see Definitions section
		80% after deductible	60% after deductible	50% after deductible	25% after deductible	See the Hospital and Physician services row of this Schedule	60% after deductible

Outpatient Surgery Facility	• See the Specialized Health Care Facility row in this schedule.						

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Preventive Care Program–Children (Covered Preventive Services for Children under Federal Guidelines and PPACA) • **Alcohol & Drug Use** annual assessments for adolescents age 11-21 years • **Autism** screening for children at 18 & 24 months. • **Behavioral** annual assessments for children of all ages, 0-21 years • **Blood Pressure** screening for children 0-30 months, risk assessment every 2-3 months; annually for 3–21 years • **Cervical Dysplasia** screening for sexually active females, age 11 – 21 years (risk assessment) • **Congenital Hypothyroidism** screening one time for newborns • **Depression** screening for adolescents at higher risk • **Developmental** screening for children under age 3 (9, 18, & 30 months); surveillance throughout childhood (0-6; 12, 15, & 24 months); then annually to age 21 years • **Dyslipidemia** screening • **Fluoride Chemoprevention** supplements for children older than 6 months but < 5years of age without fluoride in their water source • **Gonorrhea** preventive medication for the eyes one time for newborns • **Hearing** screening one time for newborns	• **Screening for depression: adolescents** - The USPSTF recommends screening of adolescents (age 12-18 years) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up • **Dyslipidemia Screening:** Risk assessment at 2, 4, 6 & 8 years; age 10-17 years annually; at 20 years	100% covered	No Coverage	100% covered	No Coverage	100%, no copay	No Coverage

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Preventive Care Program-Children (Covered Preventive Services for Children under Federal Guidelines and PPACA) • **Height, Weight and Body Mass Index** measurements for children annually, age 2-21 years • **Hematocrit or Hemoglobin** screening for children • **Hemoglobinopathies** or sickle cell screening one time for newborns • **HIV screening** for adolescents and adults at higher risk for HIV infection • **Immunization** vaccines for children from birth to age 18 • **Iron** supplements • **Lead** screening at 12 & 24 months • **Medical History** for children annually up to age 21 • **Obesity** screening and counseling • **Oral Health** risk assessment for young children • **Phenylketonuria (PKU)** screening for this genetic disorder one time for newborns	• **Hematocrit or Hemoglobin:** risk assessment at 4 months, 18 months, 24 months & annually from 3–21 years • **Immunization vaccines:** doses, recommended ages and populations vary: http://www.cdc.gov/vaccines/recs/schedules/downloads/child/0-6yrs-schedule-pr.pdf; and http://www.cdc.gov/vaccines/recs/schedules/downloads/child/7-18yrs-schedule-pr.pdf • **Quadrivalent HPV Vaccinations:** one time (3 doses) age 9–18 years • **Iron supplementation in children:** U.S. Preventive Services Task Force (USPSTF) recommends routine iron supplementation for asymptomatic children age 6–12 months who are at increased risk for iron deficiency anemia • **Lead screening:** Risk assessment at 6, 9, and 18 months; then annually, 3–6 years of age • **Obesity screening and counseling for children:** the USPSTF recommends screenings for children age 6+ years for obesity & offer/refer for comprehensive, intensive behavioral interventions to promote improvement in weight status	100% covered	No Coverage	100% covered	No Coverage	100%, no copay	No Coverage

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Preventive Care Program-Children (Covered Preventive Services for Children under Federal Guidelines and PPACA) • **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk • **Smoking Cessation** counseling and education for school-age children (effective 1/1/15) and adolescents to age 21 • **Tuberculin** testing for children at higher risk of tuberculosis • **Vision** screening for children • **Well-baby and well-child** visits from birth to age 21	• **Counseling for STIs: Risk assessment 11 – 21 years:** the USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STI's • **Smoking Cessation:** Maximum in each 365 day period: Nicotrol NS 90 days, Nicotrol Inhaler 90 days, Zyban 90 days, Chantix 180 days, Nicorette Gum/Lozenge 90 days, Nicotine Transdermal System 90 days (covered under Drugs and Medicines section) • **Tuberculin Test:** Risk assessment at 1, 6, 12, 18, and 24 months; and 3 – 21 years, annually • **Screening for visual acuity in children:** the USPSTF recommends screening to detect amblyopia, strabismus and defects in visual acuity in children younger than 5 years	100% covered	No Coverage	100% covered	No Coverage	100%, no copay	No Coverage

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Preventive Care Program – Adults (Covered Preventive Services for men and/or women under Federal Guidelines and PPACA) • **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked • **Alcohol Misuse** screening and counseling • **Aspirin** use for men and women of certain ages • **Blood Pressure** screening for all adults annually • **Cholesterol** screening for adults of certain ages or at higher risk	• **Screening for abdominal aortic aneurysm (AAA):** USPSTF recommends one-time screening for AAA by ultrasonography in men age 65-75 who have ever smoked • **Screening and counseling to reduce alcohol misuse:** USPSTF recommends screening & behavioral counseling interventions to reduce alcohol misuse by adults 21+, including pregnant women in primary care settings • **Aspirin to prevent CVD:** USPSTF recommends the use of aspirin for men and women age 45 years and older when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage • **Aspirin to prevent Preeclampsia:** USPSTF recommends the use of aspirin for women age 12 years and older who are pregnant and at high risk for Preeclampsia • **Screening for high blood pressure:** The USPSTF recommends screening for high blood pressure in adults aged 18 and older • **Screening for cholesterol abnormalities: men 35 & older -** USPSTF strongly recommends screening men age 35+ for lipid disorders. • **Screening for cholesterol abnormalities: men under 35 -** USPSTF recommends screening men age 20-35 for lipid disorders if they are at increased risk for coronary heart disease	100% covered	No Coverage	100% covered	No Coverage	100%, no copay	No Coverage

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Preventive Care Program – Adults (Covered Preventive Services for men and/or women under Federal Guidelines and PPACA) • **Colorectal Cancer** screening for adults over age 50 through 74 years • **Depression** screening for adults • **Type 2 Diabetes** screening for adults with high blood pressure • **Diet** counseling for adults at higher risk for chronic disease	• **Screening for Colorectal Cancer:** USPSTF recommends screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy or colonoscopy (including bowel preparation medications under Drugs and Medicines section) • **Screening for depression:** USPSTF recommends screening adults age 21+ for depression • **Screening for diabetes:** USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg • **Counseling for a healthy diet:** USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.	100% covered	No Coverage	100% covered	No Coverage	100%, no copay	No Coverage

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Preventive Care Program – Adults (Covered Preventive Services for men and/or women under Federal Guidelines and PPACA) • **Hepatitis C** viral infection screening effective 1/1/15 • **HIV** screening for all adults at higher risk • **Immunization** vaccines and **HPV vaccination** for adults-- doses, recommended ages, and populations vary; coverage based upon CDC schedule except Shingles vaccination based upon age 50+ FDA guidelines: http://www.cdc.gov/vaccines/recs/schedules/downloads/adult/adult-schedule.pdf • **Lung Cancer** screening for smokers or former smokers • **Obesity** screening and counseling for all adults • **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk • **Syphilis** screening for all adults at higher risk • **Tobacco Use** screening for all adults and **Smoking Cessation** interventions for tobacco users (including prescription drug therapies)	• **Screening for Hepatitis C**: USPSTF recommends one time screening for adults born between 1945 and 1965 and all other populations at high risk for infection • **Screening for HIV:** USPSTF recommends screenings in adolescents & adults at increased risk for HIV infection • **Human Papillomavirus** vaccination (HPV): age 19–26 years, one time (3 doses) • **Lung Cancer screening** annually with low dose computed tomography (LDCT) for adults age 55-80 with 30+ years smoking history including quit in last 15 years • **Screening and counseling for obesity in adults -** USPSTF recommends screenings, counseling and behavioral interventions for adults age 21+ for obesity • **STO Counseling:** USPSTF recommends screening/counseling to prevent sexually transmitted infections (STIs) for sexually active adolescents & for adults at increased risk for STI's • **Smoking Cessation drug therapies:** effective 11/1/14 - 168 days of therapy in each 365 day period: Nicotrol NS, Nicotrol Inhaler, nicotine replacement gum/lozenge/Transdermal (generic only), Zyban (generic only) and Chantix (covered under Drugs and Medicines section)	100% Covered	No Coverage	100% Covered	No Coverage	100%, no copay	No Coverage

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Preventive Care Program – Women (Covered Preventive Services for Women under Federal Guidelines and PPACA) • **Anemia** screening on a routine basis for pregnant women • **Bacteriuria** urinary tract or other infection screening for pregnant women • **BRCA** counseling about genetic testing for women at higher risk • **Breast Cancer Mammography** screenings every 1 to 2 years for women age 40 and over	• **Screening for iron deficiency anemia:** USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women • **Screening for bacteriuria:** USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12-16 weeks' gestation or at first prenatal visit • **Counseling related to BRCA screening:** USPSTF recommends women whose family history is associated with increased risk for deleterious mutations in BRCA1 or BRCA2 genes get genetic counseling & evaluation for BRCA testing; see Fertility, Genetic, Reproductile Services in this Schedule for BRCA testing coverage	100% Covered	No Coverage	100% Covered	No Coverage	100%, no copay	No Coverage

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Preventive Care Program – Women (Covered Preventive Services for Women under Federal Guidelines and PPACA) • **Breast Cancer Chemoprevention** counseling for women at higher risk • **Breast Feeding** interventions during and after birth to support and promote breast feeding; see Durable Medical Equipment section for information about Breast Feeding pump and supplies • **Cervical Cancer** screening for sexually active women who have a cervix • **Chlamydia Infection** screening for younger women and other women at higher risk	• **Chemoprevention of breast cancer:** USPSTF recommends discussion/screening for chemoprevention with women at high risk for breast cancer & at low risk for adverse effects of chemo-prevention; see Drugs and Medicines section for coverage of breast cancer risk reduction drugs • **Screening for chlamydial infection in women:** USPSTF recommends screening for chlamydial infection for all pregnant women and sexually active non-pregnant women age 24 & younger & for older non-pregnant women who are at increased risk	100% Covered	No Coverage	100% Covered	No Coverage	100%, no copay	No Coverage

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Preventive Care Program – Women (Covered Preventive Services for Women under Federal Guidelines and PPACA) • **Cholesterol** screening for adults of certain ages or at higher risk • **Contraceptive method** counseling for women with reproductive capacity • **Folic Acid** supplements for women < 55 years old, who may become pregnant • **Gonorrhea** screening for women at higher risk • **Hepatitis B** screening for pregnant women at first prenatal visit • **HIV infection** counseling annually for all sexually active women • **Interpersonal and Domestic Violence** screening and counseling annually • **Osteoporosis** screening for women over age 60 depending on risk factors	• **Screening for cholesterol abnormalities:** USPSTF recommends screening women age 20+ for lipid disorders if at increased risk for coronary heart disease • **Supplementation with folic acid:** USPSTF recommends all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid • **Screening for gonorrhea: women -** USPSTF recommends screenings for sexually active women, including those who are pregnant, for gonorrhea infection if at increased risk for infection (if they are young or have other individual or population risk factors) • **Screening for osteoporosis:** USPSTF recommends women age 65+ be screened routinely for osteoporosis; routine screening begin at age 60 for women at increased risk for osteoporotic fractures	100% Covered	No Coverage	100% Covered	No Coverage	100%, no copay	No Coverage

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Preventive Care Program – Women (Covered Preventive Services for Women under the Federal Guidelines and PPACA) • **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk • **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users • **Syphilis** screening for all pregnant women or other women at increased risk		100% Covered	No Coverage	100% Covered	No Coverage	100%, no copay	No Coverage
Radiology (X-Ray), Nuclear Medicine and Radiation Therapy Services (Outpatient) • Technical and professional fees associated with diagnostic and curative services, including radiation therapy	• Covered only when medically necessary and ordered by a Physician/Health Care Practitioner • See also Preventive Care Program for Women mammogram benefit described in this Schedule • See Hospital Services section of this Schedule for inpatient radiology services	80% after deductible	60% after deductible	50% after deductible	25% after deductible	100%, no copay	60% after deductible

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Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers

Reconstructive Services and Breast Reconstruction after Mastectomy
• Includes expenses for Reconstructive Surgery, procedures or treatment intended to correct a deformity resulting from disease, infection, trauma, congenital anomaly that causes a functional defect, or prior covered therapeutic procedure
• Breast reconstruction as described to the right
	• See specific exclusions related to Cosmetic Services (including Re-constructive Surgery) in Exclusions chapter
	• Most Cosmetic and Dental services are excluded from coverage
	• For any covered person receiving benefits for mastectomy and subsequent breast reconstruction, coverage will be provided for:
	  • Reconstruction of the breast on which the mastectomy was performed
	  • Surgery to produce a symmetrical appearance
	  • Prosthesis and physical complications for all stages of mastectomy, including lymphedemas
	  • Post-Mastectomy Reconstruction Tattooing
	• External silicone breast prosthesis payable as medically necessary once every two (2) calendar years
	• Fabric, foam, or fiber-filled breast prosthesis payable as medical necessary up to twice per calendar year
	• Up to four post-mastectomy bras payable as medically necessary every calendar year
	• See Corrective Appliances row
		80% after deductible	60% after deductible	50% after deductible	25% after deductible	Office Visits: 100% after $20 copay/visit
						
						Hospital: 100% after $200 copay per admission
							60% after deductible

Rehabilitation Services (Physical, Occupational, Music, Speech, Applied Behavioral Analysis/Therapeutic Behavioral , Cardiac and Pulmonary Therapies) • **Outpatient, short-term, active, progressive** Rehabilitation Services (Occupational, Physical, Music or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician in an outpatient facility or under Home Health Care services • **Inpatient Rehabilitation Services** in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility are payable for short-term, **active, progressive** Rehabilitation Services that **cannot** be provided in an outpatient or home setting • **Chiropractic modalities that are not spinal manipulation services** e.g. Physical Therapy • **Cardiac Rehabilitation** for those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.) • Pulmonary rehabilitation • All Rehab services covered only when ordered by a Physician	• **In-patient Rehabilitation admissions require pre-certification** - see Utilization Management section • **All Outpatient Physical or Occupational Therapy requires pre-certification** – except physical therapy provided by Chiropractor during annual 25 visit limitation (see Chiropractic Services section and Utilization Management chapter) • **Music or Speech therapy:** requires pre-certification; see Utilization Management chapter • Speech therapy covered if directly associated with medical illness or injury & services are provided by a licensed or duly qualified speech therapist to restore normal speech or to correct dysphagic or swallowing defects/ disorders lost due to illness, injury or surgical procedure • Speech therapy for functional purposes, including but not limited to stuttering, stammering and conditions of psychoneurotic origin, is not covered, except as secondary to a specific medical condition • **Effective 1/1/16 : Annual visit limitation for Outpatient Physical, Occupational, Speech, Music and Applied Behavioral Analysis/Therapeutic Behavioral Therapies – coverage for up to 90 pre-certified visits, combined all therapies and in-network or out-of network, per person per year; medically necessary visits above 90 combined visits per person per year, subject to reduced benefit provisions by plan (see right hand columns)** • Maintenance Rehabilitation & coma stimulation services **not** covered ; see exclusions related to Rehabilitation Therapies in Exclusions chapter	Outpatient Therapy: 80% after deductible up to 90 combined visits (PT, OT, MT, ST, ABA/TBT) both in and out-of-network, per person per year 40% after deductible for visits above 90 combined visits (both in and out-of-network) per person per year Inpatient rehabilitation admission: 80% after deductible	Outpatient Therapy: 60% after deductible up to 90 combined visits (PT, OT, MT, ST, ABA/TBT) both in and out-of-network, per person per year 30% after deductible for visits above 90 combined visits (both in and out-of-network) per person per year Inpatient rehabilitation admission: 60% after deductible	Outpatient Therapy: 50% after deductible up to 90 combined visits (PT, OT, MT, ST, ABA/TBT) both in and out-of-network, per person per year 25% after deductible for visits above 90 combined visits (both in and out-of-network) per person per year Inpatient rehabilitation admission: 50% after deductible	Outpatient Therapy: 25% after deductible up to 90 combined visits (PT, OT, MT, ST, ABA/TBT) both in and out-of-network, per person per year 15% after deductible for visits above 90 combined visits (both in and out-of-network) per person per year Inpatient rehabilitation admission: 25% after deductible	Outpatient Therapy: 100% after a $20 copay up to 90 combined visits (PT, OT, MT, ST, ABA/TBT) both in and out-of-network, per person per year; 100% after $50 copay for visits above 90 combined visits (both in and out-of-network) per person per year Inpatient rehabilitation admission: 100% after $200 copay per admission	Outpatient Therapy: 60% after deductible up to 90 combined visits (PT, OT, MT, ST, ABA/TBT) both in and out-of-network, per person per year 30% after deductible for visits above 90 combined visits (both in and out-of-network) per person per year Inpatient rehabilitation admission: 60% after deductible
Second and Third Opinions • Includes only **one** Office Visit per opinion	• See the chapter on Utilization Management for details of the Second and Third Opinion Program and when the Plan may require a second or third opinion • Additional Medically Necessary tests are covered under other Plan provisions	Plan-required: 100% after deductible Patient-requested: 80% after deductible	Plan-required: 100% after deductible Patient-requested opinion: 60% after deductible	Plan-required: 100% after deductible Patient-requested: 50% after deductible	Plan-required: 100% after deductible Patient-requested: 25% after deductible	Plan-required: 100%, no copay Patient-requested 100% after $20 copay	Plan-required: 100% after deductible Patient-requested: 60% after deductible

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Skilled Nursing Facility	• See the Specialized Health Care Facility row						
Specialized Health Care Facilities • Outpatient Surgery Center/Facility • Birthing Center. • Skilled Nursing Facility (SNF). • Sub-Acute Care Facility (also called Long Term Acute Care – LTAC – facility)	• **Admission to Specialized Health Care Facility requires pre-certification;** see Utilization Management for details • Outpatient Surgery Center/Facility or Hospital based Outpatient Facility specializing in same day surgery or procedures where an overnight hospital stay is not required • Specialized Health Care Facility services must be ordered by a Physician; see Definitions chapter • **Birthing Center:** Benefits will not be more than those that would have been paid had charges been incurred in conventional labor, delivery or recovery rooms of hospital which maintains the birthing center • Benefits for use of **Skilled Nursing** or **Sub Acute Care Facility** or any combination of either type of confinement is payable up to 60 days per calendar year	80% after deductible	60% after deductible	50% after deductible	25% after deductible	Outpatient Surgery Center/Facility or Birthing Center: Copay: $100 per outpatient admission then 100% Copay: $20 per outpatient Wound Care procedure SNF/LTAC Facility: Copay: $200 per inpatient admission then 100%	60% after deductible
Spinal Manipulation Services • Spinal Manipulation Services from a Physician (MD or DO) or Chiropractor	• See Chiropractic Services above						
Sub-Acute Care Facility	• See Specialized Health Care Facility row.						

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Transplantation (Organ & Tissue) • Coverage provided only for eligible services directly related to **Transplantation of human organs or tissue** to include: bone marrow, cornea, heart, kidney, liver, or lung(s), pancreas including facility & professional services, FDA approved drugs, & Medically Necessary equipment & supplies • **Donor related transplant expenses** payable over a 12-month period beginning on date of procedure; when donor expenses are payable by the donor's own health plan, this plan reserves the right to coordinate benefits as outlined in this document	• See specific exclusions related to Experimental & Investigational Services & Transplantation in Exclusions • **Transplantation services subject to pre-certification** - see Utilization Management section • Benefits payable **only if** services are provided in Hospital or Specialized Health Care Facility • **No coverage for travel & lodging expenses**	80% after deductible	60% after deductible	50% after deductible	25% after deductible	Inpatient Admission and Outpatient Surgical Facility copays apply, then 100%	60% after deductible

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Vision (Eye Care) Services • Eyeglasses or corrective lenses only as described to the right • See separate Vision Care Plan described in this document	• Coverage for cost of one pair of corrective eyeglasses/lenses or contact lenses required after surgery to remove the lens of the eye; additional medically necessary corrective eyeglasses/lenses or contact lenses after first pair may be available through Vision Care Plan (see Vision Plan Benefits chapter) • Eyeglasses (including lenses) or contact lenses covered for certain other eye conditions such as keratoconus; coverage limited to basic lenses and frames only • No coverage for eye refraction or routine vision care associated with this benefit • Vision therapy, such as orthoptic or pleoptic services not covered	80% after deductible	60% after deductible	50% after deductible	25% after deductible	100% After $20 copay per visit or medically necessary lenses/frames purchase	60% after deductible

SCHEDULE OF MEDICAL BENEFITS

This table displays the medical plan options available and how the benefits are paid by the Plan. See also the Exclusions and Definitions chapters of this document for important information about Plan benefits. Most benefits are subject to the deductible except where noted.

IMPORTANT: Out-of-Network providers are paid according to the Allowed or Contracted Charge as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice PPO		Basic Choice PPO		Copay Choice	
		In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers	In-Network PPO Providers	Out-of-Network Providers
Weight Management Services • Expenses for the surgical treatment of obesity (bariatric surgery) are payable including, but not limited to, gastric restrictive procedures (e.g. lap band) and intestinal bypass for adult participants who meet the criteria for Bariatric Surgery as noted to the right • Pre-certification required – see Utilization Management section • Must be performed by an in-network provider/facility and meet the criteria noted to the right	**Criteria for Bariatric Surgery:** Clinical Documentation to include: 1. Complete History & Physical 2. Bariatric surgical consultation documenting • patient's current BMI (body mass index) of 40 or greater, [if BMI is 35 – 39.9, evidence of severe comorbidities presenting a life-threatening situation that medical management alone would not be sufficient, weight-related illnesses that can be successfully alleviated with surgically assisted weight loss; and • patient does not have untreated or under-treated endocrinopathy that may contribute to the patient's morbid obesity; and • a defined pre-operative & post-operative weight management program provided by bariatric surgeon to ensure best outcome for the surgery and the patient; and 3. (6)-months physician supervised diet prior to surgery with nutritional consultations; and 4. Cardiac/Pulmonary Clearance; and 5. Basic Labs (within the last 6 months); and 6. Psychiatric Evaluation within last 12 months recommending approval of bariatric surgery and behavioral outcomes expected to warrant performance of surgery (covered under Behavioral Health benefit) 7. Bariatric surgical alternatives: Roux-en-Y (short or long limb), Vertical Banded Gastroplasty, Laparoscopic Gastric Banding, Duodenal Switch, & Bilio-pancreatic Diversion, when considered medically necessary by Utilization Management 8. See Drug Coverage row of this Schedule for coverage of weight loss prescription medication 9. **No coverage for post-weight loss skin reduction surgery/treatment**	80% after deductible	No coverage	Office Visits: 100% after a $20 copay per visit All other services: 50% after deductible	No coverage	Office Visits: 100% after $20 copay per visit All other services: 100% Hospital: $200 copay per admission then plan pays 100%	No coverage

MEDICAL PLAN EXCLUSIONS

The following is a list of medical services and supplies or expenses **not covered by any of the medical plan options.** In addition, exclusions applicable to the Dental Plan appear in the Dental Plan Benefits chapter of this document. The Plan Administrator, Appropriate Claims Administrators and other Plan fiduciaries and individuals to whom responsibility for the administration of the Medical Plan has been delegated, have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan, and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan.

GENERAL EXCLUSIONS APPLICABLE TO ALL SERVICES AND SUPPLIES

1. **Autopsy:** Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.
2. **Costs of Reports, Bills, etc.:** Expenses for preparing forms and medical reports/medical records, bills, disability/sick leave/ or claim forms and the like; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, mailing charges, prescription refill charges, disabled/handicapped plates/automotive forms/interest charges, late fees and mileage costs, provider administration fees, concierge/retainer agreement/membership fees or photocopying fees.
3. **Educational Services:** Even if they are required because of an injury, illness or disability of a Covered Individual, the following expenses are not payable by the Plan: educational services, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory or speech aids/synthesizers, auxiliary aids such as communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices.
4. **Employer-Provided Services:** Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by the City, or if benefits are otherwise provided under this Plan or any other plan that the City contributes to or otherwise sponsors.
5. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan Benefit limitation, Annual Maximum Plan Benefits, or Overall Maximum Plan Benefits as described in the Medical Expense Coverage chapter of this document.
6. **Expenses Exceeding Allowed or Contracted Charges:** Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Allowed or Contracted Charge as defined in the Definitions chapter of this document.
7. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the Medical Plan; or after the date the patient's coverage ends, except under those conditions described in the COBRA chapter of this document.
8. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay are not covered.
9. **Expenses used to satisfy Plan Deductibles, copays** or expenses for a plan penalty for failure to comply with Utilization Management procedures.
10. **Expenses which are eligible for consideration under any other Plan of the employer**.
11. **Expenses arising from complications of any non-covered surgery, service or procedure (except for medical complications arising from an abortion).**
12. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Definitions chapter of this document.
13. **Expenses related to complications of a non-covered service.**
14. **Failure to Comply with Medically Appropriate Treatment:** Expenses incurred by any Covered Individual as a result of failure to comply with medically appropriate treatment, as determined by the Plan Administrator or its designee.
15. **Military service related injury/illness**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan.
16. **Illegal Act:** Expenses incurred by any covered individual for injuries resulting from or sustained as a result of commission or attempted commission of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual, unless such injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor. Upon receipt of notification of denial, the individual then has the right to appeal the denial of

claims payment related to the injury or illness resulting from or sustained as a result of the alleged illegal act. Such appeal should be directed to the Plan Administrator who will submit it through the Appeal Process outlined in the Claims Information chapter of this plan document.

17. **Internet/Virtual Office/Telemedicine Services:** Expenses related to an online internet consultation with a Physician or other Health Care Practitioner, also called a virtual office visit/consultation, web visit, physician-patient web service or physician-patient e-mail service, or telemedicine (real time or store and forward types) telehealth, e-health, remote diagnosis and treatment, real-time video-conferencing including receipt of advice, treatment plan, prescription drugs, durable medical equipment or medical supplies obtained from an online internet provider.
18. **Leaving a Hospital Contrary to Medical Advice:** Hospital or other Health Care Facility expenses if you leave the facility against the medical advice of the attending Physician within 72 hours after admission.
19. **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in the Definitions chapter of this document.
20. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a covered individual, including, without limitation, construction or modification of ramps, elevators, hand rails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, etc., except as pre-approved by the Plan Administrator.
22. **Never Events (i.e. Services for which reimbursement will never be made)**: Expenses for services performed as a result of an inexcusable outcome(s) in a health care setting or adverse event(s) that is serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability are not covered under the Plan. See Definitions chapter for further information. The plan reserves the right for itself and parties acting on behalf of the plan to review charges processed and/or paid by the Plan, to identify charges and/or services that are not Reasonable (as that term is defined in the Definitions Chapter of this Plan Document) and therefore not eligible for payment. The Plan Administrator or its designee may use a variety of resources in making these determinations, including The National Medical Associations, Societies, and other organizations such as the Food and Drug Administration.
21. **No-Cost Services:** Expenses for services rendered or supplies provided for which a covered person is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.
22. **No Physician Prescription:** Expenses for services rendered or supplies provided that are not recommended or prescribed by a Physician, except for covered services provided by a Behavioral Health Practitioner, Nurse Midwife, Physician Assistant, Nurse Practitioner, Chiropractor, Acupuncturist, Homeopath, Naturopath, or Podiatrist.
23. **Non-Emergency Travel and Related Expenses**: Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, covered person or family member of a covered person, unless those expenses have been pre-approved by the Plan Administrator.
24. **Occupational Illness/Injury or Third Party Expenses:** All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law. Expenses for the treatment of conditions covered by workers' compensation or occupational disease law; or expenses for services or supplies for which another person, entity or third party may be liable for any payment. See the Coordination of Benefits Chapter for more information.
25. **Personal Comfort Items:** Expenses for patient convenience, including, but not limited to, care of family members while the covered individual is confined to a Hospital or other Specialized Health Care Facility or to bed at home, guest meals, television, VCR/DVD/Compact disc (CD) and other similar devices, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.
26. **Physical Examinations and Tests for Employment, School, etc.:** Expenses for physical examinations, sports physicals, functional capacity/job analysis examinations and testing required for employment, government or regulatory purposes, insurance, vocation, workers compensation, retirement/disability status or pension, or by any third party.
27. **Private Room in a Hospital or Specialized Health Care Facility:** The use of a private room in a Hospital or other Specialized Health Care Facility, unless the facility has only private room accommodations or unless the use of a private room is certified as Medically Necessary by the Plan Administrator or designee.
28. **Relatives Providing Services:** Expenses for services provided by any Physician or other Health Care Practitioner who is the parent, spouse, sibling (by birth or marriage) or child of the patient or covered Employee.
29. **Services Performed by Certain Health Care Practitioners:**
    - **Medical Students, Interns or Residents:** Expenses for the services of a medical student, intern or resident.

- **Stand-By Physicians or Health Care Practitioners:** Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Practitioner was available to do so on a stand-by basis.

30. **Travel Contrary to Medical Advice:** Expenses incurred by any Covered Individual during travel if a Physician or other Health Care Provider has specifically advised against such travel because of the health condition of the Covered Individual.
31. **Telephone Calls:** Any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Utilization Management Company, or any representative of the Plan for any purpose whatsoever, including, without limitation:
    - Communication with any representative of the Plan or its Utilization Management Company for any purpose related to the care or treatment of a Covered Individual;
    - Consultation with any Health Care Provider regarding medical management or care of a patient;
    - Coordinating medical management of a new or established patient;
    - Coordinating services of several different health professionals working on different aspects of a patient's care;
    - Discussing test results;
    - Initiating therapy or a plan of care that can be handled by telephone;
    - Providing advice to a new or established patient;
    - Providing counseling to anxious or distraught patients or family members;
32. **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES

33. **Allergy/Alternative/Complementary Health Care Services Exclusions**
    a. Expenses for chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.
    b. Expenses for prayer, religious healing, or spiritual healing including services provided by a Christian Science Practitioner.
    c. Expenses for medications, natural remedies or treatments recommended or provided by a naturopath or homeopath, except office visits as payable under Alternative Health Care Services in the Schedule of Medical Benefits.
    d. Expenses for experimental/investigational allergy treatments including but not limited to sublingual (under the tongue) drops/oral antigen, rhino-phototherapy (use of ultraviolet lights as a treatment for allergic rhinitis and other nasal conditions), repository emulsion therapy (a form of therapy where certain materials are placed inside the body to improve allergies).
34. **Behavioral Health Care Exclusions**
    a. Expenses for Behavioral Health Care services related to: adoption counseling; court-ordered Behavioral Health Care services; custody counseling; developmental disabilities; dyslexia; family planning counseling; learning disorders; marriage, couples, and/or sex counseling; mental retardation; pregnancy counseling; transsexual counseling; and vocational disabilities.
    b. Expenses for diagnosis, treatment, and prevention of Behavioral Health Disorders, including substance abuse, except as provided under Behavioral Health in the Schedule of Medical Benefits.
    c. Expenses for the following residential care services: residential treatment programs that are <u>not</u> solely for substance abuse treatment, residential schools for non-acute mental health care, wilderness programs, non-acute residential behavioral programs/admission, half-way house and group homes.
    d. Expenses for biofeedback or hypnosis/hypnotherapy.
    e. Expenses for Behavioral Health Care services related to:
        - Dyslexia, including tests and related expenses to determine the presence of or degree of a person's dyslexia;
        - vocational disabilities;
        - court-ordered Behavioral Health Care services or custody counseling (unless the services are determined by the Plan Administrator or its designee, to be medically necessary in the absence of a court order and such services are a covered benefit under the Plan);
        - family planning/pregnancy/adoption counseling, transsexual/gender reassignment/sex counseling;
        - marriage/couples counseling. Note: marital/family counseling is available through the EAP services discussed under Behavioral Health in the Schedule of Medical Benefits.

    Note that Psychological testing that is medically necessary for the evaluation of a mental health diagnosis (e.g., serious psychiatric illness, alcohol and/or drug abuse) and medically necessary **neuropsychological testing** for evaluation of a medical diagnosis (e.g., traumatic brain injury, stroke, epilepsy, hydrocephalus, Alzheimer's disease) is considered for coverage under the Physician services row in the Schedule of Medical Benefits.

35. **Corrective Appliances and Durable Medical Equipment Exclusions**
    a. Expenses for any items that are not Corrective Appliances, including Orthotic Devices and/or Prosthetic Appliances, or Durable Medical Equipment as each of those terms is defined in the Definitions chapter of this document, including but not limited to swimming pools, spas, air purifiers, vehicles, elevators and exercise equipment.
    b. Expenses for replacement of **lost/missing/stolen, duplicate or personalized/characterized** Corrective Appliances, including Orthotic Devices and/or Prosthetic Appliances, or Durable Medical Equipment.
    c. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they **exceed the cost of standard models** of such appliances or equipment.
    d. Expenses for **orthopedic or corrective shoes,** or for the fitting or casting of these items.
    e. Durable Medical Equipment purchased online through the Internet.
36. **Cosmetic Services Exclusions**
    a. Expenses for surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to removal of tattoos, breast augmentation, or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. The Medical Plan **does** cover Medically Necessary Reconstructive Services, including Reconstructive Surgery and breast reconstruction after a mastectomy and medically necessary breast reduction.
    b. To determine the extent of this coverage, see the Schedule of Medical Benefits chapter of this document. Covered individuals should use the Plan's Pre-certification procedure to determine if a proposed surgery or service will be considered Cosmetic Surgery or Medically Necessary.
37. **Custodial Care Exclusions**
    a. Expenses for Custodial Care as defined in the Definitions chapter of this document, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, except when Custodial Care is provided by Home Health aides as part of a covered Hospice program.
    b. Services required to be performed by Physicians, Nurses or other skilled Health Care Providers are **not** considered to be provided for Custodial Care services, and are covered if they are determined by the Plan Administrator or its designee to be Medically Necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician, Nurse or other skilled Health Care Provider are **not covered**, even if they are Medically Necessary.
38. **Dental Services Exclusions**
    a. Expenses for **Dental Prosthetics or Dental services** (as listed in the definition of Dental in the Definitions chapter of this document) or dental supplies of any kind, even if they are necessary because of symptoms, illness or injury affecting another part of the body, except prescription drugs required for a dental purpose are payable under the Drug benefit of this Medical Plan.
    b. Expenses for Dental services may be covered under the Medical Plan **only if** they are incurred for the repair or replacement of an injury to teeth or restoration of the jaw if damaged by an external object in an accident. See Oral and Craniofacial Services in the Schedule of Medical Benefits and the Definitions chapter for additional information regarding these services.
    c. Expenses for the treatment of **Temporomandibular Joint (TMJ) Dysfunction or Syndrome**. See the Definition of TMJ Syndrome in this document. See the Dental Plan for coverage for TMJ dysfunction/syndrome.
    d. Expenses for **Orthognathic and other craniomandibular or maxillary or mandibular disorders for the treatment of Prognathism and Retrognathism and other aesthetic malposition of the bones of the jaw**, including but not limited to Orthodontia (terms are defined in the Definitions chapter), except when medically necessary as determined by the Plan Administrator or his/her designee.
    e. Expenses for **Oral Surgery** to remove impacted teeth, gingivectomies, treatment of dental abscesses, and Root Canal (Endodontic) Therapy.
    f. Expenses covered under the Dental Plan, and all expenses excluded under the Dental Plan unless coverage is specifically provided under the Schedule of Medical Benefits.
    g. Expenses submitted to the medical plan **for hospital confinement or outpatient surgery facility related to diagnosis or treatment of a dental condition** or any dental preventive services, except as determined to be medically necessary.
    h. Expenses for dental services such as removal of teeth including wisdom teeth, procedures in preparation for future dental work or dental implant (such as sinus lift, soft tissue graft, bone graft/replacement), except as approved by the Plan Administrator.

39. **Drugs, Medicines and Nutrition Exclusions**
    a. Pharmaceuticals requiring a prescription that have **not** been approved by the U.S. Food and Drug Administration (FDA); or are **not** approved by the FDA for the condition, dose, route and frequency for which they are prescribed; or are Experimental and/or Investigational as defined in the Definitions chapter of this document.
    b. Non-prescription or non-legend or over-the-counter (OTC) drugs or medicines, except as otherwise described for coverage in Schedule of Medical Benefits sections on Drugs and Medicines, Nondurable Supplies and Preventive Care Programs e.g. OTC insulin, diabetic supplies, aspirin, preventive bowel preparation medications.
    c. Foods and nutritional supplements including, but not limited to, home meals, foods, diets, vitamins and minerals except when provided during Hospitalization, and except for therapeutic vitamins requiring a prescription such as prenatal vitamins. Formula is excluded (except prescription formula that serves as the sole nutritional intake for a child or adult when prescribed by a Physician and pre-approved by the Plan Administrator).
    d. Naturopathic, naprapathic or homeopathic remedies and substances.
    e. Drugs, medicines or devices for:
        - cosmetic purposes;
        - non-prescription contraceptive products;
        - fertility and/or infertility (except if such drugs are used to treat a non-fertility condition and the drug is FDA approved/indicated for treatment of the non-fertility condition);
        - topical fluoride preparations for dental purposes;
        - hair growth and hair removal products used for cosmetic purposes (*i.e.* Propecia, Rogaine, Vaniqa);
        - drugs for anti-aging, bodybuilding/athletic enhancement or to improve physical performance including but not limited to androgen products, anabolic steroids.
    f. Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal or state law.
    g. Vaccinations, immunizations, inoculations, vitamin injections or preventive injections, except those provided by the Plan for children and/or adults (under the Well Child and Well Adult Benefits); and those required for treatment of an injury or exposure to disease or infection (such as anti-rabies, tetanus, anti-venom, or immunoglobulin or B12 for treatment of pernicious anemia). See the Well Child and Well Adult Benefits section of the Schedule of Medical Benefits.
    h. Medical marijuana, regardless of medical necessity.
40. **Durable Medical Equipment Exclusions:** Refer to the Corrective Appliances exclusion.
41. **Fertility, Genetic, Reproductive and Sexual Dysfunction Services Exclusions**
    a. Expenses for the **treatment of infertility** and complications thereof, including, but not limited to, services, drugs and procedures or devices to achieve fertility; in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, cryostorage of egg or sperm, reversal of sterilization procedures, except certain fertility diagnosis and adoption expenses as noted under Fertility in the Schedule of Benefits.
    b. Expenses for **surgical treatment of sexual dysfunction** or inadequacy, and any complications thereof.
    c. Expenses for medical or surgical treatment related to **transsexual (sex change) procedures**, or the preparation for such procedures, or any complications resulting from such procedures.
    d. Expenses related to **non-prescription prevention of pregnancy.**
    e. Expenses for **genetic services, tests and/or procedures** except when performed for the purpose of detecting, evaluating or treating chromosomal abnormalities or genetically transmitted characteristics in pregnant women (including amniocentesis, chorionic villus sampling (CVS), and alpha-fetoprotein analysis in pregnant women) and in high–risk individuals.
    f. Expenses for **elective termination of pregnancy** (abortion), unless the attending physician certifies that the health of the woman would be endangered if the fetus were carried to term or medical complications arise from an abortion.
42. **Foot Care Exclusions**
    a. Expenses for routine foot care, including but not limited to trimming of toenails, removal of corns or callouses, removal thick/cracked skin on heels, foot massage, hygienic/and preventive care (hygienic/preventive care includes cleaning and soaking of the feet, applying skin creams to help maintain skin tone and other services that are performed when there is no evidence of a localized illness, injury or symptoms involving the foot). Expenses for hand care including manicure and skin conditioning and other hygienic/preventive care performed in the absence of localized illness, injury or symptoms involving the hand, unless the Plan Administrator or its designee determines such care to be medically necessary. Routine foot care (as described above) when administered by a podiatrist is payable when medically necessary for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.
43. **Genetic Testing and Counseling Exclusions**

a. **Genetic Testing**: Expenses for genetic tests, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, including:
   - **Pre-parental genetic testing (also called carrier testing)** intended to determine if an individual is at risk of passing on a particular genetic mutation, such as a family member who is unaffected but at risk for producing affected children. **No coverage for pre-parental/carrier genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents**; and
   - **Prenatal genetic testing** intended to determine if a developing fetus is a risk for inheriting identifiable genetic diseases or traits **except** when those tests are performed in accordance with state-mandated newborn screening or tests using fluid or tissue samples obtained through amniocentesis, chorionic villus sampling (CVS), fetoscopy and alpha-fetoprotein (AFP) analysis in pregnant women.

   Genetic testing and non-covered individuals: No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the treatment of a covered individual. See the Genetic Services row of the Schedule of Medical Benefits for a description of the genetic services that are covered by the Plan.

   Plan Participants should use the Plan's Pre-certification procedure to determine if proposed Genetic Testing is covered or excluded.

b. **Genetic Counseling**: Expenses for genetic counseling are excluded in every case (except for BRCA).

44. **Hair Exclusions**
   a. Expenses for hair removal or hair transplantation and other procedures to replace lost hair or to promote the growth of hair for cosmetic purposes, for the use of Propecia, Rogaine, or Minoxidil or other Prescription/non-prescription drugs or services used to promote the growth of hair, remove hair or for hair replacement devices including, but not limited to, wigs, toupees and/or hairpieces, except that the Plan will provide benefits for a single wig, toupee or hairpiece if it is required to replace hair lost as a result of chemotherapy. See Chemotherapy in the Schedule of Medical Benefits.
45. **Home Health Care Exclusions**
   a. Expenses for any Home Health Care services other than part-time, intermittent skilled nursing services and supplies, except when the services of Home Health aides are payable as Home Health Care Services as described in the Schedule of Medical Benefits.
   b. Expenses under a Home Health Care program for services that are provided by someone who ordinarily lives in the patient's home or is a parent, spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a Physician.
   c. Expenses for a homemaker, Custodial Care, childcare, adult care or personal care attendant, except as provided as part of the Plan's Hospice coverage.
46. **Hormone Replacement Therapy**
   a. Hormone Pellets that are not FDA approved are not covered. If hormone pellet therapy is combined with an office visit and/or surgical implantation, these services will be covered as described in the Schedule of Medical Benefits, with coverage determined based on the type of provider (i.e. MD, ND) providing the services (e.g. coverage for services provided by a Naturopath will only include the office visit).
47. **Maternity/Family Planning Exclusions**
   a. **Termination of Pregnancy:** Expenses for elective induced abortion unless the attending physician certifies that the health of the woman would be endangered if the fetus were carried to term or medical complications arise from an abortion
   b. **Home Delivery Expenses:** for pre-planned home delivery services performed by a midwife who is not a Certified Nurse Midwife.
   c. Expenses for **childbirth education, Lamaze classes**.
   d. Expenses related to **cryostorage of umbilical cord blood or other tissue or organs.**
48. **Rehabilitation Therapies Exclusions (In-patient or Outpatient)**
   a. Expenses for educational, job training and/or vocational rehabilitation.
   b. Expenses for massage therapy (except massage therapy when performed by a physical therapist or Chiropractor as part of a medically necessary rehabilitation program), Rolfing and related services.
   c. Expenses incurred at an inpatient rehabilitation facility for any inpatient Rehabilitation Therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is **otherwise incapable of participating in a purposeful manner with the therapy services**, including, but not limited to coma

stimulation programs and services. Continued Hospitalization for the primary purpose of providing Passive Rehabilitation (as defined in this Plan) will not be considered to be Medically Necessary for the purposes of this Plan.

d. This plan does not provide payment for admission and confinement in an inpatient rehabilitation facility to provide rehab services to a person who currently has a cognitive deficit (that is, the person is unable to learn and remember the services being taught to them).
e. Expenses for Maintenance Rehabilitation as defined in the Definitions chapter of this document.
f. Expenses for speech therapy for functional purposes including, but not limited to, stuttering, stammering and conditions of psychoneurotic origin, except as provided under the Rehabilitation section of the Schedule of Medical Benefits.
g. Expenses for treatment of delays in childhood speech development unless as a direct result of an injury, surgery or result of a covered treatment.

49. **Sexual/Erectile Dysfunction Services Exclusions**
    a. Sex Change Counseling, Therapy and Surgery: Expenses for medical, surgical or prescription drug treatment related to transsexual/gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.
50. **Transplantation (Organ and Tissue) Exclusions**
    a. Expenses for human organ and/or tissue transplants that are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplantation, post-operative services and drugs or medicines, and all complications thereof, except those transplantation services noted under the Transplantation Services section of the Schedule of Medical Benefits.
    b. Expenses related to nonhuman (Xenografted) organ and/or tissue transplants/implants, except heart valves/skin grafts.
    c. Expenses for insertion and maintenance of an artificial organ or related device, and all complications thereof, except artificial heart, heart valves and kidney dialysis.
    d. Expenses related to the donor of any organ or tissue for transplantation, including but not limited to donor screening, donor organ or tissue removal, donor procurement fees, donor organ or tissue transport charges, except when the donor is donating to a person whose transplantation is covered under this Plan. Refer to the Transplantation section of the Schedule of Medical Benefits.
51. **Vision Care Exclusions**
    a. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK) and Automated Lamellar Keratoplasty (ALK), Photorefractive Keratectomy (PRK), corneal ring implants and Laser Assisted In Situ Keratomileusis (LASIK).
    b. Expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies, except one pair of eyeglasses or contact lenses provided as a Prosthetic device following lens extraction surgery. See also the separate Vision Plan in another chapter of this document.
    c. Vision therapy (orthoptics) and supplies.
52. **Weight Management and Physical Fitness Exclusions**
    a. Expenses for medical or surgical treatment of obesity, including, but not limited to, gastric restrictive procedures, intestinal bypass and reversal procedures, weight loss programs, dietary instructions, and any complications thereof, **except** that the Plan will cover bariatric (weight loss) surgery for adult participants as outlined in the Schedule of Medical Benefits. Note however that the Plan **does not** pay for post-weight loss skin reduction surgery/treatment. See the Weight Management row in the Schedule of Medical Benefits for more information.
    b. Expenses for medical or surgical treatment of severe underweight, including, but not limited to high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with Medically Necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by Physicians to determine normal body weight.
    c. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility or exercise equipment for physical fitness.

IN-NETWORK AND NON-NETWORK SERVICES – MEDICAL PLAN

You may select your medical doctor(s) or Behavioral Health Providers from one of the Network Providers or you may go to an out-of-network (Non-Network) provider of your choice. The amount of benefits paid is determined by the provider chosen. There are two networks available under this Plan:

- A network for plan participants who live in Arizona; and
- A network for plan participants who do not live in Arizona

The two different networks are listed on the Quick Reference Chart in the front of this document under In-State Medical Plan and Out-of-State (OOS) Medical Plans, respectively.

IN-NETWORK SERVICES

In-Network Health Care Providers have agreements with the Plan's Preferred Provider Organizations (PPO) under which they provide health care services and supplies for a favorable negotiated fee for Plan participants. When a Plan Participant uses the services of an In-Network Health Care Provider, except with respect to any applicable Deductible, the Plan Participant is responsible for paying the applicable Coinsurance or Copay for Medically Necessary services or supplies. The In-Network Health Care Provider generally deals directly with the Plan for any additional amount due.

Preferred Providers are PPO Providers (hospitals, physicians, behavioral health providers and other ancillary medical vendors) that have agreed to a special reduction in fees to the network subscribers. Use of a preferred provider will result in the greatest discount to both you and the Plan. Preferred providers will accept payment from the plan as payment in full less any applicable deductible, coinsurance or copay that is your responsibility. The plan pays the rest.

Preferred providers may not seek additional reimbursement from you for the difference between their billed charges and the contracted amount that is allowed by this Plan for covered services (the Allowed or Contracted Charge).

In-State (Arizona) Medical Plan: Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross Blue Shield Association, provides network access only and does not provide administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. **No provider network access is available from Blue Cross Blue Shield of Arizona outside of Arizona, for In-State medical plan members**.

NON-NETWORK SERVICES

Non-Network Health Care Providers (also called out-of-network providers, Non-PPO) have no agreements with the PPO or the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will reimburse the Plan Participant for the Allowed or Contracted Charge (as defined by this Plan) for any Medically Necessary covered services or supplies, subject to the Plan's Deductibles, Coinsurance, Copayments, Limitations and Exclusions. Plan Participants must submit proof of claim before any such reimbursement will be made.

- **IMPORTANT NOTE: Non-Network Health Care Providers may bill you for any balance that may be due in addition to the amount payable by the Plan**.

MEDICAL COVERAGE FOR OUT-OF-STATE MEMBERS (OOS MEDICAL PLAN)

The Plan has contracted with a third party administrator (Appropriate Claims Administrator) listed in the Quick Reference Chart in the Introduction chapter of this document, to provide an out-of-state network for employees and retirees **that live most of the year outside the state of Arizona (or who have at least one covered family member who lives most of the year outside the state of Arizona). These out-of-state network and Plans are not for members who are temporarily traveling outside the state.** For Out-of-State Plan members and/or families who use a network provider (either in Arizona or another state), the Plan will reimburse the Plan Participant at the in-network benefit structure for the plan selected. For Out-of-State Plan members and/or families that use a non-network provider (either in Arizona or another state), services will be processed as out-of-network. **If the City of Mesa is your primary or only carrier**, the provider needs to submit the claim to the address listed in the Quick Reference Chart in the Introduction chapter of this document. **If the City of Mesa is your secondary carrier,** the provider needs to submit the claim to the primary carrier first. After the primary insurance has processed the claim, send the itemized bill with the primary carrier's Explanation of Benefits to the Appropriate Claims Administrator for the OOS Medical Plan at the address listed in the Quick Reference Chart in the Introduction chapter of this document.

EXCEPTIONS TO NORMAL PLAN REIMBURSEMENT FOR NON-NETWORK PROVIDERS

There are three exceptions to the Plan's payment for Non-Network Providers:

* Reason for Non-PPO Provider Use	What the Plan Pays
1. The patient had a medical emergency inside or outside the PPO service area.	The in-network benefit allowed according to the Schedule of Medical Benefits.
2. The patient had to use a non-PPO provider because there was no Preferred PPO provider who could perform the required service as determined by Utilization Management.	The in-network benefit allowed according to the Schedule of Medical Benefits.
3. The patient had no knowledge or choice of ancillary services provided by non-PPO provider(s) in conjunction with elective primary services provided by Preferred PPO provider(s)*	The in-network benefit allowed according to the Schedule of Medical Benefits

* For example, if you have an elective surgical procedure, please note that is your responsibility to ensure that ALL providers involved (such as the surgeon, anesthesiologists, assistant surgeons) and the facility, are in-network providers. However, if ancillary service providers are non-PPO providers and you have no control over ancillary provider selection (e.g. selection of an anesthesiologist, nurse anesthetist, assistant surgeon, etc.), your claim for these ancillary service providers can be adjudicated at in-network benefit levels.

UTILIZATION MANAGEMENT (UM) – MEDICAL PLAN

PURPOSE OF THE UTILIZATION MANAGEMENT (UM) PROGRAM

The Plan is designed to provide you and your covered family members with financial protection from significant health care expenses. New medical technology innovation and development and the **ever-increasing cost of providing health care, may make it difficult for the City to continue to afford the cost of maintaining the Plan.** As a result, the Plan has adopted a Utilization Management Program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the City is better able to afford to maintain the Plan and all its Benefits. If you follow the procedures of the Plan's Utilization Management Program, you may avoid some out-of-pocket costs. However, **if you don't follow these procedures, your Plan may not pay Benefits, and you'll be responsible for paying more out of your own pocket.**

The Plan's Utilization Management Program consists of:

1. **Pre-certification (pre-service) Review:** Review of proposed health care services **before** the services are provided;
2. **Concurrent (Continued Stay) Review:** Ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a Hospital or Specialized Health Care Facility;
3. **Second and Third Opinions:** Consultations and/or examinations designed to take a second, and, when required, a third look at the need for certain Elective health care services;
4. **Retrospective Review:** Review of health care services **after** they have been provided; and
5. **Case Management:** A process whereby the patient, the patient's family, Physician and/or other Health Care Providers, and the City work together under the guidance of the Plan's independent Utilization Management Companies to coordinate a quality, timely and cost-effective treatment plan. Case Management services may be particularly helpful for patients who require complex, high-technology medical services and who may therefore benefit from professional assistance to guide them through the maze of choices of health care services, providers and practices.

MANAGEMENT OF THE UM PROGRAM

The Plan's Utilization Management Program is administered by independent, professional Utilization Management Companies (hereafter referred to as the UM Company) operating under administration contracts with the Plan. The UM Company may be an affiliate or division of the respective Appropriate Claims Administrators for In-state and Out-of-State Medical plans (or may be under a separate administration contract with the Plan). The names and phone numbers of the UM Company that applies to your Plan are listed on the Quick Reference Chart in the Introduction chapter of this document. (Certain classes of prescription drugs must also be pre-certified. You or your doctor can do this by calling the Prescription Drug Program, whose phone number is listed on the Quick Reference Chart in the front of this document).

The health care professionals in the UM Company focus their review on the necessity and appropriateness of Hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the Plan, the UM Company has been given discretionary authority by the Plan Administrator to determine if a course of care or treatment is Medically Necessary with respect to the patient's condition and within the terms and provisions of this Plan.

VERY IMPORTANT INFORMATION ABOUT RESTRICTIONS & LIMITATIONS OF THE UM PROGRAM

1. The fact that a Physician recommends Surgery, Hospitalization, confinement in a Specialized Health Care Facility, or that your Physician or other Health Care Provider proposes or provides any other medical services or supplies, doesn't mean that the recommended services or supplies will be considered Medically Necessary for determining coverage under the Medical Plan.
2. The Utilization Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan Benefits. The UM Company's certification that a service is Medically Necessary doesn't mean that a Benefit payment is guaranteed. Eligibility for and actual payment of Benefits are subject to the terms and conditions of the Plan as described in this document. For example, Benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.
3. All treatment decisions rest with you and your Physician (or other Health Care Provider). You should follow whatever course of treatment you and your Physician (or other Health Care Provider) believe to be the most appropriate, even if the UM Company does not certify a proposed Surgery or other proposed medical treatment as Medically Necessary; or the Plan will not pay regular Plan Benefits for a Hospitalization or confinement in a Specialized Health Care Facility because the UM Company does not certify a proposed confinement;
4. The Benefits payable by the Plan may, however, be affected by the determination of the UM Company.

5. With respect to the administration of this Plan, the Employer, the Plan and the UM Company are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the UM Company as Medically Necessary, or for the results if the patient chooses not to receive health care services that have not been certified by the UM Company as Medically Necessary.

PRE-CERTIFICATION (PRE-SERVICE) REVIEW

Pre-certification Review is a procedure, administered by the Utilization Management (UM) Company, to assure that the admission and length of stay in a Hospital or Specialized Health Care Facility, Surgery, and other health care services (including certain invasive procedures, sleep studies, Durable Medical Equipment exceeding $1,000, to name a few) are Medically Necessary.

The UM Company's medical staff use established medical standards to determine if recommended Hospitalizations, confinements in Specialized Health Care Facilities, Surgery and/or other health care services meet or exceed accepted standards of care. See the Section titled Very Important Information About Restrictions and Limitations of the Utilization Management Program in this chapter.

WHO IS RESPONSIBLE FOR PRE-CERTIFICATION?

Under this Plan, the plan participant (employee, retiree or spouse) is responsible to properly pre-certify the services requiring pre-approval, on behalf of themselves or their covered family members, including children. While the physician's or provider's office may provide the Utilization Management company with specific medical or surgical information related to a case, **it is ultimately the plan participant's responsibility to assure that the pre-certification process has been completed**.

WHAT SERVICES MUST BE PRE-CERTIFIED? (i.e. reviewed and approved before they are provided or covered)

The following must be pre-certified by the UM Company contracted to provide these services to the medical plan in which the participant is enrolled. Note: this list may not be all inclusive of all services requiring pre-certification, and services are considered for coverage subject to medical necessity. This list is subject to change:

1. No pre-certification is required for a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery, or ninety-six (96) hours or less for a cesarean delivery (although **notification** of the admission to the Utilization Management Company within 48 hours, is preferred); pre-certification is required for lengths of stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a Cesarean delivery (C-section).
2. No pre-certification is required for Chemotherapy/Radiation treatment, but members may choose to notify the UM Company in advance of, or during the course of receiving services in order to access Case Management or Disease Management services.
3. **Inpatient, elective, non-emergency Hospital** admissions and **Behavioral Health admissions** (including day-treatment rehabilitation facility or program); **emergency admissions** do not require pre-certification but **must be notified** to the UM Company **within forty-eight (48) hours** after the admission.
4. **Outpatient surgery or procedures** (excluding surgeries/procedures rendered in a physician's office and excluding certain diagnostic procedures like endoscopy services, regardless of where performed) but including any Specialized Health Care Facility services:
   - **Free-standing or hospital-based surgery center/facility**
   - **Hospice** (home and facility based)
   - **Skilled Nursing Facility (SNF)**
   - **Sub-Acute Facility**
   - **Long-term Acute Care Facility**
5. **Home Health Care** and **Home Infusion Services** (including Skilled Nursing)
6. **Newborn stays beyond the mother**
7. **OB related admissions (i.e. complications)**
8. **Genetic Testing for high-risk pregnancies e.g. women >35**
9. **Durable Medical Equipment (DME) with an estimated cost over $1,000 per piece of equipment**
10. **Transplantation services**
11. **Bariatric (Weight Management) Surgery**
12. Partial/Intensive outpatient **Behavioral Health/Substance Abuse Therapy**
13. **Applied Behavioral Analysis (ABA) Therapy/Therapeutic Behavioral Therapy (TBT)** for Autism Spectrum Disorders (ASD)
14. Outpatient **Physical/Occupational/Pulmonary/Music/Speech Therapy** (except PT provided by Chiropractor during first 25 visit annual limitation)
15. **Chiropractic Spinal Manipulation** services **beyond 25 visits** per person per year

16. Non-emergency **Ambulance Transport**
17. **Cochlear Implants**
18. **Pain Management** treatments
19. **Sleep Studies**
20. **Synagis** shots
21. **Testosterone** Treatments

NOTE: Certain classes of prescription drugs must be pre-certified (Prior Authorization) or are subject to Step Therapy or Quantity Limitations by the Prescription Drug Program as noted under Drugs and Medicines in the Schedule of Medical Benefits.

How to Request Pre-certification from the UM Company:
You or your Physician must call the UM Company contracted with the medical plan in which you or the patient is enrolled, at the telephone number shown in the Quick Reference Chart in the Introduction chapter of this document. Calls for Elective services should be made at least **7 days** before the expected date of service.

Emergency Admissions must be **notified** within 48 hours after the admission (see below). Calls to the UM Company may be made 24 hours/day, 7 days/week. If you are not sure whether a procedure needs to be pre-certified, call the UM Company.

The caller should be prepared to provide all of the following information:
1. the employer's name;
2. the employee's name, address, phone number and insured identification number;
3. the patient's name, address, and phone number (if different from the employee)
4. the Physician's name, address, phone number;
5. the name of any Hospital, Specialized Health Care Facility or any other Health Care Provider that will be providing services along with the reason for the health care services or supplies; and
6. the proposed date for performing the services or providing the supplies.

If additional information is needed, the UM Company will advise the caller. The UM Company will review the information provided, and will let you, your Physician and the Hospital, Specialized Health Care Facility, any other Health Care Provider, and the Appropriate Claims Administrator know whether or not the proposed health care services have been certified as Medically Necessary. The UM Company will usually respond to your treating Physician or other Health Care Provider by telephone within 3 working days after it receives the request and any required medical records and/or information, and its determination will then be confirmed in writing.

Appeal of a Denial of Pre-certification from the UM Company
See the Claims and Appeal chapter for details on how to appeal and the timeframes for appealing a UM decision.

CONCURRENT (CONTINUED STAY) REVIEW BY THE UM COMPANY

How Concurrent (Continued Stay) Review Works: When you are receiving medical services in a Hospital or Specialized Health Care Facility, the UM Company contracted to provide these services to the medical plan in which the participant is enrolled, may contact your Physician or other Health Care Providers to assure that continuation of medical services is Medically Necessary and help coordinate your medical care with the Benefits available under the Plan. Concurrent Review may include such services as:
1. coordinating Home Health Care or the provision of Durable Medical Equipment;
2. assisting with discharge plans;
3. determining the need for continued medical services; and/or
4. advising your Physician or other Health Care Providers of the various options and alternatives available under this plan for your medical care.

No Benefits will be paid for any charges related to days of confinement to a Hospital or other Specialized Health Care Facility that have not been determined to be Medically Necessary by the UM Company.

Appeal of a Denial of a Concurrent Review:
See the Claims and Appeal chapter for details on how to appeal and the timeframes for appealing a UM decision.

EMERGENCY HOSPITALIZATION
If an Emergency requires Hospitalization, there may be no time to contact the UM Company before you are admitted. If this happens, the **UM Company must be notified of the Hospital admission within 48 hours**. Your Physician, the facility, a family member or friend can make that phone call. This will enable the UM Company to assist with discharge plans, determining the need for continued medical services, and/or advising your Physician or other Health Care Providers of the various recommendations, options and alternatives for your medical care, under this plan.

PREGNANCIES

It is recommended but not required, that pregnant women notify the UM Company as soon as possible once they know they are pregnant.

SECOND AND THIRD OPINIONS

How the Second and Third Opinion Process Works: At any time during the review process, you may be asked by the UM Company contracted to provide these services to the medical plan in which the participant is enrolled to obtain a Second Opinion about a proposed health care service to help determine if the health care service is Medically Necessary, or if an alternative effective approach to the individual patient's health care management exists. A Second Opinion may be requested when it appears that:

1. there may be a question regarding the effectiveness or reliability of a proposed service;
2. the proposed service involves a high risk in relation to the anticipated benefit; or
3. there appear to be conflicting diagnoses, vague indications, or questions concerning clinical management.

If a Second Opinion is required, the UM Company will arrange for an examination by a Physician who:

1. is certified by the American Board of Medical Specialists in the field related to the proposed service;
2. is independent of the Physician who proposed the service.

The Second Opinion Physician may review past medical records along with clinical findings from his or her own examination of the patient, and will report his or her findings to the UM Company. If the Second Opinion recommendation differs from the treating Physician's recommendation, you may be required to obtain a Third Opinion from another Physician who will be selected in the same manner as the Second Opinion Physician. The results of the Third Opinion will be reviewed by the UM Company, and the recommendation of the majority of the Physicians (the attending Physician, and the Second and Third Opinion Physicians) will prevail.

If, as a result of the Second and/or Third Opinion, it is determined that the procedure recommended by the treating Physician is not Medically Necessary, **no Benefits will be payable if you choose to undergo the procedure**. See also the section titled Failure to Follow Required Utilization Management Procedures.

Cost of the Second and Third Opinions: The Plan will pay the full cost for any Second and Third Opinion required by the UM Company.

Appeal of a UM Required Second or Third Opinion That Disagrees with a Recommended Procedure: If the UM required Second or Third Opinion disagrees with the procedure recommended by the treating Physician, and the disagreement cannot be resolved by discussion between the treating and reviewing Physicians, you and/or your Physician may submit a written appeal of the decision, accompanied by any additional information to support the need for the proposed health care service.

The appeal, with supporting information, should be sent to the UM Company at the office or to the fax number shown in the Quick Reference Chart in the Introduction chapter of this document. The UM Company will respond in writing within 30days after it receives the request and any required medical records and/or information.

Patient-Requested Second and Third Opinions: If the UM Company does not require a Second Opinion, but you or your covered Dependent would like one, you or your covered Dependent may get the Second (or Third) Opinion from any Physician and it will be covered in accordance with the Schedule of Medical Benefits for Physician services and applicable deductible, coinsurance/copay will apply. Voluntary Second or Third Opinions are not subject to appeal processes under the plan.

RETROSPECTIVE REVIEW BY THE UM COMPANY

All claims for medical services or supplies that have not been reviewed under the Plan's Pre-certification, Concurrent (Continued Stay) Review, or Second and Third Opinion Programs may be subject to retrospective review, at the option of the Appropriate Claims Administrator, to determine if they are Medically Necessary. If the Appropriate Claims Administrator determines that the services or supplies were not Medically Necessary, **no Benefits will be provided by the Plan for those services or supplies.** After your Claim has been processed, you may request a review of the Claim decision. **For complete information on Claim Review, see the Claim Information chapter of this document.**

CASE MANAGEMENT

How Case Management Works: Case Management is a process, administered by the UM Company contracted to provide these services to the medical plan in which the participant is enrolled. Its medical professionals work with the patient, family, care-givers, Health Care Providers, Appropriate Claims Administrator and Employee Benefits Administration as necessary, to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers. See also the section titled Failure to Follow Required Utilization Management Procedures in this chapter.

Working with the Case Manager: Any Plan Participant, Physician or other Health Care Provider can request Case Management services by calling the UM Company at the telephone number shown in the latest version of the Quick Reference Chart in the Introduction chapter of this document. However, in most cases, the UM Company will be actively searching for those cases where the patient could benefit from Case Management services, and it will initiate Case Management services automatically.

The Case Manager of the UM Company will work directly with your Physician, Hospital, and/or other Specialized Health Care Facility to review proposed treatment plans and to assist in coordinating services and obtaining discounts from Health Care Providers as needed. From time to time, the Case Manager may confer with your Physician or other Health Care Providers, and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services.

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

FAILURE TO FOLLOW REQUIRED UM

If you do not follow the Pre-certification Review, Concurrent (Continued Stay) Review, or Case Management procedures, if you fail to obtain a required Second or Third Opinion, or if you undergo a medical procedure that has not been determined to be medically necessary, **claims for these services may be denied.**

DISEASE MANAGEMENT PROGRAM (DM) – MEDICAL PLAN

PURPOSE OF THE DISEASE MANAGEMENT (DM) PROGRAM

Each of the City's medical plans provide Disease Management (DM) programs that are voluntary, individual, education, information, coaching and support services (mail, telephonic and certain online resources) for covered employees/retirees and eligible dependents. DM programs and services do not replace the participant's physician-patient relationships. They are designed to complement the relationship and reinforce the treatment plan of care established by the participant and the physician. All Personal Health Information obtained, used or disclosed in the DM program is highly confidential, will be kept confidential as required by law, and shall not be improperly used or disclosed.

DM programs assist participants who have chronic disease states, high risk pregnancy or other complex health status, to understand and take control of their medical condition and ultimately improve their quality of life. DM participants can be proactive about care and treatment options, knowledgeable and adherent to provider and pharmacy recommendations and, as a result, reduce the risk of complications and worsening health conditions wherever possible. This not only improves the participant's quality of life but has the potential to reduce both participant and Plan health care costs over the long term.

See the Quick Reference Chart in the Introduction section of this document for the Disease Management Administrator available for each medical plan. A health coach, who is a registered nurse, educates the participant in self-management of their condition as well as communicating with health care providers (with the patient's permission) to complement and reinforce treatment plans and other services. Participants may either self-refer into a Disease Management program or may be invited to participate based upon demographic, medical and prescription drug claims information that is submitted to the Plan. In addition to a Maternity Program, here are some examples of chronic disease states that have a DM program available:

- Asthma
- Hypertension
- Hyperlipidemia (high cholesterol and/or triglycerides)
- Chronic Back Pain
- COPD
- Cardiac/Stroke
- Diabetes
- Weight Management

Regardless of whether or not there is a DM program specifically designed for your condition, you may benefit from contact with DM nurses who can provide information and resources individualized to your needs.

EMPLOYEE ASSISTANCE PROGRAM (EAP) BENEFITS

These EAP benefits are treated as a standalone (or excepted) benefit under Health Care Reform (PPACA).

THE EMPLOYEE ASSISTANCE PROGRAM (EAP)

This section describes the Employee Assistance Program (EAP) benefits available to all employees, COBRA continuation members, retiree medical plan participants during the first 18 months after retirement, and all their dependents/household members.

The Employee Assistance Program (EAP) provides **confidential counseling and referral services at no charge to the member up to a maximum of eight (8) visits per person, per issue, per year**. The EAP program also offers a comprehensive website and customer service call center that includes legal, financial, ID theft, eldercare and childcare resources and a host of other work-life research and referral resources; telephone and internet chat consultations with legal, financial, eldercare and childcare specialists. The legal consultation includes a free 30-minute evaluation appointment and a 25% discount if a local network lawyer is selected.

The EAP is an employer-paid benefit for employees and their household members, that is designed to help you and your family members with personal problems and work-life research and referral issues. Counseling is short-term and confidential. All counseling and referral services are offered at no charge to you or your covered household members.

To receive services, please contact the Employee Assistance Program provider shown in the Quick Reference Section of this Plan Document.

All employees are eligible to use the services offered by the EAP immediately upon becoming employed by the City of Mesa. Household members are also eligible and **do not have to be enrolled** in one of the City's medical plans in order to make an appointment with one of the counselors.

Behavioral Health benefits for extended behavioral health care are available to individuals (employees, retirees and their covered family members) enrolled in one of the Medical plans offered by the City, and are described in the Behavioral Health section of the Schedule of Medical Benefits in this document.

DENTAL PLAN BENEFITS

These self-insured Dental Plan benefits are treated as a standalone (or excepted) benefit under Health Care Reform (PPACA).

Dental Plan Options: The City offers three Dental Plan Options to plan enrollees, described below. You and all your family members who are enrolled for dental coverage must all be enrolled in the same plan option.

- **Dental Choice Plan:** This plan option is a deductible and coinsurance plan allowing you to use any dental provider for preventive, basic and major restorative dental services. No coverage for orthodontia.
- **Dental Choice Plus Plan**: This plan option is a deductible and coinsurance plan allowing you to use any dental provider for preventive, basic and major restorative dental services along with coverage for orthodontia.
- **Preventive Choice Plan**: This plan option is a deductible and coinsurance plan allowing you to use any dental provider for preventive and basic restorative dental services only. No coverage for major dental services or orthodontia.

All Dental Plan Options have a PPO dental network benefit available. You may continue to use any dental provider of your choice, but if your provider is part of the contracted PPO dental network you may experience a discount for all services and not have any balance billing for the difference if any, between billed charges and allowed discounted charges. See the Quick Reference Chart in the Introduction chapter of this document for information about the PPO Dental Network and Appropriate Claims Administrator.

Covered Dental Expenses: You are covered for expenses you incur for most, but not all, dental services and supplies provided by a Dental Care Provider (as defined in the Definitions chapter of this document) that are determined by the Plan Administrator or its designee to be "**Medically Necessary,"** but only to the extent that the Plan Administrator or its designee determines that the services are the most cost effective ones that meet acceptable standards of dental practice and would produce a satisfactory result; and the charges for them are "Allowed or Contracted Charges**."** See the Definitions chapter of this document for the definitions of "Medically Necessary" and "Allowed or Contracted Charge."

Non-Eligible Dental Expenses Explained: The Plan will not reimburse you for any expenses that are not Eligible Dental Expenses, including any services received prior to the individual's effective date for dental coverage. That means you must pay the full cost for all expenses that are not covered by the Plan, as well as any charges for Eligible Dental Expenses that exceed the amount determined by the Plan to be an Allowed or Contracted Charge.

This chapter of the document explains which expenses for dental services and supplies are covered (i.e., which are Eligible Dental Expenses) and which are not. Generally, the Plan will not reimburse you for all Eligible Dental Expenses. Usually, you will have to satisfy some **Deductible** and pay some **Coinsurance** toward the amounts you incur that are Eligible Dental Expenses.

DEDUCTIBLES

Dental Deductible for Individual and Family: Each calendar year, you are responsible for paying all your Eligible Dental Expenses classified as Restorative treatment, until you satisfy the annual Deductible. Then, the Dental Plan begins to pay benefits. There are two types of Deductibles: Individual and Family.

- The Individual Deductible is the maximum amount one covered person has to pay before Plan benefits begin. **The Plan's Individual Dental Deductible is $50.**
- The Family Deductible is the maximum amount that a family of three or more has to pay before Plan benefits begin. **The Plan's Family Dental Deductible is $150.** If you have a family and there are less than three eligible members in your family, each individual must meet his/her individual deductible before benefits will be paid. If however, your family includes more than three eligible members, your family deductible will be based on expenses for all eligible family members with no more than $50 applied to any one individual.

Eligible Dental Expenses incurred for Preventive (and, where applicable, Orthodontia) Services **ARE NOT** subject to the Dental Deductible.

COINSURANCE

Coinsurance Explained: Once you've met your annual Deductible, the Plan pays a percentage of the Eligible Dental Expenses, and you are responsible for paying the rest. The applicable percentage paid by the Plan is shown in the Schedule of Dental Benefits. The part you pay is called the Coinsurance. Eligible Dental Expenses incurred for Preventive Services are not subject to Coinsurance (but in some cases may contribute to Annual Maximum Dental Plan Benefit amounts).

OUT-OF-POCKET EXPENSES

Out-of-Pocket Expenses You Are Responsible for Paying Yourself: Under this Plan, each calendar year, you will be responsible for paying, out of your pocket, the following expenses for dental services and supplies:

1. Your Individual or Family Deductible.
2. Any applicable Coinsurance, subject to the Overall and/or Annual Maximum Dental Plan Benefits shown below.
3. All expenses for dental services or supplies that are **not** covered by the Plan.
4. All charges in excess of the Allowed or Contracted Charge (for non-network providers) determined by the Appropriate Claims Administrator.

MAXIMUM PLAN BENEFITS

- **Annual Maximum Dental Plan Benefits:** The maximum annual dental plan benefit payable for dental expenses for any individual is displayed on the Schedule of Dental Benefits and varies according to the Dental Plan you choose. Some Preventive Dental Services are not subject to the annual maximum Dental plan benefits (see the Schedule of Dental Benefits for details).
- **Overall Lifetime Maximum Orthodontia Plan Benefits**: The Overall "Lifetime" Maximum Plan Benefits payable for Orthodontia services under this Plan is $3,000, while the Annual Maximum Plan Benefit for Orthodontia is $1,500.

GUIDELINES ON PLAN PAYMENT IF DENTAL COVERAGE ENDS (Extension of Dental Benefits)

If dental coverage ends, this Plan will continue to pay Dental Plan benefits (but not orthodontia benefits) for you or your covered dependents **only for certain conditions** noted below:

1. A Prosthesis (such as a bridge or full or partial Denture), if the Dentist took the impressions and ordered the prosthesis prior to termination under the dental plan AND delivers and installs the device within 30 days after coverage ends.
2. A Crown/Implant, if the Dentist prepared the Crown/Implant while you were covered and installs it within 30 days after coverage ends.
3. Root canal treatment, if the Dentist opened the tooth while you were covered and completes the treatment within 30 days after coverage ends.

These extended dental benefits do NOT apply to orthodontia services.

See also the section on Continuation of Coverage (COBRA) for information on how to continue dental coverage when eligibility under the Dental Plan ceases.

SCHEDULE OF DENTAL BENEFITS

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

SCHEDULE OF DENTAL BENEFITS

This table explains what the Plan pays. All benefits are determined according to Allowed or Contracted Charge allowances and PPO Network Discounted Charges as defined in this document. See the Definition and Exclusions chapters of this document for important information on Plan benefits. ***IMPORTANT: Non-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Dental Choice	Dental Choice Plus	Preventive Choice Plan
Annual Maximum Payable for Dental Services		$1,700 per person per calendar year	$2,000 per person per calendar year	$700 per person per calendar year
Dental Plan Deductible per Calendar Year		$50/person $150/family (applies to Basic & Major Restorative services only)		
Preventive Services • Preventive Oral examination. • Prophylaxis (cleaning of the teeth). • Bitewing x-rays and Full mouth x-rays. • Topical application of sodium or stannous fluoride*. • Application sealants (under age 19)* • Examination in connection with emergency palliative treatment**.** • Examination for consultation purposes**.** * *These services apply toward the Annual Maximum Dental Plan benefits.*	• **Preventive services are NOT subject to the Annual Maximum Plan Benefits except where marked with an asterisk*.** • Preventive Oral examination is limited to twice per calendar year. • Prophylaxis, scaling, cleaning and polishing is limited to twice per calendar year. • Bitewing x-rays are limited to twice per calendar year. • Full mouth or Panoramic x-rays limited to once in a period of 36 consecutive months.	100% of Allowed Charges, no deductible	100% of Allowed Charges, no deductible	100% of Allowed Charges, no deductible
Orthodontia Services • Necessary services related to an active course of orthodontia treatment including diagnosis, evaluation and pre-care. • The initial installation of orthodontic appliances for an active course of orthodontia treatment. • Adjustment of active orthodontia appliances. • This orthodontia benefit is for non-surgical services provided to correct malocclusion (alignment of the teeth and or jaws) that significantly interferes with their function. • Expenses related to orthodontia will be covered only when one or more of the conditions noted to the right have been satisfied.	• Orthodontia services are subject to Annual and Overall Lifetime Maximum Dental Plan benefits. • Payment for orthodontia benefits will **not continue** if treatment ceases **for any reason**. Repair of orthodontia appliances is **not covered**. • **Orthodontia treatment that is started before the patient's effective date with the City of Mesa Health Plan is not reimbursable under this Plan option**.	Not covered	80% of Allowed Charges, no deductible • Maximum payable is $1,500/year • Maximum payable is $3,000 per lifetime.	Not covered
Basic Restorative Services • Tooth extractions. • Amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration for decayed or broken teeth.		80% of Allowed Charges, after deductible	80% of Allowed Charges, after deductible	80% of Allowed Charges, after deductible

SCHEDULE OF DENTAL BENEFITS

This table explains what the Plan pays. All benefits are determined according to Allowed or Contracted Charge allowances and PPO Network Discounted Charges as defined in this document. See the Definition and Exclusions chapters of this document for important information on Plan benefits. ***IMPORTANT: Non-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	Dental Choice	Dental Choice Plus	Preventive Choice Plan

Major Restorative Services
• Dental x-rays for diagnosis of a dental condition.
• Injection of necessary antibiotic drugs by attending Dentist.
• Space maintainers.
• Periodontal prophylaxis and treatment of periodontal and other diseases of the gums and supporting structures of the mouth (gingiva and/or alveolar bone).
• Occlusal adjustment.
• Oral surgery, including extractions and surgical procedures.
• Administration of general anesthesia and/or intravenous sedation only in connection with covered oral surgery services. Administration of local anesthesia in connection with covered dental services.
• Endodontic treatment, including root canal therapy.
• Implantology - artificial root structures placed into the jaw to support bridgework, crowns or dentures
• Onlays and crowns, including repair or re-cementing of crowns, inlays or onlays.
• Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace natural teeth that were extracted.
• Dentures and cast inlays, including adjusting, relining or re-basing of removable dentures. Replacement of an existing partial or full removable denture or fixed bridgework; addition of teeth to an existing partial or removable denture; bridgework to replace extracted teeth if evidence, satisfactory to the Plan Administrator or its designee, is presented that the conditions shown to the right have been satisfied
• Precision/semi-precision attachments for prosthetic devices.
• Gold restorations if teeth cannot be restored with other materials.
• Treatment of Temporomandibular Joint Syndrome/Dysfunction (TMJ). See also TMJ treatment in the Medical Plan.
• Expenses for dental services or appliances to stabilize tooth structure lost by wear or bruxism (clenching/grinding of teeth) and devices for harmful habits such as thumb-sucking.
	• Restorative services are **subject to Annual Maximum Plan Benefits.**
	• Oral surgery is limited to removal of impacted teeth or as necessary for teeth covered partially or totally by bone, root canal treatment or gingivectomy.
	• Laboratory services, including cultures necessary for diagnosis and/or treatment of a specific dental condition are NOT covered under this dental plan. Contact your medical plan to determine if such services are reimbursable under a medical plan.
	• Outpatient prescription drugs and medicines prescribed by a Dentist are NOT payable under this dental plan. Contact your medical plan to determine if such services are payable under a medical/prescription drug plan.
	• For replacement of an existing partial or full removable denture, the following applies
	  • The replacement or addition of teeth is necessary to replace one or more teeth extracted after the existing denture or bridgework was installed.
	  • The existing denture or bridgework cannot be made serviceable and was installed at least 3 years prior to the replacement date.
	  • The existing denture is an immediate temporary denture replacing one or more natural teeth. Replacement by a permanent denture is required. The replacement must take place within 12 months from the placement of the temporary denture.
	  • The replacement is due to accidental injury requiring oral surgery and the replacement takes place within 3 years of the accident.
		80% of Allowed Charges, after deductible	80% of Allowed Charges, after deductible	Not covered

DENTAL PLAN EXCLUSIONS

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

1. **Analgesia, Sedation, Hypnosis, etc.:** Expenses for analgesia, sedation, hypnosis, nitrous oxide and/or related services provided for apprehension or anxiety, except when approved by the Plan Administrator for use of nitrous oxide on children with complex dental and oral surgical procedures.
2. **Bacteriologic studies and susceptibility testing** for dental caries (cavities) not covered.
3. **Cosmetic Services:** Expenses for dental Surgery or dental treatment for cosmetic purposes, as determined by the Plan Administrator or its designee, including but not limited to veneers and facings. However, the following will be covered if they otherwise qualify as covered dental expenses and **are not covered** under your Medical Expense Coverage:
   - Reconstructive dental Surgery when that service is incidental to or follows Surgery resulting from trauma, infection or other diseases of the involved part;
   - Surgery or treatment to correct deformities caused by sickness;
   - Surgery or treatment to correct birth defects outside the normal range of human variation;
   - Reconstructive dental Surgery because of congenital disease or anomaly of a covered Dependent Child that has resulted in a functional disorder;
4. **Costs of Reports, Bills, etc.:** Expenses for preparing dental reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken appointments, telephone calls and/or photocopying fees.
5. **Drugs and Medicines:** Expenses for outpatient prescription drugs and medications.
6. **Duplicate or Replacement Lost, Stolen or Missing Bridges, Dentures or Appliances:** Expenses for any duplicate or replacement Bridge, Denture or Orthodontic Appliance.
7. **Duplication of Dental Services:** If a person covered by this Plan transfers from the care of one Dentist to the care of another Dentist during the course of any treatment, or if more than one Dentist renders services for the same dental procedure, the Plan will not be liable for more than the amount that it would have been liable had only one Dentist rendered all the services during each course of treatment, nor will the Plan be liable for duplication of services.
8. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan Benefit limitation, Annual Maximum Plan Benefits, or Overall Maximum Plan Benefits as described in the Dental Plan Benefits chapter of this document.
9. **Expenses Exceeding Allowed** or Contracted **Charges:** Any portion of the expenses for covered dental services or supplies that are determined by the Plan Administrator or its designee to exceed the Allowed or Contracted Charge as defined in the Definitions chapter of this document.
10. **Expenses related to complications of a non-covered service.**
11. Expenses for and related to **cryostorage of stem cells in teeth or other tissue.**
12. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the Dental Plan; or after the date the patient's coverage ends, except under those conditions described in the section entitled "Guidelines on Plan Payment if Dental Coverage Ends" in the Dental Benefits chapter of this document.
13. **Experimental and/or Investigational Services:** Expenses for any dental services and supplies that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Definitions chapter of this document.
14. **Military service related injury/illness**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan
15. **Gnathologic Recordings for Jaw Movement and Position:** Expenses for gnathologic recordings for jaw movement and position.
16. **Home Use Supplies:** Expenses for home use supplies, including, but not limited to, toothpaste, toothbrush, water-pick, fluoride, mouthwash, dental floss, etc.
17. **Hospital Expenses Related to Dental Care:** Expenses for Hospitalization related to Dental Services or use of an outpatient surgical facility related to Dental Services or care except as determined to be medically necessary.
18. **Illegal Act:** Expenses incurred by any covered individual for injuries resulting from or sustained as a result of commission or attempted commission of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual, unless such injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an

underlying health factor. Upon receipt of notification of denial, the individual then has the right to appeal the denial of claims payment related to the injury or illness resulting from or sustained as a result of the alleged illegal act. Such appeal should be directed to the Plan Administrator who will submit it through the Appeal Process outlined in the Claims Information chapter of this plan document.

19. **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in the Definitions chapter of this document.
20. **Mouth Guards:** Expenses for athletic mouth guards and associated devices.
21. **Myofunctional Therapy:** Expenses for myofunctional therapy.
22. **Never Events (i.e. Services for which reimbursement will never be made)**: Expenses for services performed as a result of an inexcusable outcome(s) in a health care setting or adverse event(s) that is serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability are not covered under the Plan. See Definitions chapter for further information. The plan reserves the right for itself and parties acting on behalf of the plan to review charges processed and/or paid by the Plan, to identify charges and/or services that are not Reasonable (as that term is defined in the Definitions Chapter of this Plan Document) and therefore not eligible for payment. The Plan Administrator or its designee may use a variety of resources in making these determinations, including The National Medical Associations, Societies, and other organizations such as the Food and Drug Administration. **No-Cost Services:** Expenses for dental services or supplies which a covered person is not required to pay or which are obtained without cost; or there would be no charge if the person receiving treatment were not covered under this Plan.
23. **Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Dentist or other Dental Care Provider, covered person or family member of a covered person.
24. **Occupational Illness/Injury or Third Party Expenses:** Expenses for the treatment of conditions covered by workers' compensation or occupational disease law; or expenses for services or supplies for which another person, entity or third party may be liable for any payment. See the Coordination of Benefits Chapter for more information.
25. **Oral Hygiene and/or Dietary Instruction:** Expenses for oral hygiene and/or dietary instruction or for a plaque control program (a series of instructions on the care of the teeth).
26. **Orthodontia That Started Before Coverage Began:** Expenses for any dental services relating to any active course of Orthodontic treatment that began before the effective date of coverage under this Plan, even if those services are provided after the effective date of coverage under this Plan.
27. **Orthognathic services, surgery**: Expenses for orthognathic treatment including surgical procedures.
28. **Periodontal Splinting:** Expenses for periodontal splinting.
29. **Personalized Bridges, Dentures, Retainers or Appliances:** Expenses for personalization or characterization of any Dental Prosthesis, including but not limited to any Bridge, Denture, Retainer or Appliance.
30. **Pictures/Photographs:** Expenses related to pictures (photographs) of teeth and/gums.
31. **Relatives Providing Services:** Expenses for dental services provided by any Dentist or other Dental Care Practitioner who is the parent, spouse, sibling (by birth or marriage) or child of the patient or covered Employee.
32. **Sealants for Individuals age 19 and older.**
33. **Services Not Performed by a Dentist or Dental Hygienist:** Expenses for dental services not performed by a Dentist (except for services of a Dental Hygienist that are supervised and billed by a Dentist and are for cleaning or scaling of teeth or for fluoride treatments).
34. **Services that are an integral component of a covered treatment (e.g. unbundling)**.
35. **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

VISION PLAN BENEFITS

These insured Vision Plan benefits are treated as a stand-alone (or excepted) benefit under Health Care Reform (PPACA).

Vision Care Plan coverage is provided by a contracted independent Vision Care Plan vendor/company (fully insured) whose name, address and telephone number are listed on the Quick Reference Chart in the Introduction chapter of this document.

Vision care services for persons covered under the Plan are delivered through a network of contracted preferred vision professionals/contracted retail chains (and through allowances for certain out-of-network services). There are two options available for vision coverage: **Basic Vision Plan and Vision Plus Plan**. The primary difference between these two options is in the frequency of coverage for materials purchases such as eyeglasses/lenses and contact lenses (in lieu of eyeglasses). The Vision Plan is designed to cover routine wellness visual needs rather than cosmetic or upgraded services and materials (although these may be available at discounted rates with preferred vision professionals).

All full-time and part-time benefit eligible employees and eligible retirees may elect coverage under either the Basic Vision Plan or Vision Plus Plan. The City of Mesa pays a portion of the premium for the coverage that is elected and employees/retirees pay the rest (subject to change on an annual basis).

To Obtain Vision Services: please contact the Vision Care Plan whose name, address and telephone number are listed in the Quick Reference Chart in the Introduction chapter of this document.

Services Provided: the following is a list of covered services under the Vision Care Plans. Services described below, when provided by a provider contracted with the Vision Care Plan vendor, are at no additional expense to you except for certain copayments, negotiated "up to" amounts or the amounts over and above the discounted rates or amounts over and above "allowances".

SERVICES NOT COVERED BY THE VISION PLANS (EXCLUSIONS):
There are no benefits under this vision plan for professional services or materials for:

1. Orthoptics or vision training and any supplemental testing;
2. Plano (non-prescription or less than a + or - .50 diopter power) lenses; or two pair of lenses in lieu of bifocals;
3. Replacement of lost or broken lenses or frames, except when the patient is normally eligible for services;
4. Medical or surgical treatment of the eyes (including refractive eye surgery); corrective vision treatment of an experimental nature.
5. Any eye examination required by an employer as a condition of employment;
6. Services or materials provided as a result of any Workers' Compensation Law, or similar legislation, or any services or materials obtained through, or required by any government agency;
7. Any services or materials provided by any other vision care plan, and/or group benefit plan containing benefits for vision care.
8. Costs for services and/or materials above Plan Benefit allowances.
9. Services and/or materials not indicated on the Schedule as covered Plan benefits.

FILING A VISION CLAIM/APPEALING A DENIED CLAIM
When you use the services of an in-network vision provider, you should pay the provider for your appropriate copays, scheduled amounts and amounts above allowances, along with any discounted services or services you purchased that are not covered by the Vision Plan. The provider will typically send the remainder of their bill directly to the Vision Care Plan Network for reimbursement.

If you use the services of a non-network vision provider, you will need to pay the provider for all services and then, at a later date but **within 6 months** of the date of service, submit the bill to the Vision Care Plan (whose name and address are listed on the Quick Reference Chart in the front of this section of the handbook). You will be reimbursed up to the amount allowed under the Vision Plan as noted in the Schedule of Vision Benefits for Out-of-Network coverage.

Vision claims submitted beyond 6 months of the date of service may not be considered for reimbursement.

Reimbursement for services provided by or obtained from a non-network vision provider will be the lesser of the actual amount charged or the Allowed Charges fees or the amount listed in the Schedule of Vision Benefits under the section titled "Out-of-Network Coverage". Your appeal of any denied vision claims should also be submitted to the Vision Care Plan.

SCHEDULE OF VISION BENEFITS

Basic Vision Plan			Vision Plus Plan		
Coverage with an In-Network Provider			Coverage with an In-Network Provider		
Benefit	**Description**	**Member Cost**	**Benefit**	**Description**	**Member Cost**
Well Vision Exam	• Focuses on eyes and overall wellness • **Every calendar year**	$10 copay	**Well Vision Exam**	• Focuses on eyes and overall wellness • **Every calendar year**	$10 copay
Prescription Glasses		$10 copay	**Prescription Glasses**		$10 copay
Frames (selection varies by provider)	• $130 allowance for standard selection of frames • $150 allowance for featured frame brands • $70 allowance at Costco • 20% savings on the amount over applicable allowances • **Every other calendar year**	Included in Prescription Glasses copay + Discounted amounts above allowances (if applicable)	**Frames (selection varies by provider)**	• $130 allowance for standard selection of frames • $150 allowance for featured frame brands • $70 allowance at Costco • 20% savings on the amount over applicable allowances • **Every calendar year**	Included in Prescription Glasses copay + Discounted amounts above allowances (if applicable)
Lenses	• Single vision and lined bifocal, trifocal and lenticular lenses • **Every other calendar year**	Included in Prescription Glasses copay	**Lenses**	• Single vision and lined bifocal, trifocal and lenticular lenses • **Every calendar year**	Included in Prescription Glasses copay
Lens Enhancements	• Polycarbonate (no copay for children under age 18) • Standard progressive • Premium progressive • Custom progressive • Average savings of 20-25% on all other non-covered options/enhancements (e.g. UV protection, scratch resistant and anti-reflective coatings, tints, photochromic lenses) • **Every other calendar year**	$10 copay Up to $55 From $95 - 105 From $150 - $175	**Lens Enhancements**	• Polycarbonate (no copay for children under age 18) • Standard progressive • Premium progressive • Custom progressives • ***UV Protection (1/1/16)*** • Average savings of 20-25% on all other non-covered options/enhancements (e.g. scratch resistant and anti-reflective coatings, tints, photochromic lenses) • **Every calendar year**	$10 copay Up to $55 From $95 - $105 From $150 - $175 ***$0 copay***
Contacts (available in lieu of eyeglasses)	• $200 allowance for elective contacts; copay does not apply • Medically necessary contacts (e.g. after cataract surgery, extreme low vision corrections or certain refractive conditions) • Contact lens fitting and evaluation • **Every other calendar year**	Amounts above allowance $10 copay Up to $60	**Contacts (available in lieu of eyeglasses)**	• $200 allowance for elective contacts; copay does not apply • Medically necessary contacts (e.g. after cataract surgery, extreme low vision corrections or certain refractive conditions) • Contact lens fitting and evaluation • **Every calendar year**	Amounts above allowance $10 copay Up to $60

SCHEDULE OF VISION BENEFITS cont.

In-Network Diabetic Eye Care Plus Program	Frequency as medically necessary. $20 copay for exams/services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD) with in-network provider
In-Network Low Vision Benefit	Up to $1,000 benefit every other calendar year for low vision analysis/diagnosis and supplemental testing; supplemental visual aids generally paid at 75% of cost (included in $1000 benefit)
In-Network Retail Affiliate Locations	1. Vision care materials' purchases with different allowances and discounts than non-retail providers - include Costco Optical and Visionworks (exam services at these locations are out-of-network coverage/allowances only) 2. Online Retail Purchasing for Contacts, Frames and Sunglasses – through Eyeconic - if prescription is from in-network provider, in-network copays, allowances or discounts apply; if prescription is from out-of-network provider, out-of-network allowances apply
Out-of-Network Direct Pay locations	Include Walmart and Sam's Club – out-of-network exams and materials purchases with Direct Pay agreements with Vision Plan that allow members to pay only the balance between their out-of-network allowances and the cost of the services.
Out-of-Network Vision Care Coverage	**Frequency of coverage same as in-network services (varies by Basic Vision or Vision Plus Plan)** Exam – up to $45 coverage Contacts – up to $200 allowance ($250 for medically necessary contacts) – both including fitting and evaluation Frames – up to $70 coverage Single vision lenses – up to $40 coverage Lined bifocal lenses – up to $60 coverage Lined Trifocal Lenses – up to $80 coverage Lined Lenticular lenses – up to $100 coverage Progressive lenses – up to $60 coverage
Extra Savings – Discounts (Not Covered Benefits)	**Glasses and Sunglasses** • 20% savings on additional glasses and sunglasses, including lens enhancements, from any in-network provider within 12 months of Well Vision Exam **Digital/Photographic Retinal Screening** • Up to $39 copay on routine retinal screening service as enhancement to a Well Vision Exam **Laser Vision Correction** • Average 15% discount off regular prices or 5% off promotional prices from affiliated contracted facilities **Hearing Aid Discount Program** • Through TruHearing DHMO – large selection of digital hearing aids through five manufacturers; free enrollment/membership in TruHearing DHMO Member Plus Program

CLAIMS AND APPEAL INFORMATION

OVERVIEW

This chapter describes the procedures for filing claims for certain benefits under this Plan and for appealing adverse benefit determinations in connection with those claims. **Claims covered by these procedures include those claims filed under the Medical Plan (including the Prescription Drug Program) and the Dental Plan.** For claims administration and appeals process under the Flexible Spending Account Plan, and the fully insured Vision Care Plan, Life Insurance, AD&D Insurance, STD or LTD Disability Plans, refer to the respective chapters in this document or contact those insurance companies or administrators for information.

The Plan takes steps to assure that **Plan provisions are applied consistently** with respect to you and other similarly situated Plan participants. The claims procedures outlined in this chapter are designed to **afford you a full, fair and fast review of the claim to which it applies**.

This chapter also discusses the process the Plan undertakes on certain appealed claims, to consult with a Health Care Professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not medically necessary, is experimental or investigational).

CLAIMS - HOW BENEFITS ARE PAID

Payment of Eligible Benefits in General: All Plan Benefits are considered for payment on the receipt of **written** proof of claim (itemized bill from the provider of services). Sometimes additional information or records are also needed.

TIME LIMIT FOR FILING CLAIMS UNDER MEDICAL/PRESCRIPTION DRUG OR DENTAL PLANS

All claims must be submitted to the Plan within ONE YEAR from the date of service - no Plan benefits will be paid for any claim submitted after this period.

Claims When Using PPO Providers: If eligible services are provided through one of the Plan's Preferred Provider Organizations (PPO), the PPO Health Care Provider will submit the claim directly to the Appropriate Claims Administrator instead of sending the bill to you or the patient.. The Appropriate Claims Administrator will review the claim and pay the PPO provider directly, and in accordance with the benefit provisions of the Plan. PPO Providers should **not**:

1. Require you to submit (at the time the service is rendered) any money other than the deductible, copay or co-insurance, if these apply. Many PPO providers however, may not require coinsurance or deductible at the time the service is rendered but will bill you AFTER the PPO provider has received payment from the Plan. Also, your portion of the coinsurance should be based on the allowed amount to the PPO provider and not the total billed charges (unless such amounts are the same);
2. Send the initial bill for services to you; instead the PPO provider must bill the Plan directly by sending the initial claim to the applicable Appropriate Claims Administrator (via the underlying PPO Network if different to the Appropriate Claims Administrator).

If a PPO provider does not adhere to the above claim/fee submission guidelines, contact the Appropriate Claims Administrator for assistance. If however, you pay a PPO Provider an amount in excess of any required deductible, coinsurance or copay (at the time service is rendered or later), and subsequently want to be reimbursed for that overpayment, you may not seek reimbursement from the Plan. Instead, you must discuss and obtain your reimbursement from the PPO provider directly.

Claims When Using Non-PPO Providers: Non-PPO providers may send their claims either to the Appropriate Claims Administrators or directly to you. If the provider sends the claim to you, forward the claim to the Appropriate Claims Administrator. Non-PPO providers may also require you to pay (at the time service is rendered) all or part of the charge for the services they provide. Once the non-PPO provider is paid the Allowed or Contracted Charge amount under this Plan, they may also bill you for any difference between their originally billed charges and the amount allowable by the Plan, commonly called "balance billing". Balance billing is in addition to any out-of-network deductible, coinsurance or copayment that you may owe.

For a non-PPO provider claim to be considered for processing, the claim must list the following information:

- A description of the services or supplies provided using proper coding techniques
- Details of the charges for those services or supplies
- Diagnosis code(s)
- Date(s) and location where the services or supplies were provided
- Patient's name, social security or ID number, address and date of birth
- Member or Subscriber's name, ID number and date of birth

- Provider's name, address, phone number, professional degree or license, federal tax identification number and appropriate provider identifier number

If a claim is submitted without the above required information and all data elements are not provided, this Plan or Appropriate Claims Administrator cannot consider that claim for payment.

COORDINATION OF BENEFITS WITH MEDICARE

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

Note: If **you** pay a non-PPO provider for services **and then** submit the claim to the Appropriate Claims Administrator for reimbursement to you, the Plan will send you reimbursement for eligible medical or dental expenses, subject to Allowed or Contracted Charges fees. A receipt indicating payment must be submitted along with the claim in order for you to receive the reimbursement payment. Payments in excess of $500 may be sent to the provider if, upon verification with the provider, it is determined that you have not made payment to that provider.

Assignment of Benefits: This is a method under which the plan participant requests that benefits for a claim be paid to some person or institution, usually a physician or hospital. This provision applies to Non-PPO providers only. The permission for assignment of benefits must be sent to the Appropriate Claims Administrator.

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

When You Must Repay Plan Benefits: if it is found that the Plan Benefits paid by the Plan are too much because:

1. some or all of the eligible expenses were not paid or payable by you or your covered Dependent; or
2. you or your covered Dependent received the money to pay some or all of those eligible expenses from a source other than the Plan; or
3. the Plan erroneously paid Benefits to which you were not entitled under the terms and provisions of the Plan, **then** the Plan will be entitled to a refund from you or your Health Care Provider of the difference between the amount of Plan Benefits actually paid by the Plan for those expenses and the amount of Plan Benefits that should have been paid by the Plan for those expenses based on the actual facts.

ADDITIONAL INFORMATION NEEDED

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

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

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

APPEALS

KEY DEFINITIONS

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

Adverse Benefit Determination: For purposes of an initial claim and any appeal processes, an adverse benefit determination is defined as:

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

Claim: For purposes of benefits covered by these procedures, a claim is a request for a Plan benefit made by an individual (commonly called the "claimant" but hereafter referred to as "you") or that individual's authorized representative (as defined later in this chapter) in accordance with the Plan's claims procedures, described in this chapter. There are **four types of claims** covered by the procedures in this chapter: **Pre-service, Urgent, Concurrent and Post-service**, described later in this chapter. The type of claim is determined as of the time the claim or review of denial of the claim is processed.

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

1. be written or electronically submitted (oral communication is acceptable only for urgent care claims),
2. be received by the Appropriate Claims Administrator as that term is defined in this chapter;
3. name a specific individual including their social security number or Medicare HICN number,
4. name a specific medical condition or symptom,
5. name a specific treatment, service or product for which approval or payment is requested,
6. made in accordance with the Plan's benefit claims filing procedures described in this chapter; and
7. includes all information required by the Plan and its Appropriate Claims Administrator, such as the existence of additional health coverage that would assist the Plan in coordinating benefits.

A claim is NOT:

1. a request made by **someone other than** the individual or his/her authorized representative;
2. a request made by a **person who will not identify him/herself** (anonymous);
3. a **casual inquiry about benefits** such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
4. a request for **prior approval of Plan benefits where prior approval is not required** by the Plan;
5. an **eligibility inquiry that does not request Plan benefits**. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
6. a **request for services and claims for a work-related injury/illness**, unless the Workers' Compensation program has provided a written confirmation that the injury/illness is not compensable as a work-related claim;
7. a **submission of a prescription** with a subsequent adverse benefit determination at the point of sale at a retail pharmacy or from a mail order service.

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

Appropriate Claims Administrator	Types of Claims Processed
Appropriate Claims Administrator	• Medical post-service claims • Dental post-service claims
Utilization Management Company (may also be the same entity as the Appropriate Claims Administrator, by plan)	• Urgent, Concurrent and Pre-service claims
Prescription Drug Program Administrator (PBM)	• Pre-service/post-service in-network, outpatient drugs • Post-service claims for out-of-network outpatient drugs • Per Drug row of the Schedule of Medical Benefits section

Pre-Service Claim: A pre-service claim is a request for benefits under this Plan where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care. The services that require pre-certification (also called

prior authorization) are listed in the Utilization Management chapter and the Drugs and Medicines row of the Schedule of Medical Benefits in this document.

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

Urgent Care Claim: An urgent care claim is a claim (request) for medical care or treatment in which applying the time periods for pre-certification:

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

The services that require pre-certification (also called prior authorization) are listed in the Utilization Management chapter and the Drugs and Medicines row of the Schedule of Medical Benefits in this document.

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

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

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

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

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

IF ADDITIONAL INFORMATION IS NEEDED

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

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

Some Plan benefits are payable only if the Plan approves payment **before** you receive the services. The requests for these benefits are referred to as pre-service claims, also known as pre-authorization or pre-certification. (see the definition of pre-service claims in the Definitions section). You are not required to obtain approval in advance for emergency care including care provided in a hospital emergency room, or hospital admission for delivery of a baby (up to certain timeframes). Services that require advance approval are listed in the Utilization Management section of this Plan document.

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

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

AUTHORIZED REPRESENTATIVE/AUTHORIZED RELEASE OF PROTECTED HEALTH INFORMATION

This Plan recognizes an authorized representative as any person at least 18 years old whom you (or an adult Plan member) have designated in **writing** as the person who can have access to your (or the adult Plan member's) Protected Health Information (PHI), or can act on your behalf (or the adult Plan member's behalf) to file a claim and appeal an adverse benefit determination under this Plan. An authorized representative under this Plan may also be a health care professional. The Appropriate Claims Administrator requires a written statement from an individual that he/she has designated an authorized representative along with the representative's name, address and phone number. To designate an authorized representative or authorize the Appropriate Claims Administrator to release your PHI, you must submit a completed Authorization to Release Protected Health Information form, available from the Appropriate Claims Administrator.

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

Once the Appropriate Claims Administrator receives an authorized representative/release form all future claims and appeals-related correspondence will be available to the authorized representative as well as the individual. The Appropriate Claims Administrator will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. A participant may revoke a designated authorized representative/release of PHI by submitting a completed Revocation form available from and to be returned to the Appropriate Claims Administrator.

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

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

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

1. Plan benefits for post-service claims are considered for payment upon receipt of a **written** (or electronic where appropriate) proof of claim, commonly called a bill. A completed claim usually contains the necessary proof of claim but sometimes additional information or records may be required. The Appropriate Claims Administrator will not accept a balance due statement, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim.
2. Generally, Plan benefits for a hospital or health care facility will be paid directly to the facility. Plan benefits for surgery will usually be paid directly to the surgeon and anesthesiologist providing the services. This is because the Plan's financial responsibility for eligible benefits is generally automatically assigned to the provider of the service unless the claim is marked that the bills have been paid by the covered person. For eligible claims, the Plan pays their portion of the billed services and you, the covered person, are responsible to pay your portion of the claim to the provider.
3. Occasionally a health care provider will send a claim directly to you. In this case you should forward the claim to the Appropriate Claims Administrator for processing.
   - Review your bills to be sure they are appropriate and correct. **Report any discrepancies in billing to the Appropriate Claims Administrator.** This can reduce costs to you and the Plan.
   - If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.
   - Mail the provider's actual claim to the Appropriate Claim Administrator.
4. In all instances, when deductibles, coinsurance or copayments apply, you are responsible for paying your share of the charges.
5. The Appropriate Claims Administrator will review your post-service claim no later than 30 calendar days from the date the claim is received. You will be notified if you did not properly follow the post-service claims process.
   - This 30-day period may be extended one time for up to 15 additional calendar days if the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond its control, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 30 day period using a written Notice of Extension.
   - The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. You will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
   - (If a period of time is extended due to failure to submit information, the time period is suspended ("tolled") from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.
   - The Appropriate Claims Administrator will then make a claim determination no later than 15 calendar days from the earlier of the date the Plan receives the additional information or the date displayed in the Notice of Extension on which the Plan will make a decision if no additional information is received.
6. Before the Plan issues an adverse benefit determination, the Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. **If the post-service claim is approved,** you will be notified in writing (or electronically, as applicable) on

a form commonly referred to as an Explanation of Benefits or EOB. The provider of service (or you when applicable) will be paid according to Plan benefits.

7. **If the post-service claim is denied** in whole or in part, notice of this initial denial will be provided to you in writing (or electronically, as applicable) on the Explanation of Benefits or EOB form. This notice of initial denial will:
   - identify the claim involved (e.g. date of service, health care provider, claim amount if applicable, diagnosis and treatment codes);
   - give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
   - reference the specific Plan provision(s) on which the determination is based;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - provide an explanation of the Plan's internal appeal procedure and external review processes along with time limits and information regarding how to initiate an appeal;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - disclose the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with internal claims and appeals and external review processes.
8. **If you disagree with a denial of a post-service claim**, you or your authorized representative may ask for a post-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A POST-SERVICE CLAIM

This Plan maintains a two (2) level post-service appeals process. Appeals must be submitted in writing to the Appropriate Claims Administrator for the first and second level of appeal review. The Appropriate Claims Administrator will forward all second level appeals that are **not** based on medical necessity, experimental treatment or similar exclusion or limit, to the Plan's Employee Benefits Advisory Committee for the second level appeal review, both of whom have their contact information listed on the Quick Reference Chart in this document. You will be provided with:

- upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate plan fiduciary will:
  - consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

1. Under this Plan's appeal process, a first level determination on the post-service appeal will be made no later than 30 calendar days from receipt of the first level appeal.
   - You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.
   - If dissatisfied with the first appeal level determination you will have 180 calendar days from receipt of the first level review determination to request a second level appeal review.
   - The Appropriate Claims Administrator will make a second level appeal determination no later than 60 calendar days from receipt of the second level appeal

- If the second level appeal is **not** based on medical necessity, experimental treatment, or similar exclusion or limit, the Appropriate Claims Administrator will forward the second level appeal to the Plan's Employee Benefits Advisory Committee for their review and determination.
- There is **no extension permitted** in the first or second level of the appeal review process.

2. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.
3. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit, the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, or the subordinate of any such individual.
4. You will receive a notice of the appeal determination at each level. If that determination is adverse, it will include at each level of the appeal review, the following:
   - the specific reason(s) for the adverse appeal review decision;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

   In the notice of first level appeal review determination, the notice will describe the process and timeframes to proceed to a second level appeal review if still dissatisfied with the first level determination.
5. This concludes the post-service appeal process under this Plan. **This Plan does not offer a voluntary appeal process.**

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

If your claim involves urgent care (as defined earlier in this chapter), you may file the claim or the Plan will honor a health care professional as your authorized representative in accordance with the Plan's urgent care claims procedures described below.

1. Urgent care claims (as defined previously in this chapter) may be requested by you orally or by writing to the Appropriate Claims Administrator (Utilization Management Company, Prescription Benefit Program) whose contact information is listed on the quick reference chart in this document.
2. In the case of an urgent care claim, if a health care professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), the Health Care Professional will be considered by this Plan to be the authorized representative bypassing the need for completion of the Plan's written authorized representative form.
3. You will be notified of the Plan's benefit determination as soon as possible but **no later than 24 hours** after receipt of an urgent care claim by the Utilization Management Company, or Prescription Benefit Program. You will be notified if you fail to follow the urgent care claim procedures or fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan.
4. **If you fail to provide sufficient information to decide an urgent care claim**, you will be notified as soon as possible, but no later than 24 hours after receipt of the urgent care claim by the Utilization Management Company or Prescription Benefit Program, of the specific information necessary to complete the urgent care claim and you will be allowed not less than 48 hours to provide the information. You will then be notified of the Plan's benefit determination on the urgent care claim as soon as possible but no later than 24 hours after the earlier of the receipt of the needed information **or** the end of the period of time allowed to you in which to provide the information.
5. **If the urgent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.
6. **If the urgent care claim is denied** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice provided no later than 3 calendar days after the oral notice. The notice of initial urgent care claim denial will:
   - give the specific reason(s) for the denial;
   - reference the specific Plan provision(s) on which the determination is based;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;

- provide an explanation of the Plan's appeal procedure along with time limits;
- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request, and
- you will be provided a description of the expedited appeal review process for urgent care claims.

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

APPEAL OF A DENIAL OF AN URGENT CARE CLAIM

1. You may request an appeal review of an urgent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator (Utilization Management Company or Prescription Drug Program), whose contact information is listed on the quick reference chart in this document.
2. You will be provided with:
   - upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   - a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
   - in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate Plan fiduciary will:
     - consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
     - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.
3. The Plan will make a determination on the appeal (without the opportunity for an extension) as soon as possible but no later than 72 hours after receipt of the appeal.
4. The notice of appeal review of an urgent care claim will be provided orally with written confirmation (or electronic, as appropriate). You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - the specific reason(s) for the adverse appeal review decision;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement of the voluntary Plan appeal procedures, if any;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."
5. This concludes the urgent care claim appeal process under this Plan. **This Plan does not offer a voluntary appeal process.**

HOW TO FILE A CONCURRENT CLAIM FOR BENEFITS UNDER THIS PLAN

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

1. If a decision is made to reduce or terminate an approved course of treatment, you will be provided notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.
2. Concurrent claims that are an urgent care claim will be processed according to the initial review and appeals procedures and timeframes noted under the Urgent care claim section of this chapter.
3. Concurrent claims that are not an urgent care claim will be processed according to the initial review and appeals procedures and timeframes applicable to the claims as noted under the Pre-service or Post-service claim sections of this chapter.
4. **If the concurrent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.
5. **If the concurrent care claim is denied,** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice. The notice of initial concurrent denial will:
   - give the specific reason(s) for the denial;
   - reference the specific Plan provision(s) on which the determination is based;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - provide an explanation of the Plan's appeal procedure along with time limits;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.
6. **If you disagree with a denial of a concurrent claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A CONCURRENT CARE CLAIM

1. You may request an appeal review of a concurrent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator (Utilization Management Company or Prescription Drug Program), whose contact information is listed on the Quick Reference Chart in this document.
2. You will be provided with:
   - upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   - a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
   - in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate Plan fiduciary will:
     - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
     - provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.
3. A determination will be made on the appeal (without the opportunity for extension) as soon as possible before the benefit is reduced or treatment is terminated.
4. The notice of appeal review for the concurrent claim may be provided orally (for urgent care claims), with written (or electronic, as appropriate) notice. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - the specific reason(s) for the adverse appeal review decision;
   - reference the specific Plan provision(s) on which the determination is based;

- a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- a statement of the voluntary Plan appeal procedures, if any;
- if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
- the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

5. This concludes the concurrent claim appeal process under this Plan. **This Plan does not offer a voluntary appeal process.**

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

1. A claim for pre-service (as defined in this chapter) must be made by a claimant or the claimant's authorized representative (as described in this chapter) in accordance with this Plan's claims procedures outlined in this chapter.
2. A pre-service claim (claim which requires pre-certification) must be submitted (orally or in writing) in a timely fashion (as discussed in the Utilization Management chapter and Drug row of the Schedule of Medical Benefits of this document) to the Appropriate Claims Administrator (as defined in this chapter).
3. The pre-service claim will be reviewed no later than 15 calendar days from the date the pre-service claim is received by the Appropriate Claims Administrator. If you do not follow the pre-service claim filing process, you will be notified as soon as possible or within 5 calendar days from your request.
4. The 15 calendar day review period may be extended one time for up to 15 additional calendar days if it is determined that an extension is necessary due to matters beyond the control of the Appropriate Claims Administrator, and the Appropriate Claims Administrator notifies you prior to the expiration of the initial 15-day period by using a written notice of extension.
5. If a period of time is extended due to failure to submit information, the time period is suspended ("tolled') from the date on which the notice of extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the notice was sent to you.
6. The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.
7. In either case noted above, you will be notified of the need for additional information in the notice of extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
8. A claim determination will be made no later than 15 calendar days from the earlier of the date the additional information is received or the date displayed in the notice of extension on which a decision will be made if no additional information is received.
9. **If the pre-service claim is approved** you will be notified orally and in writing (or electronic, as applicable).
10. **If the pre-service claim is denied in whole or in part**, a notice of this initial denial will be provided to you orally and in writing (or electronic, as applicable). This notice of initial denial will:
    - give the specific reason(s) for the denial;
    - reference the specific Plan provision(s) on which the determination is based;
    - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
    - provide an explanation of the Plan's appeal procedure along with time limits;
    - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request; and
    - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.
11. **If you disagree with a denial of a pre-service claim,** you or your authorized representative may ask for a pre-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A PRE-SERVICE CLAIM

This Plan maintains a two (2) level pre-service appeals process. Appeals must be submitted in writing to the Appropriate Claims Administrator for the first and second level of appeal review. The Appropriate Claims Administrator will forward all second level appeals that are **not** based on medical necessity, experimental treatment or similar exclusion or limit, to the Plan's Employee Benefits Advisory Committee for the second level appeal review, both of whom have their contact information listed on the Quick Reference Chart in this document. You will be provided with:

- upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate Plan fiduciary will:
  - consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

1. Under this Plan's two (2) level appeal process, the first level determinations on the pre-service appeal will be made no later than 30 calendar days from receipt of the appeal.
2. There is **no extension permitted** in the appeal review process. You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.
3. If still dissatisfied with the initial appeal level determination you will have 180 calendar days under this Plan from receipt of the first level review determination to request a second level appeal review.
4. The Appropriate Claims Administrator will make a second level determination no later than 60 calendar days from receipt of the second level appeal
5. If the second level appeal is **not** based on medical necessity, experimental treatment, or similar exclusion or limit, the Appropriate Claims Administrator will forward the second level appeal to the Plan's Employee Benefits Advisory Committee for their review and determination.
6. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.
7. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit, the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, or the subordinate of any such individual.
8. You will receive a notice of the appeal determination at each level. If that determination is adverse, it will include at each level of the appeal review, the following:
   - the specific reason(s) for the adverse appeal review decision;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

   In the notice of first level appeal review determination, the notice will describe the process and timeframes to proceed to a second level appeal review if dissatisfied with the first level appeal determination.

9. This concludes the pre-service appeal process under this Plan. **This Plan does not offer a voluntary appeal process.**

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

Overview of Claims and Appeals Timeframes				
	Urgent	**Concurrent**	**Pre-service**	**Post-service**
Plan must make **Initial Claim Benefit Determination** as soon as possible but no later than:	24 hours	Before the benefit is reduced or treatment terminated	15 days	30 days
Extension permitted during initial benefit determination?	No[1]	No	15 days	15 days
First Level Appeal Request must be submitted to the Plan within:	180 days of the date of initial benefit determination	180 days of the date of initial benefit determination	180 days of the date of initial benefit determination	180 days of the date of initial benefit determination
Plan must make **First Level Appeal Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated	15 days	30 days
Second Appeal Request must be submitted to the Plan within:	NA	NA	180 days of date of the first level appeal determination	180 days of date of the first level appeal determination
Plan must make **Second Level Appeal Determination** as soon as possible but no later than:	N/A	N/A	60 days	60 days
Extension permitted during appeal reviews?	No	No	No	No

[1] No formal extension for urgent care claims but regulations allow that if claimant files insufficient information they will be allowed up to 48 hours to provide the information.

EXTERNAL REVIEW OF CLAIMS

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

If your appeal of a claim, whether urgent, concurrent, pre-service or post-service claim is denied, you may request further review by an independent review organization ("IRO") as described below. **Generally, you may only request external review after you have exhausted the internal review and appeals processes described above.**

This external review process does not pertain to claims for the dental plan, insured vision plan benefits, life/death benefits, AD&D, disability, the Plan's health flexible spending account (FSA) or if your claim was denied due to your failure to meet the requirements for eligibility and payment under the terms of the Plan.

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

1. **External Review of Standard (Non-Urgent) Claims**.

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

   Because the Plan's internal review and appeals process generally must be exhausted before external review is available, in the normal course, external review of standard claims will only be available following second level appeal claim benefit determinations.

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

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

Contact information for the Medical Plan Appropriate Claims Administrator, the Prescription Drug Program provider, and the Utilization Management Program provider is identified in the Quick Reference Chart, as amended from time to time.

A. **Preliminary Review of Standard Claims**.
   1. Within five (5) business days of the Plan's or appropriate Plan designee's receipt of your request for an external review of a standard claim, the Plan or appropriate Plan designee will complete a preliminary review of the request to determine whether:
      (a) You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
      (b) The adverse determination does not relate to your failure to meet the requirements for eligibility or payment under the terms of the Plan;
      (c) You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and
      (d) You have provided all of the information and forms required to process an external review.
   2. Within one (1) business day of completing its preliminary review, the Plan or appropriate Plan designee will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:
      (a) If your request is complete and eligible for external review; or
      (b) If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
      (c) If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

B. **Review of Standard Claims by an Independent Review Organization (IRO)**.
   1. If the request is complete and eligible for an external review, the Plan or appropriate Plan designee will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:
      a. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days).
      b. Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its adverse determination.
      c. If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse determination that is the subject of the external review. **Reconsideration** by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its adverse determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
      d. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
         In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care

providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

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

f. The assigned IRO's decision notice will contain:

1.) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

2.) The date that the IRO received the request to conduct the external review and the date of the IRO decision;

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

4.) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;

5.) A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);

6.) A statement that judicial review may be available to you; and

7.) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

2. **External Review of Expedited Urgent Care Claims**.

A. You may request an expedited external review if:

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

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

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

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

Contact information for the Utilization Management Program provider and the Prescription Drug Program is identified in the Quick Reference Chart, as amended from time to time.

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

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

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

Following the preliminary review that a request is eligible for expedited external review, the Plan or appropriate Plan designee will assign an IRO (following the process described under Standard Review above). The Plan or appropriate Plan designee will expeditiously (such as via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

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

IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

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

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

i. If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim.
ii. If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim.

3. **Overview of the Timeframes During the Federal External Review Process**.

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
Claimant requests an external review (*generally after internal claim appeals procedures have been exhausted*)	Within 4 months after receipt of an Adverse Claim Benefit Determination (benefits denial notice)	After receipt of an Adverse Claim Benefit Determination (benefits denial notice)
Plan or appropriate Plan designee performs preliminary review	Within 5 business days following the Plan's or appropriate Plan designee's receipt of an external review request	Immediately
• Plan's or appropriate Plan designee's notice to claimant regarding the results of the preliminary review	Within 1 business day after Plan's or appropriate Plan designee's completion of the preliminary review	Immediately
• When appropriate, claimant's timeframe for perfecting an incomplete external review request	Remainder of the 4 month filing period or if later, 48 hours following receipt of the notice that the external review is incomplete	Expeditiously
Plan or appropriate Plan designee assigns case to IRO	In a timely manner	Expeditiously
Notice by IRO to claimant that case has been accepted for review along with the timeframe for submission of any additional information	In a timely manner	Expeditiously
Time period for the Plan or appropriate Plan designee to provide the IRO documents and information the Plan considered in making its benefit determination	Within 5 business days of assigning the IRO to the case	Expeditiously
Claimant's submission of additional information to the IRO	Within 10 business days following the claimant's receipt of a notice from the IRO that additional information is needed (IRO may accept information after 10 business days)	Expeditiously
IRO forwards to the Plan any additional information submitted by the claimant	Within 1 business day of the IRO's receipt of the information	Expeditiously
If (on account of the new information) the Plan reverses it's denial and provides coverage, a Notice is provided to claimant and IRO	Within 1 business day of the Plan's decision	Expeditiously
External Review decision by IRO to claimant and Plan	Within 45 calendar days of the IRO's receipt of the request for external review	As expeditiously as the claimant's medical condition or circumstances require but in no event more than 72 hours after the IRO's receipt of the request for expedited external review. (If notice is not in writing, within 48 hours of the date of providing such non-written notice, IRO must provide written notice to claimant and Plan.)

Steps in the External Review Process	Timeframe for Standard Claims	Timeframe for Expedited Urgent Care Claims
Upon Notice from the IRO that it has reversed the Plan's adverse benefit determination	Plan must immediately provide coverage or payment for the claim	Plan must immediately provide coverage or payment for the claim

ELIMINATION OF CONFLICT OF INTEREST

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

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal review procedures described in this document) **for every issue deemed relevant by you**, or until 60 days have elapsed since you filed a request for appeal review if you have not received a decision. No lawsuit may be started more than three years after the time proof of claim must be given.

FACILITY OF PAYMENT

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

IF YOU NEED ASSISTANCE WITH THIS PROCESS

If you have questions about this process or need assistance, you can contact the following:

Arizona Department of Insurance

Consumer Services, 2910 N. 44th Street, Ste. 210, Phoenix, AZ 85018-7269

Phoenix: (602) 364-2499; Spanish: (602) 364-2977; Toll free: (800) 325-2548

http://www.id.state.az.us/

consumers@azinsurance.gov

COORDINATION OF BENEFITS (COB)

HOW COORDINATION OF BENEFITS OCCURS

This chapter describes the circumstances when you or your covered Dependents may be entitled to medical (including Behavioral Health), dental and/or prescription benefits under this Plan and may also be entitled to recover all or part of these expenses from some other source. It also describes the rules that apply when this happens. There are several circumstances that may result in you and/or your covered Dependents being reimbursed for your healthcare expenses not only from this Plan but also from some other source. This can occur if you or a covered Dependent is also covered by:

1. Another group health care plan; or
2. Medicare or some other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, or any coverage either provided by a federal, state or local government or agency or Exchange/Marketplace coverage, or any coverage required by federal, state or local law, including, but not limited to, any motor vehicle no-fault coverage for medical expenses or loss of earnings that is required by law; or
3. Workers' compensation.

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

This Plan operates under rules that prevent it from paying Benefits which, together with the benefits from any other source described in the above paragraphs, would allow you to recover more than 100% of eligible expenses you incur. In many instances, you may recover less than 100% of those eligible expenses from the duplicate sources of coverage or recovery. **In some instances, this Plan will not provide coverage if you are eligible to recover from some other resource.**

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

When and How Coordination of Benefits (COB) Applies: For the purposes of this Coordination of Benefits section, the word "plan" refers to any group medical, dental, prescription drug or Behavioral Health policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of services incurred by the covered person or that provides services to the covered person. A "group plan" provides its benefits or services to employees, retirees or members of a group who are eligible for and have elected coverage. Some families that have more than one family member working outside the home who are covered by more than one health plan. If this is the case with your family, **you must let the Appropriate Claims Administrator know about all your family coverage when you submit a claim.**

Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the expenses incurred.** Sometimes, the combined benefits that are paid will be **less than** the total expenses.

- **NOTE: The City of Mesa Health Plan does not coordinate benefits with plans in which the claimant's responsibility is a copayment and does not coordinate benefits on outpatient prescription drugs regardless of plan type.**

WHICH PLAN PAYS FIRST: ORDER OF BENEFIT DETERMINATION RULES

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules always pays its benefits first.** If the first rule does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. The rules are:

1. **Rule 1: Non-Dependent/Dependent**
   A. The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the plan that covers the same person as a dependent pays second.
   B. There is one exception to this rule: As a result of the provisions of Title XVIII of the Social Security Act and implementing Medicare regulations, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as **other than** a dependent, for example:
      i. Active Employees and Dependents: Both the employee and dependent can waive Medicare coverage but if it is not waived, Medicare is secondary for both employee and dependent if eligible.
      ii. Retirees and Dependents: Must have enrolled in Medicare if eligible to remain on the City of Mesa Plan. Medicare is primary.

2. **Rule 2: Dependent Child Covered Under More Than One Plan**
   A. The plan that covers the parent whose Birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose Birthday falls later in the calendar year pays second, if the parents are married; the parents are not separated (whether or not they ever have been married); or a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.
   B. If both parents have the same Birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.
   C. The word "**Birthday"** refers only to the month and day in a calendar year; not the year in which the person was born.
   D. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does **not** apply during any Plan Year during which any Benefits were actually paid or provided before the Plan had actual knowledge of the specific terms of that court decree.
   E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:
      - The plan of the custodial parent pays first;
      - The plan of the spouse of the custodial parent pays second; and
      - The plan of the non-custodial parent pays third; and
      - The plan of the spouse of the non-custodial parent pays last.
3. **Rule 3: Active/Laid-Off or Retired Employee**
   A. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.
   B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
   C. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.
4. **Rule 4: Continuation Coverage**
   A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.
   B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
   C. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.
5. **Rule 5: Longer/Shorter Length of Coverage**
   A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.
   B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.
   C. The start of a new plan does **not** include a change:
      - In the amount or scope of a plan's benefits;
      - In the entity that pays, provides or administers the plan; or
      - From one type of plan to another (such as from a single employer plan to a multiple employer plan).
6. **Rule 6: Medicaid and Tricare**

   Other non-Medicare governmental programs pay last.

   The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY

When this Plan pays second, it will pay, with respect to each claim submitted for payment, 100% of "Allowable Expenses" **less** whatever payments were actually made by the Plan (or plans) that paid first, after the applicable deductible has been met. In

addition, when this Plan pays second, it will never pay more in Benefits than it would have paid during the Plan Year (for each claim as it is submitted) had it been the Plan that paid first.

1. "**Allowable Expense"** means a health care service or expense, including deductibles, coinsurance or copayments, which is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:
   - The difference between the cost of a semi-private room in a Hospital or Specialized Health Care Facility and a private room, unless the patient's stay in a private Hospital room is Medically Necessary.
   - If the coordinating plans determine Benefits on the basis of Allowable Charges, any amount in excess of the highest Allowable Charge is not an Allowable Expense.
   - If the coordinating plans provide Benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
   - If one coordinating plan determines Benefits on the basis of Allowable Charges and the other coordinating plan provides Benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the Allowable Expense for all plans.
   - When benefits are reduced by a primary plan because a covered person did not comply with the primary plan's provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an Allowable Expense by this Plan when it pays second.
2. Allowable Expenses **do not** include expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

ADMINISTRATION OF COB

To administer COB, the Plan reserves the right to:

1. exchange information with other plans involved in paying claims;
2. require that you or your Health Care Provider furnish any necessary information;
3. reimburse any plan that made payments this Plan should have made; or
4. recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment. To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.

If this Plan is secondary, this Plan will pay secondary medical benefits **only** when the coordinating primary plan pays medical benefits, and it will pay secondary dental benefits only when the primary plan pays dental benefits. This Plan will not pay secondary medical benefits on a claim when the coordinating primary plan paid dental benefits on that claim, nor will this Plan pay secondary dental benefits on a claim when the coordinating primary plan paid medical benefits on the claim.

If this Plan is secondary, and if the coordinating primary plan provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the Allowable Expense and the benefits paid by the primary plan. If this Plan is secondary, and if the coordinating primary plan does **not** cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan only to the extent they would have been payable if this Plan were the primary plan.

Benefit Reserve: Effective 1/1/08, this Plan does not administer a benefit reserve (also called a benefit bank, credit balance, credit reserve or credit savings) calculation in the coordination of benefits.

MEDICARE

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period. If you, your covered Spouse or Dependent Child becomes covered by Medicare, either because of disability or age, you may either retain or cancel your and their coverage under this Plan, as may apply. If you, your Spouse and/or your Dependent Child are covered by this Plan and by Medicare, and you or them retain coverage under this Plan, as long as you remain actively employed, your health care coverage will continue to provide the same benefits and your contributions for coverage will remain the same, and this Plan pays first and Medicare pays second.

Medicare and Total Disability: If you cancel your coverage under this Plan due to your Medicare eligibility, coverage of your Spouse and/or your Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. See the chapter on COBRA for more information. However, if you become Totally Disabled and entitled to Medicare because of your disability, you will no longer be considered to remain actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this Plan pays second.

Medicare and ESRD: If, while you are actively employed, you or any of your covered dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the **earlier** of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

When the Plan Participant Is Covered by Medicare Advantage (formerly called Medicare + Choice or Part C): This Plan does not coordinate with Medicare Advantage plans.

Medicare and Medicare Private Contracts: Under the law a Medicare participant is entitled to enter into a Medicare private contract with certain health care practitioners. A Medicare private contract must be in writing and it states that neither the health care practitioner nor the Medicare participant can submit claims to Medicare for services furnished by that practitioner. When such a contract exists, Medicare will not pay any benefits for any services or supplies provided by that practitioner. If a Medicare participant enters into such a contract this Plan will pay normal plan benefits for eligible services as if the participant used a non-Medicare contracted provider.

When Covered by this Plan and also by a Medicare Part D Plan such as a Prescription Drug Plan: If you have dual coverage under both this Plan and Medicare Part D, this Plan will not coordinate that dual prescription drug coverage. **You will be disenrolled from the prescription drug coverage under this Plan while you are enrolled in a Medicare Part D plan.**

Medicaid: If a covered individual is covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second.

TRICARE: If a covered individual is covered by both this Plan and TRICARE (formerly known as CHAMPUS), this Plan pays first and TRICARE pays second.

Veterans Affairs/Military Medical Facility Services: If a covered individual receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a **military service-related illness or injury**, benefits are **not** payable by the Plan. If a covered individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Allowed or Contracted Charges.

Motor Vehicle No-Fault Coverage Required by Law: If a covered individual is covered for medical, dental, prescription drug or behavioral health benefits by both this Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this Plan pays second.

Other Coverage Provided by State or Federal Law: If you are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

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

Subrogation: There is no subrogation provision under this Plan.

COBRA CONTINUATION OF COVERAGE

CONTINUATION OF COVERAGE IN GENERAL

Except with respect to certain dental services described in the Dental Plan Benefits chapter of this document, your Plan does **not** provide for an extension of Plan benefits for any services or expenses incurred **after** coverage ends. However, under certain circumstances your medical/prescription drug, health FSA, dental, EAP and vision coverage may be continued for a limited period of time. This chapter explains when and how this continuation of coverage occurs. Continuation of coverage applies only to medical/prescription drug, health FSA, dental, EAP and vision coverage and does **not** apply to life insurance, accidental death and dismemberment, short-term disability, long-term disability or other income replacement coverage. See the Life Insurance section of this Plan Document for information about portability or conversion options that may be available when active life and accidental death and dismemberment insurance coverage ends.

CONTINUATION OF COVERAGE (COBRA)

Entitlement to COBRA Continuation Coverage

In compliance with a federal law commonly called COBRA, this Plan offers its employees and their covered Dependents (called **"Qualified Beneficiaries"** by the law) the opportunity to elect a temporary continuation (**"COBRA Continuation Coverage"**) of the group health coverage sponsored by the City, including medical/prescription drug, dental, vision, EAP services and the health care flexible spending account (the **"Plan"**), when that coverage would otherwise end because of certain events (called **"Qualifying Events"** by the law). Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense. (Note, effective April 1, 2014, Committed Partners and Committed Partner child(ren) are not Qualified Beneficiaries and therefore not entitled to COBRA Continuation coverage.)

This notice is provided to all covered Employees and their Covered Spouses, and is intended to inform them (and their covered Dependents, if any) in a summary fashion, of rights and obligations under the continuation coverage provisions of the law. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. Note: It is important that you and your spouse take the time to read this notice carefully and be familiar with its contents.

COBRA Administrator

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

Who Is Entitled to COBRA Continuation Coverage; When (the Qualifying Event); and For How Long

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event, that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. A parent or legal guardian may elect COBRA for a minor child. A qualified beneficiary also has the same rights under the Plan as other covered individuals including Open and Special enrollment.

1. **"Qualified Beneficiary":** Under the law, a Qualified Beneficiary is any Employee, his or her Spouse or Dependent Child who was covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered employee during a period of COBRA Continuation Coverage is also a Qualified Beneficiary. A person who becomes the new spouse of an employee during a period of COBRA Continuation Coverage is not a Qualified Beneficiary.
2. **"Qualifying Event":** Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**. If a covered individual has a qualifying event but does not lose their health care coverage under this Plan, (e.g. employee continues working even though entitled to Medicare) then COBRA is not yet offered.

Failure to Elect COBRA Continuation Coverage

In considering whether to elect COBRA, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law, as noted below:

1. You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage; and electing COBRA may help you not have such a gap; and
2. You will also lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA continuation coverage for the maximum time available to you.

Special Enrollment Rights
You have special enrollment rights under federal law that allows you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 31 days after your group health coverage ends because of the qualifying events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

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

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

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

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries[1]		
	Employee	Spouse	Dependent Child(ren)
Employee terminated (for other than gross misconduct)	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the same coverage)	18 months	18 months	18 months
Employee dies	N/A	36 months	36 months
Employee becomes divorced or legally separated	N/A	36 months	36 months
Dependent Child ceases to have Dependent status	N/A	N/A	36 months
Retiree coverage is terminated or coverage is substantially reduced within one year before or after the City files for bankruptcy reorganization under Chapter 11 of the federal Bankruptcy Act.	Life	Varies[2]	Varies[2]

1. *When a covered employee's qualifying event (i.e. termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the employee's covered spouse and dependent children who are qualified beneficiaries (but not the employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.*
2. *Employer's bankruptcy under Title 11 of the US Code may trigger COBRA coverage for certain retirees and their related qualified beneficiaries such as COBRA coverage for the life of the retiree. The retiree's spouse and dependent children are entitled to COBRA for the life of the retiree and if they survive the retiree, for 36 months after the retiree's death. If the retiree is not living when the qualifying event occurs, but the retiree's surviving spouse is alive and covered by the group health Plan, then that surviving spouse is entitled to coverage for life.*

Procedure on When the Plan Must Be Notified of a Qualifying Event (Very Important Information)
In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "dependent child" under the Plan, you and/or a family member **must inform the Plan in writing of that event no later than 60 days after that event occurs.**

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

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

Other City officials or employees will usually notify the COBRA Administrator of the employee's death, termination of employment, reduction in hours. However, you or your family **should also notify** the COBRA Administrator promptly of these changes as well as any entitlement to Medicare in writing to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Notices Related to COBRA Continuation Coverage

When:

1. **your employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to coverage under the Plan, you died, or
2. **you notify the COBRA Administrator** that a Dependent Child lost Dependent status, you divorced or have become legally separated, or you have become entitled and enrolled in Medicare

then the COBRA Administrator will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage.

Note: Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage.

Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice, to elect COBRA Continuation Coverage.

NOTE: If you and/or any of your covered dependents do not choose COBRA Coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.

The COBRA Continuation Coverage That Will Be Provided

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on Paying for COBRA Continuation Coverage that appears later in this subchapter for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will be made in your COBRA Continuation Coverage.

When COBRA continuation coverage of your participation in the health care flexible spending account is available, it will be on the same terms outlined above for group health coverage, but since the person who elects it will not be employed by the City, **it will not be possible** to make contributions to the health care flexible spending account on a **before-tax** basis.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

By law, any person who elects COBRA Continuation Coverage will have to pay the full cost of the COBRA Continuation Coverage. The City is permitted to charge the full cost of coverage for similarly situated active employees and families (including both the City's and employee's share), plus an additional 2% administration fee. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

Grace Periods

The initial payment for the COBRA Continuation Coverage is due to the COBRA Administrator 45 days after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect, even though an election may have occurred in a timely manner. Under this Plan, after the initial COBRA payment, subsequent payments are **due on the first (1st) of the month for that month's coverage, but there will be a 31-day grace period (including the due date) to make those payments**. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage and you, your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** you, your Spouse or Dependent Child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the

COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Addition of Newly Acquired Dependents
If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the COBRA Administrator to add a dependent.

Loss of Other Group Health Plan Coverage
If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA Plan and, when enrollment was previously offered under that pre-COBRA healthcare Plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the spouse or dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Notice of Unavailability of COBRA Coverage
In the event the Plan is notified of a qualifying event but the COBRA Administrator determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

1. If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced, become entitled to Medicare, or if a covered child ceases to be a Dependent Child under the Plan, **the maximum COBRA Continuation period for the affected spouse and/or child is extended to 36 months from the date of your termination of employment or reduction in hours** (or the date you first became entitled to Medicare, if that is earlier, as described below). Medicare entitlement is not a qualifying event under the Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for spouses and dependents who are qualified beneficiaries.
2. **Notifying the Plan**: To extend COBRA when a second qualifying event occurs, you must notify the COBRA Administrator in writing within 60 days of a second qualifying event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. For information on how to notify the Plan, see the subsection in this chapter entitled "Procedure on When the Plan Must be Notified of a Qualifying Event."
3. **This extended period of COBRA Continuation Coverage is <u>not</u> available to anyone who became your Spouse after the termination of employment or reduction in hours**. However, this extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with you during the 18-month period of COBRA Continuation Coverage.
4. In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.
5. In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months except for retirees who become entitled to COBRA because of a Chapter 11 bankruptcy reorganization proceeding on the part of the City.

Extended COBRA Continuation Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period

1. If, at any time during or before the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child become totally and permanently disabled so as to be entitled to Social Security Disability Income benefits, the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare (whichever is sooner).
2. **This extension is available only** if:
   - the Social Security Administration determines that the individual's disability began no later than 60 days after the termination of employment or reduction in hours; **and**
   - **Notifying the Plan:** you or another family member follow this procedure to notify the Plan by sending a written notification to the COBRA Administrator of the Social Security Administration determination **within 60 days after that determination was received by you** or another covered family member (failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage). For information on how to notify the Plan see the subsection in this chapter entitled "Procedure on When the Plan Must be Notified of a Qualifying Event"; **and**
   - that notice is received by the COBRA Administrator before the end of the 18-month COBRA Continuation period.
3. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage will be much higher for the disabled individual than the cost for that coverage during the 18-month period.
4. The COBRA Administrator must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

Early Termination of COBRA Continuation Coverage

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of **any** of the following events:

1. The date on which the City no longer provides group health coverage to any of its employees;
2. The first day of the time period for which the amount due for the COBRA Continuation Coverage is not paid on time;
3. The date, after the date of the COBRA election, on which the covered person first becomes entitled to Medicare;
4. The date the lifetime benefit maximum is exhausted on all benefits;
5. The date, after the date of the COBRA election, on which the covered person first becomes covered under another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a preexisting condition that the covered person may have;
6. The date the Plan has determined that the covered person must be terminated from the Plan for cause.
7. During an extension of the maximum coverage period to 29 months due to the disability of the covered person, the disabled person is determined by the Social Security Administration to no longer be disabled.

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a qualified beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the qualifying event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the qualified beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the COBRA Administrator determines that COBRA coverage will terminate early.

No Entitlement to Convert to an Individual Health Plan after COBRA Ends

There is no opportunity to convert to an individual health plan after COBRA ends under this Plan.

COBRA Questions or To Give Notice of Changes in Your Circumstance

If you have any questions about your COBRA rights, please contact the COBRA Administrator located in the Employee Benefits Administration Office.

Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you <u>must</u> notify the COBRA Administrator:

1. within 31 days of a **change in marital status (e.g. marry, divorce)**; or have **a new dependent child**; or
2. within 60 days of the date you or a covered dependent spouse or child has been determined to be **totally and permanently disabled** by the Social Security Administration; or
3. within 60 days if a covered child **ceases to be a "dependent child"** as that term is defined by the Plan; or
4. promptly if an individual has **changed their address, become entitled to Medicare, or is no longer disabled**.

BRIEF OUTLINE ON HOW CERTAIN LAWS INTERACT WITH COBRA

FMLA and COBRA

Taking a leave under the Family & Medical Leave Act (FMLA) is not a COBRA qualifying event. A qualifying event can occur **after** the FMLA period expires, **if** the employee does not return to work and thus loses coverage under their group health plan. Then, the COBRA period is measured from the date of the qualifying event, in most cases, the last day of the FMLA leave. Note that if the employee notifies the employer that they are not returning to employment prior to the expiration of the maximum FMLA 12-week period, a loss of coverage could occur earlier.

LEAVE of ABSENCE (LOA) and COBRA

If an employee is offered alternative health care coverage while on LOA, and this alternate coverage is **not identical** in cost (increase in premium), or benefits to the coverage in effect on the day before the LOA, then such alternate coverage does not meet the COBRA requirement, and is considered to be a loss in coverage requiring COBRA to be offered. If a qualified beneficiary rejects the COBRA coverage, the alternative plan is considered to be a different group health plan and, as such, after expiration of the LOA, no COBRA offering is required. If the alternative coverage is identical in cost and benefits but the coverage period is **less than** the COBRA maximum period (18, 29, 36 months), the lesser time period can be credited toward covering the 18, 29, or 36 month COBRA period. For example, if an employee is allowed to maintain the same coverage and premium for six months while on an LOA, the six months can be credited toward the COBRA maximum period.

HEALTH CARE REFORM - HEALTH INSURANCE MARKETPLACE

There may be other coverage options for you and your covered family members, when you are otherwise eligible for COBRA Continuation Coverage. After October 1, 2013, you may be able to buy coverage through the Health Insurance Exchange/Marketplace instead of electing COBRA Continuation Coverage. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premiums, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or for a tax credit through the Marketplace. Visit HealthCare.gov for more information.

GENERAL INFORMATION

NAME OF THE PLAN: The City of Mesa Health Plan

EMPLOYER IDENTIFICATION NUMBER: 86-6000252

TYPE OF ADMINISTRATION:
The City of Mesa offers a variety of benefits to employees, retirees and eligible dependents. Some of the benefits offered are contractual arrangements with insurance vendors such as the vision plan, EAP, life insurance, accidental death and dismemberment insurance, business travel accident/commuter travel accidental death benefits, short term disability and long term disability. Refer to the Quick Reference Chart in the Introduction chapter of this document for the names of any insurance companies or service providers administering these benefits.

Other services are self-insured by the City, including the Medical/Prescription Drug and Dental Plan options, and the Flexible Spending Account Plan. The City contracts with third party administrators and other service providers (Appropriate Claims Administrators and Utilization Management Companies) to administer these self-insured benefits, including claims and appeals administration.

The City of Mesa has contracted with a stop-loss reinsurance company to provide stop-loss reinsurance to the self-insured portions of the medical and prescription drug benefit Plan. Stop-loss insurance reimburses the Plan for certain losses in excess of amounts described in the stop-loss insurance policy. Under this policy, there is no guarantee, and no obligation to pay any Plan benefits or to make any other payments to any Plan Participant. Contact Employee Benefits Administration for the name of the stop-loss carrier.

PLAN ADMINISTRATOR:
The City of Mesa Employee Benefits Administrator is the Plan Administrator. The Plan Administrator is located in the Employee Benefits Administration Office whose address is listed in the Quick Reference Chart in the Introduction chapter of this document.

CLAIMS FIDUCIARY:
With respect to all matters regarding general benefits information, medical claims, dental claims, flexible spending accounts and appeals administration, contact any of the Plan's contracted third party claims administration services (Appropriate Claims Administrators) for each Plan, whose addresses and contact information are listed in the Quick Reference Chart in the front of this document.

AGENT FOR SERVICE OF LEGAL PROCESS:
For disputes arising under the Plan, service of legal process may be made on the Plan Administrator.

THIS IS NOT AN ERISA PLAN:
This Plan is not subject to the provision of the Employee Retirement Income Security Act of 1974 (ERISA) and participants are not entitled to certain rights and protections under (ERISA).

PLAN AMENDMENTS OR TERMINATION OF PLAN:
The City of Mesa reserves the right to amend or terminate this Plan, or any part of it at any time. Amendments may be recommended by the Plan Administrator and become effective on the written recommendation of the Employee Benefits Advisory Committee and approval of the Mesa City Council, or on such other date as may be specified in the amended Plan Document whichever is later. The Plan or any coverage under it may be terminated by the City Council and new coverage may be added by the City Council.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES:
In carrying out their respective responsibilities under the Plan, the Plan Administrator and Claims Fiduciaries (individuals and contracted third party administrators or insurers) to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF THE CITY'S RIGHTS:
The City of Mesa makes no representation that employment with it represents lifetime security or a guarantee of continued employment. An individual's employment may be terminated because of:

1. unsatisfactory job performance;
2. unsatisfactory attendance;
3. violation of the City's rules and policies; or

4. because an individual's services become excess to the City's staffing needs.

An individual's employment may also be terminated whenever the City, in its sole judgment, deems that to be in its best interest. The City, as Plan Sponsor, intends that the terms of the Plan described in this document, including those relating to coverage and benefits, are legally enforceable, and that each Plan is maintained for the exclusive benefit of participants, as defined by law. Any written or oral statement other than a written statement signed by the City Manager that is contrary to the provisions of this section **is invalid**, and no prospective, active or former employee should rely on any such statement.

NO LIABILITY FOR PRACTICE OF MEDICINE:

The Plan, Plan Administrator or any of their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 14, 2003, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, requires that health plans like the City of Mesa Health Plan (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI).

- The term "Protected Health Information" (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- PHI does not include health information contained in employment records held by the City of Mesa in its role as an employer, including but not limited to health information related to disability, work-related illness/injury, sick leave, Family or Medical leave (FMLA), life insurance, dependent care FSA, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was previously distributed to you or distributed to you upon enrollment in the Plan and is also available from the Employee Benefits Administration Office or via our website at www.mesaaz.gov/benefits. Information about HIPAA in this document is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor (the City of Mesa), will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim or for other reasons related to the administration of the Plan.

1. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.
   - **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your health care providers.
   - **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:
     a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;
     b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, , billing, collection activities and related health care data processing, and claims auditing;
     c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization review, including pre-certification, concurrent review and/or retrospective review.
   - **Health Care Operations** includes, but is not limited to:
     a. Business planning and development, such as conducting cost management and strategic planning related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment,
     b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions,

c. Underwriting, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,
d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers, and resolution of internal grievances.

2. **When an Authorization Form is Needed**: Generally the Plan will require that you sign a valid authorization form, available from the Appropriate Claims Administrator in order for the Plan to use or disclosure your PHI other than when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations. The Plan's Privacy Notice also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.
3. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:
4. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law,
5. Ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.
6. Not use or disclose the information for employment-related actions and decisions,
7. Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices).
8. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
9. Make PHI available to the individual in accordance with the access requirements of HIPAA,
10. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
11. Make available the information required to provide an accounting of PHI disclosures,
12. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA, and
13. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.
14. In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and/or disclose PHI:
15. The Plan Administrator,
16. Employees of the City of Mesa Employee Benefits Administration Unit.
17. Staff designated by the Plan Administrator, such as Payroll staff, certain other City staff that provides financial, technological, and administrative support and assistance, and the Employee Benefits Advisory Committee for appeals and grievances.
18. Business Associates under contract to the Plan including but not limited to the medical and dental plan preferred provider organization network, Appropriate Claims Administrators, utilization review/case management/disease management firms, prescription benefit manager and subsidiary firms, vision plan administrator, and employee assistance program administrator.
19. The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer whose address and phone number are listed on the Quick Reference Chart in the front of this document.
20. **Effective April 21, 2005 in compliance with HIPAA Security** regulations, the Plan Sponsor will:
21. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,

22. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
23. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
24. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

INFORMATION YOU OR YOUR DEPENDENTS MUST FURNISH TO THE PLAN (Very Important Information):
In addition to information you must furnish in support of any claim for Plan benefits under this Plan, you or your covered Dependents must furnish, within **30 days** after the event, any information you or they may have that may affect eligibility for coverage under the Plan. This includes, but is not limited to:

1. Change of name.
2. Change of address.
3. Marriage, divorce, or death of you or any covered Spouse or Dependent Child.
4. Any information regarding the status of a Dependent Child, including, but not limited to:
5. The Dependent Child reaching the Plan's limiting age; or
6. The existence of any physical or mental Disability or the fact that a disability no longer exists.
7. Medicare enrollment or disenrollment (notify applicable Appropriate Claims Administrators).
8. The existence of other medical or dental coverage (notify applicable Appropriate Claims Administrators).

Notices of the foregoing information should be sent, **in writing**, to the Plan Administrator (or Appropriate Claims Administrators) at the addresses shown in the Quick Reference Chart in the Introduction chapter of this document. See also the timeframes relating to Special Enrollment in the Eligibility chapter of this document.

HEADINGS DO NOT MODIFY PLAN PROVISIONS:
The headings of chapters and subchapters, sections (APPEARING IN **BOLD** TEXT WITH SOLID CAPITAL LETTERS) and paragraphs and subparagraphs (Appearing in Bold Text with Upper and Lower Case Letters) are included for the sole purpose of generally identifying the subject matter of the substantive text so that a table of contents and index can be constructed for the convenience of the reader. The headings are **not** part of the substantive text of any provision, and they should not be construed to modify the text of any substantive provision in any way.

FLEXIBLE SPENDING ACCOUNT PLAN

HEALTH AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS (FSA)

The Flexible Spending Account Plan (FSA) allows you to set aside pre-tax dollars from your paycheck to pay for either health or dependent care expenses (child or dependent elder care). When you enroll in the FSA program, the portion of your salary deducted from your paycheck and applied to your FSA accounts is **not** subject to federal or state income tax withholding, or social security/Medicare taxes. In other words, by contributing to the Plan, you may use tax-free dollars to pay for certain health or dependent care expenses that you would otherwise pay for with after-tax dollars.

The City's FSA Plan is administered by an Appropriate Claims Administrator. To participate in the FSA Plan, you must make your elections via the City's online enrollment system. See the Quick Reference Chart at the front of this document for contact and enrollment information. Your effective date in the FSA Plan is the same as your effective date in the medical plan if you enroll when first eligible, or any subsequent January 1 if you enroll during an Open Enrollment period, or on the first of the month following any applicable qualifying event that gives you the opportunity to enroll or change your FSA elections (see below).

Your Health FSA account balances, or your Health FSA debit card, may be used to reimburse/pay for certain health care expenses incurred during the calendar year. Your Dependent Care FSA balances may be used to reimburse you for eligible dependent care expenses incurred during the calendar year. ***NOTE: If you receive reimbursement for an expense from one of the Flexible Spending Accounts, (or use a Health FSA debit card to pay for an expense), you cannot claim that expense as a deduction, or take a federal income tax credit for that expense on your income tax return.***

HEALTH FSA

Use your Health FSA debit card or account to pay or be reimbursed for a variety of health care expenses that are not covered by your medical, prescription drug, dental or vision care programs or are out-of-pocket expenses that you are responsible for after insurance has made eligible payments for health expenses. ***NOTE: Eligible FSA expenses may be incurred by any of your family members (qualified tax dependents), whether or not they are enrolled in one of the City-sponsored health insurance plans, or if they are covered by other insurance plans.***

Expenses for services that are eligible to be covered by **any** insurance plan, must be processed by those insurance plans before being submitted to the FSA Plan for potential reimbursement of out-of-pocket expenses. You will need the Explanation of Benefits (EOB) documentation to submit (or substantiate) your Health FSA claim. Exception: if you use your Health FSA debit card to pay for eligible out-of-pocket expenses your FSA claim will process before any related EOB is available. However, when you use your Health FSA debit card, you should still keep itemized receipts and related documentation (e.g. EOB) until and if you are required by the Appropriate Claims Administrator to substantiate allowable debit card usage under the FSA Plan.

ELIGIBLE AND INELIGIBLE HEALTH FSA EXPENSES

There are many eligible expenses for your Health FSA funds for you and your qualified tax dependents, including medical, dental and vision care deductibles, copays and co-insurance amounts, prescription drug copays and co-insurance amounts and expenses for many over-the-counter items (see below). Eligible and ineligible expenses include but are not limited to:

Condition/Type of Service/Expense	Eligible	Potentially Eligible (with Prescription /LMN)	OTC Prescription Required	Not Eligible
Abortion, illegal				X
Abortion, legal	X			
Acne medication, no lotions, cleansers or soaps			X	
Acupuncture	X			
Adoption, medical costs of adopted child	X			
Adoption, medical costs of natural mother				X
Air conditioner or furnace, as permanent improvement to property				X
Alcoholism or Drug Dependency Treatment	X			
Allergy medications, such as oral medications, nasal sprays and patches			X	
Ambulance Charges, including other travel costs to obtain medical care	X			
Analgesics, such as fever and pain reducers like aspirin			X	

Condition/Type of Service/Expense	Eligible	Potentially Eligible (with Prescription /LMN)	OTC Prescription Required	Not Eligible
Antacids			X	
Antibiotic creams/ointments			X	
Anticipated medical expenses				X
Anti-diarrhea medications			X	
Anti-fungal medications			X	
Anti-gas medications			X	
Anti-itch medications			X	
Any expenses incurred in connection with an illegal operation or treatment				X
Arthritis pain relieving creams			X	
Athlete's foot treatment, such as nail and foot anti-fungal creams			X	
Auto insurance premiums, including the segment providing repayment for loss of earnings or for accidental loss of life, limb, sight, etc.				X
Band-Aids, Bandages	X			
Birth control pills	X			
Blind Persons: seeing eye dog, special education, Braille books, etc.	X			
Blood Pressure monitor		X		
Breast Pumps and Lactation Supplies	X			
Bug bite medication			X	
Burn/sunburn medications			X	
Calcium Supplements		X		
Car depreciation or insurance				X
Car: equipped to accommodate wheelchair passenger, disability controls	X			
Chap Stick/lip balm				X
Childbirth classes (Lamaze) for the mother	X			
Chiropractor fees	X			
Christian Science treatment; Native American medicine man	X			
Cleansers or soap that are considered toiletries (non-medicated)				X
Cold and flu medications such as tablets, syrups, drops and medicated throat lozenges			X	
Cold sore medicines			X	
Contact Lens solution/supplies, including insurance – if not covered by a vision service plan	X			
Contact lenses, cleaning and soaking solutions, and lens storage cases	X			
Contraceptives, prescription	X			
Cosmetic products of any kind such as make-up, cotton swabs, baby oil				X
Cosmetic surgery unless medically necessary				X
Cosmetics, toiletries, etc.				X
Cough/cold/flu/fever reducers			X	
Counseling for treatment of medical or mental diagnosis, including psychotherapy, bereavement, grief counseling and is rendered by a licensed provider	X			
Crutches	X			
Dance lessons				X
Deaf persons: hearing aid, lip-reading expenses, note taker, special education telephone, TV, visual alert system.	X			
Deductibles – Balance not paid by medical plan such as copayment and coinsurance	X			
Dental Fees, dentures	X			
Dental floss, mouthwashes, tooth brushes and toothpaste				X
Deodorants, soap, body powder, shaving cream and razors				X
Diabetic supplies, such as glucose monitor and related equipment		X		
Diaper rash ointments			X	
Dietary Supplements – used to improve or maintain general health				X
Doctor's Fees	X			
Drugs purchased in a foreign country, even when prescribed by a Physician				X

Condition/Type of Service/Expense	Eligible	Potentially Eligible (with Prescription /LMN)	OTC Prescription Required	Not Eligible
Drugs, formerly prescription only (i.e. Claritin and Prilosec)			X	
Dust elimination services				X
Dyslexia, language training, remedial reading	X			
Ear care/swimmer's ear-medications only not ear plugs			X	
Electrolysis		X		
Eye and facial makeup preparations				X
Eye care, such as contacts, saline solution and lubricant eye drops	X			
Eye exam and glasses – Lenses, frames & exams, eye surgery and contact lenses - if not covered by a vision service plan	X			
Face cream				X
Family planning, pregnancy tests/condoms with prescription	X			
Feminine care relating to treatment of vaginal infections			X	
Feminine hygiene – most likely used for general health or toiletries, but there could be exceptions.			X	
Fertility enhancement services	X			
Fiber supplements – used for general health				X
Fingernail polish				X
First aid creams/ointments			X	
Funeral expenses				X
Glucosamine/Chondroitin – used for arthritis		X		
Guide Dog – For blind and deaf, including cost of maintaining	X			
Hair care such as hair color, hair products and brushes				X
Hair transplants, ear piercing, tattoos				X
Halfway House – Care to help individual adjust from life in a mental hospital to community living	X			
Health club dues for specific exercise prescribed by physician for a medical condition.		X		
Health club dues, YMCA dues, steam bath, etc. not related to a medical condition				X
Hearing aid batteries	X			
Hearing Aids	X			
Heartburn/indigestion medications			X	
Hemorrhoid creams/suppositories			X	
Herbal medications		X		
Herbal supplements – used to improve or maintain general health				X
Home modifications for disabled individual	X			
Hormone therapy/treatments for menopause – used to treat symptoms such as hot flashes, night sweats, etc.		X		
Hospitalization	X			
Household and domestic help				X
Household products to treat allergies		X		
Hydrogen Peroxide			X	
Insurance premiums paid on an after-tax basis—for hospitalization or medical coverage by a spouse or dependent under their employer's plan				X
Laboratory Fees	X			
Laetrile – If legally qualified as a drug where purchased	X			
Laxatives			X	
Lifetime Care – Advance payment to private institution for lifetime care, treatment or training of mentally or physically disabled patient.	X			
Lipstick				X
Lodging expenses for care not provided in hospital or equivalent outpatient facility				X
Long Term Care services.	X			
Marriage counseling, Life coaching, career counseling				X
Massage Therapy		X		

Condition/Type of Service/Expense	Eligible	Potentially Eligible (with Prescription /LMN)	OTC Prescription Required	Not Eligible
Maternity clothes, diaper services, etc.				X
Medical Marijuana, regardless of medical necessity or prescription				X
Medicated shampoo for psoriasis and lice			X	
Medicated shampoos/Medicated soaps – only if physician diagnoses skin or scalp infection and prescribes special treatment to be applied for limited period of time.		X		
Medicines – Legally obtained prescription drugs for treatment of illness or injury. Certain IRS-approved over the counter medication.	X			
Menstrual cramp/pain medications			X	
Motion sickness such as tablets and patches			X	
Mouthwash				X
Nasal decongestants			X	
Nasal sprays for snoring		X		
Nausea/vomiting medications			X	
Nicotine gum			X	
Nicotine patches			X	
Nursing Home	X			
Nursing Services – By registered nurse or licensed practical nurse for medical care (other than a member of the patient's family).	X			
Nutritional and dietary supplements				X
Optometrist – Services within scope of license	X			
Orthodontia	X			
Orthopedic inserts – if medically prescribed for treatment of medical condition		X		
Orthotics, foot	X			
Over-the-counter drugs & supplies not listed as an eligible OTC expenses in this list.				X
Oxygen equipment	X			
Pain relievers/fever reducers			X	
Pain relievers-muscle pain			X	
Pedialyte for child's dehydration			X	
Pills for lactose intolerance			X	
Pinworm medication			X	
Poison treatment			X	
Prenatal vitamins – not for general well being	X			
Prescription drugs, Insulin, diabetic supplies.	X			
Prosthetics, artificial limbs	X			
Psychiatrists, Psychologists, psychotherapists	X			
Radial Keratotomy	X			
Rashes: diaper rash/fever blisters			X	
Rashes: poison oak/ivy/sumac			X	
Routine Physical Exams	X			
Sexual dysfunction, treatment of	X			
Shampoo				X
Sinus medications			X	
Skin care such as moisturizers, sun lotion, sun block and lip balms				X
Sleep aids, such as snoring strips				X
Sleeping medication for insomnia			X	
Smoking cessation program	X			
Smoking cessation treatment		X		
Spiritual guidance				X
Sterilization - legal vasectomy	X			
Sunscreen – prescribed for a specific medical condition (SPF15+, Broad Spectrum)	X			
Sunscreen – used for general health purposes				X

Condition/Type of Service/Expense	Eligible	Potentially Eligible (with Prescription /LMN)	OTC Prescription Required	Not Eligible
Suntan lotion				X
Swimming pool for treatment of polio or arthritis	X			
Teeth whitening products				X
Throat lozenges-medicated			X	
Toiletries of any kind				X
Tooth and mouth pain relief such as medicated rinse			X	
Toothbrushes				X
Toothpaste				X
Transplants, including donor's costs	X			
Transportation expense to and from work, even though a physical condition may require special means of transportation.				X
Vacation or travel taken for general health or taken to relieve physical or mental discomfort not related to a particular disease or physical defect				X
Vitamins – used to improve or maintain general health				X
Vitamins– For treatment of illness (prescribed by physician)	X			
Wart removal medication			X	
Weight Loss program – amounts paid by individuals for participation in a weight-loss program as treatment for a specific disease or diseases (including obesity) diagnosed by a physician. Items that replace normal food consumption are not reimbursable (i.e. diet foods, drinks, bars). Supplements/drugs that are purchased for general dietary health are not reimbursable.		X		
Weight Loss Program if used to treat a specific disease diagnosed by a Physician (but not membership at a gym)	X			
Weight loss programs to improve appearance				X
Weight reduction aids such as food supplements				X
Wheelchair	X			
Wig, for alleviation of physical or mental discomfort		X		
X-ray fees	X			

OVER-THE-COUNTER (OTC) MEDICINES & PRODUCTS

Over-the-Counter (OTC) items include medicines/drugs/supplements and products that alleviate or treat injuries or illness for you and your qualified tax dependents. These medicines and products must be used for a **medical purpose** only and cannot be cosmetic in nature or merely beneficial to your general health. Additionally, purchases must be in reasonable quantities that can be used in the calendar year in question (no year-end stockpiling).

OTC medicines/drugs (or dual purpose items that could be either OTC medicines/drugs or general health items), require an adequate receipt and a **physician's prescription** (or **letter of medical necessity** – LMN), to be considered for Health FSA reimbursement. The only exception is insulin and related supplies – no prescription needed. **OTC products that are <u>not</u> medicines or drugs,** but products used for medical purposes, require an adequate receipt, but generally do not require a prescription or LMN. An adequate receipt for any OTC expenses includes: the description/name of the service, medicine or drug, the date purchased, name of the service provider and the amount/cost of the item.

If your OTC medicines/drugs/supplements and products are paid for with a Health FSA debit card, keep adequate receipts, physician prescription/LMN (if applicable), for subsequent substantiation purposes if requested by the Appropriate Claims Administrator. If not paid with your Health FSA debit card, claims for reimbursement must include an adequate receipt and physician prescription/LMN (if applicable to the specific claim).

HOW TO ENROLL IN THE HEALTH FSA ACCOUNT

If you are a new Employee, you may enroll in a Health FSA when you are hired. If you do not choose to enroll in the Health FSA at that time, you must wait until the next Open Enrollment period to enroll for the following calendar year or, when you have an eligible Change in Status (as described below under "Change in Status" in this chapter). All eligible employees may enroll in Health FSA during Open Enrollment for the following calendar year.

The maximum amount you can deposit into a Health FSA is $2,500 per calendar year. Effective 1/1/15, the minimum amount you can deposit into a Health FSA is $100 per calendar year.

When you enroll in the Plan, you must determine the total amount to be deposited into your Health FSA – your annual election amount. This amount is then divided by the total number of pay periods expected during that calendar year, or the number of pay periods remaining in the calendar year if you join the Plan after the beginning of the calendar year.

****IMPORTANT NOTICE:**** You should ESTIMATE YOUR ELIGIBLE EXPENSES (ANNUAL ELECTION) CAREFULLY since money left in your account at the end of the calendar year WILL BE FORFEITED. Effective 1/1/15 however, money left in your account at the end of a calendar year, **up to and including $500**, will not be forfeited but rather, will be rolled over in your account to the next calendar year. If you are enrolling as a new employee, only expenses that are incurred **after** your benefits effective date will be eligible for reimbursement.

HOW TO SUBMIT HEALTH FSA CLAIMS FOR REIMBURSEMENT

After you are enrolled in the Health FSA, you may begin submitting claims for reimbursement for eligible expenses incurred during the calendar year for which you are enrolled (or during your employment period if shorter than the full calendar year), up to the total amount of your annual Health FSA election amount (minus any Health FSA claims amounts already paid for that calendar year). An expense is incurred when a service is received (not when a bill is paid).

There are three ways to submit reimbursement requests for Health FSA claims:

1. Use your **Health FSA payment/debit card** to pay your eligible out-of-pocket expenses. Your "claim" is automatically processed when you use the debit card to pay the expense (you should still keep itemized receipts and related documentation like an EOB, until and if you are required by the Health FSA Appropriate Claims Administrator to substantiate debit card usage under the FSA Plan).
2. **Automatic Health FSA claims submission** of completed claims, by any or all of the Appropriate Claims Administrators for medical, dental and vision plans directly to the Health FSA Appropriate Claims Administrator. View these automatic Health FSA claims submissions in your online account (or mobile app) with the Health FSA Appropriate Claims Administrator, and use a "click to pay" process to request your FSA reimbursement by check or direct deposit. (Exception: do not "click to pay" if you paid for the service with your Health FSA debit card as described in 1. above – submit receipts to substantiate the debit card usage only.) Opt-in to direct deposit in the Health FSA Appropriate Claims Administrator website or mobile app. Remember, if you do not "click to pay" by the annual submission deadline (see below), any automatic Health FSA claims will be null and void and you may forfeit account balances that might otherwise have been reimbursable to you (or an eligible rollover).
3. **Reimbursement request** that you initiate and submit to your online account, mobile app, by fax or postal mail to the Health FSA Appropriate Claims Administrator. If you submit your claim online or by mobile app, complete the information requested and provide adequate documentation by upload, fax or postal mail. If you submit both your claim and adequate documentation by fax or postal mail you will need to print/complete a Health FSA Claim Form which you can access from the Health FSA Appropriate Claims Administrator's website and fax/mail with adequate documentation. Approved reimbursement requests will be paid to you by check or direct deposit (opt-in to direct deposit in the Health FSA Appropriate Claims Administrator website or mobile app).

Adequate documentation includes an Explanation of Benefits (EOB) or other documentation that describes: name of patient, date service provided, name of service provider, description of services provided, amount/cost of the item or service and amount of your out-of-pocket expense. Inadequate (and rejected) documentation includes: credit card receipts, non-itemized cash register receipts and cancelled checks.

Claims for Health FSA reimbursement may be submitted up to 90-days after the end of the calendar year in which you are enrolled and incurred the expense. Health FSA debit card usage must be completed by December 31 of the calendar year in which you are enrolled and incur the expense.

ANY MONEY LEFT IN YOUR HEALTH FSA ACCOUNT OVER $500, AFTER THE 90-DAY DEADLINE WILL BE FORFEITED; LEFTOVER AMOUNTS IN YOUR HEALTH FSA UP TO AND INCLUDING $500 WILL BE ROLLED OVER TO THE NEW CALENDAR YEAR, DURING THE CALENDAR MONTH FOLLOWING THE 90-DAY DEADLINE (AND ADDED TO THE HEALTH FSA DEBIT CARD FOR USE IN THE BALANCE OF THAT CALENDAR YEAR).

DEPENDENT CARE FSA

The Dependent Care FSA lets you set aside money to pay for eligible child or dependent elder care services that are needed so you and your spouse (if applicable) can work. Once you incur expenses for certain qualifying child or elder care expenses you

can submit these itemized receipts to the Appropriate Claims Administrator for reimbursement from your account. The claim will be reviewed for eligibility and accuracy. Reimbursement will be equal to the amount of the claim submitted and documented, but not more than the current balance in your Dependent Care FSA account.

If you are married, you can enroll if you and your spouse both work or, in some situations, if your spouse goes to school full time or is physically or mentally incapable of self-care. Single employees may also use this account to pay for eligible dependent care expenses. See IRS Publication 503 to determine eligible dependents. Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves and be your qualified tax dependents. You and your spouse (if applicable) must maintain a home that you live in for more than half the year with the qualified child or tax dependent.

The IRS limits the amount of money that can be paid to you in a calendar year from your Dependent Care FSA. Also, in order to have the reimbursements from this account be excluded from your income, you must provide a statement from the service provider that includes their name, address, and taxpayer identification number or social security number.

A Dependent Care FSA is an alternative to the federal Dependent Care Tax Credit. You should evaluate with your tax advisor, whether you can save more money by taking the federal tax credit rather than using a Dependent Care FSA. If you decide to contribute to the Dependent Care FSA, you still need to complete and file IRS Form 2441 "Credit for Child and Dependent Care Expenses" at the end of the tax year. You will need to indicate the amount deposited in your Dependent Care FSA, which is printed in Box 10 of your Form W-2, as Dependent Care Benefits. Please contact your tax consultant or the IRS for more information.

ELIGIBLE DEPENDENT CARE FSA EXPENSES

- Before or after school care (other than tuition)
- Qualifying custodial care for dependent adults
- Licensed day care centers
- Nursery or pre-schools
- Child care at a day camp, summer or holiday camps
- Late pick-up fees
- Child care by a private individual in or outside your home (who is not your child under age 19 or anyone you claim as a dependent for federal tax purposes (*i.e.,* spouse)

INELIGIBLE DEPENDENT CARE FSA EXPENSES

- Expenses for non-disabled children age 13 an older
- Educational expenses for kindergarten or private school tuition
- Separate fees paid for food, clothing, sports, lessons, field trips and entertainment even if paid to one of the eligible care providers/facilities described above
- Overnight camp fees
- Registration fees
- Transportation expenses
- Late payment fees
- Payment for services not yet provided (payment in advance)
- Medical care

HOW TO ENROLL IN THE DEPENDENT CARE FSA

If you are a new employee, you may enroll in the Dependent Care FSA when you are hired. If you do not choose to enroll in the Dependent Care FSA at that time, you must wait until the next Open Enrollment to enroll for the following calendar year or when you have an eligible Change in Status (as described below under "Change in Status" in this chapter). All eligible employees may enroll in Dependent Care FSA during Open Enrollment for the following calendar year.

The maximum amount you can deposit into a Dependent Care FSA is $5,000 per calendar year if you are single, head of household or married and filing a joint federal tax return. If you are married and filing separate federal tax returns, you may contribute up to $2,500 per calendar year, per parent. You are responsible for determining your federal tax filing status and limiting your annual election for Dependent Care FSA purposes. Effective 1/1/15, the minimum amount you can deposit into a Dependent Care FSA is $100 per calendar year.

When you enroll in the Plan, you must determine the total amount to be deposited into your Dependent Care FSA. This amount is then divided by the total number of pay periods expected during that calendar year, or the number of pay periods remaining in the calendar year.

****IMPORTANT NOTE:**** You should ESTIMATE YOUR ELIGIBLE EXPENSES (ANNUAL ELECTION) CAREFULLY, since any money left in your Dependent Care FSA account at the end of the calendar year WILL BE FORFEITED. If you are enrolling as a new employee, only expenses that are incurred **after** your benefits effective date will be eligible for reimbursement.

HOW TO SUBMIT DEPENDENT CARE FSA CLAIMS FOR REIMBURSEMENT

If you are enrolled in the Dependent Care FSA, you should pay for your qualified dependent care expenses using personal funds on an ongoing basis. Once you have a fully itemized receipt for these services (and the service dates have already taken place), you may submit claims for reimbursement to the FSA Appropriate Claims Administrator. Claims must include documentation showing the name of the dependent for whom the care was provided, the dates services were rendered, the amount of the expense, the date the expense was paid, and the name/date of birth/address and Tax Identification Number or Social Security Number of the service provider.

Claims submitted for reimbursement will be reviewed for eligibility and accuracy. If the claim qualifies as an eligible expense, you will receive a check or direct deposit (if you have opted-in online for direct deposit) from the Appropriate Claims Administrator. Reimbursements made from the Dependent Care FSA will be equal to the amount of the claim, but not more than the amount currently in your Dependent Care FSA account. Claims may be submitted for reimbursement up to 90-days after the end of the calendar year in which you are enrolled and incur the expense.

ANY MONEY LEFT IN THE DEPEDENT CARE FSA ACCOUNT AFTER THE 90-DAY DEADLINE WILL BE FORFEITED.

ADDITIONAL INFORMATION REGARDING HEALTH AND DEPENDENT CARE FSA

Enrollment in the Health and/or Dependent Care FSA is on a year-to-year basis. To continue in the program from one year to the next, you must actively enroll and elect your Annual Election Amount each year during Open Enrollment. Employees may enroll in the Plan upon becoming employed by the City, during the Open Enrollment period, or if there is a change in status (see Change in Status below).

Once you have elected to contribute to the Health and/or Dependent Care FSA, you may not change the elected amount unless there is a change in status (see below). Furthermore, the Health and Dependent Care Accounts are separate and cannot be combined, nor can funds be transferred from one account to another at any time.

CHANGE IN STATUS

The only time you may open a new FSA account outside of the Open Enrollment period, or change your Annual Election Amount during the calendar year, is when you have a Change in Status (and the FSA election change is consistent with that Change in Status). If a Change in Status occurs, you must contact the Employee Benefits Administration Office (or follow any City online processing requirements), **within 31 days** of the change event. The following qualifying changes are **the only ones** permitted under the FSA Plan:

1. Change in employee's legal marital status, including marriage, divorce, legal separation, annulment or death of a Spouse;
2. Change in employee's Dependents, including birth, adoption, placement for adoption, or death of a Dependent Child;
3. Change in employment status or work schedule IF it impairs your, your Spouse's or your Dependent Children's eligibility for benefits, including the start or termination of employment by you, your Spouse or any Dependent Child, or an increase or decrease in hours of employment by you, your Spouse or any Dependent Child, including a switch between part-time and full-time employment, a strike or lock-out, or the start of or return from an unpaid leave of absence that is either required by law (such as FMLA and military leave or, other leave permitted by your employer);
4. Change in dependent status that satisfies or ceases to satisfy the Plan's eligibility requirements, including changes due to attainment of age, or any other reason provided under the definition of Dependent in the Definitions chapter of this document;
5. Change consistent with your right to Special Enrollment as described in the paragraph on Loss of Other Coverage in the section dealing with Special Enrollment.

GENERAL INFORMATION ON HEALTH OR DEPENDENT CARE FSA

Termination of Employment and Effect on FSA:

If you terminate your employment with the City during a year in which you have elected to participate in the FSA Plan, your rights to benefits will be determined as follows:

- **Dependent Care** – you may continue to request reimbursement for qualifying dependent care expenses for the rest of the Plan/calendar year from the balance remaining in your Dependent Care account at the time of termination. However, no further salary contributions will be made.
- **Health Care** – participation in the Health FSA will cease and no further salary contributions will be made (except for COBRA continuation privileges that you elect on an after-tax, direct pay basis). However, you may submit claims for health care expenses incurred prior to your date of termination.

FSA Plan Accounting:

The Appropriate Claims Administrator maintains a participant portal (website) and secure, interactive mobile app where you can access:

- Account balances, account alerts and transaction history

- View debit card charges for Health FSA
- Sign up for direct deposit of FSA reimbursements
- Enter requests for reimbursement
- Upload (or mobile app camera) claim documentation
- View reimbursement requests
- Read important messages
- View reimbursement schedules
- If Mobile app – tap to call Customer Service; text messaging account information and alerts
- Use health education tools
- Review FAQ's

Effect on Social Security Benefits: Participants in Health or Dependent Care FSA Plan may experience a slight reduction in Social Security benefits because, when you receive tax-free benefits under the Plan, the amount of Social Security contributions made by both you and the City are reduced.

LIFE INSURANCE PROGRAMS

The City provides several term life insurance policies for full-time employees and Elected Officials, including Basic Life Insurance, Accidental Death and Dismemberment Insurance and Business Travel Accident/Commuter Travel Accident Life Insurance, at no cost to the employee or Elected Official. Supplemental Life Insurance is available to full-time and part-time benefit eligible employees and Elected Officials, for yourself and your eligible dependents. You pay the full cost of this Supplemental Life Insurance coverage. This chapter briefly outlines information about these benefits; however for a more detailed explanation, refer to the insurance company handbooks (Certificates of Insurance) available online at www.mesaaz.gov/benefits and also available in the Employee Benefits Administration Office. The names and contact information of the carriers who insure these benefits are listed on the Quick Reference Chart in the Introduction chapter of this document.

BASIC LIFE INSURANCE & AD&D INSURANCE

Eligibility:

- **City Manager:** The Life Insurance Plan covers the City Manager at 200% of annual salary rounded up to the nearest $1,000, to a maximum of $1,000,000. AD&D benefits are provided at the same level of coverage as Life Insurance benefits.
- **Executive Pay Plan Employees:** Employees listed on the Executive Pay Plan will be covered at 150% of annual salary rounded up to the nearest $1,000. AD&D benefits are provided at the same level of coverage as Life Insurance benefits.
- **Full-time Employees**: The Life Insurance Plan covers full-time employees only, at 100% of annual salary rounded up to the nearest $1,000, with minimum coverage of $5,000. AD&D benefits are provided at the same level of coverage as Life Insurance benefits.
- **Elected Officials:** These officials receive $50,000 in Life Insurance and AD&D coverage.
- If the amount of basic life insurance coverage the City provides to you is more than $50,000, there is an imputed income and potential payroll tax withholding on your pay checks for the calculated value of this received benefit – IRS regulations.
- **Dependents and part-time employees are not eligible for Basic Life and AD&D coverage.**

Effective Date: Coverage will be effective on the first day of the month following or coincident to your date of hire. If you are not actively at work on the day you would normally become eligible, you will be eligible on the day you return to active work. Enrollment for Life Insurance occurs at the time of a new hire with the City of Mesa. To apply for a subsequent extension of life insurance coverage with a waiver of premium provision, due to total disability, contact the Employee Benefits Administration Office.

Beneficiary: If, as an employee covered under this Plan, you die while insured, the amount of Life Insurance Benefits as indicated above under Eligibility, will be payable to your beneficiary. When eligible employees enroll in the medical/dental/vision plans sponsored by the City of Mesa, a Life Insurance/AD&D beneficiary must be selected. **Changing the Beneficiary:** The beneficiary selected may be changed at any time using the City's online enrollment (and beneficiary designation) system known as eBenMesa.

- **Failure to Select a Beneficiary:** If you do not select a beneficiary, or if there is no named beneficiary living when you die, loss of life benefits will be paid in a lump sum to the survivors according to the guidelines of the life insurance and/or AD&D insurance company. If none of the above survives, benefits will be paid in a lump sum to your estate.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) BENEFIT

This benefit is provided to full-time employees and Elected Officials at no cost. If, as an employee covered under this Plan, you die as a result of an accident, the amount of AD&D benefits provided will be equal to your Basic Life Insurance coverage amounts (described above) and will be payable to the beneficiary of record. If, however, you receive a bodily injury covered by the AD&D Plan, and have any loss named in the table below, benefits will be payable as shown in the table. The loss must:

1. be caused exclusively by external and accidental means;
2. be the result of the injury, directly and independently of all other causes; and
3. occur within 90 days after the injury is sustained.

All benefits other than for loss of life will be paid to you.

SUPPLEMENTAL (Voluntary) LIFE INSURANCE

In addition to the Basic Life Insurance previously described, the City offers a Supplemental Life Insurance Plan to full-time and benefit-eligible part-time employees and Elected Officials. You may elect to have yourself and your eligible family members covered under this policy.

For new employees who elect to participate in this Plan the effective date of coverage will be first day of the month following or coincident to your date of hire. Late enrollees may elect coverage during the annual Open Enrollment period. The amount of coverage available to late enrollees is determined by the Life Insurance carrier and may be subject to Evidence of Insurability (EOI).

Eligible dependents under this Plan include your legal spouse/committed partner and children under age 26 (or disabled adult children age 26 or more who remain dependent upon you for support) or as defined by the carrier administering this Plan.

Beneficiary Selection: When you apply for coverage under this Plan, you must choose a beneficiary, using the procedure described above for Basic Life Insurance. Unless otherwise indicated, you will be beneficiary for your spouse and dependent children covered under this Plan.

Premiums: The premium for the amount of supplemental life insurance coverage you elect is deducted through after-tax payroll deduction from the first two paychecks of each month.

BUSINESS TRAVEL ACCIDENT/COMMUTER TRAVEL LIFE INSURANCE

This policy provides a $200,000 death benefit to your beneficiary in the event that you die as a result of an accident that occurs while you are travelling on City business or commuting to or from work with the City, using your normal route.

SHORT TERM DISABILITY (STD)

Voluntary Short Term Disability (STD) is a benefit offered by the City to full-time employees. This benefit is designed to protect a portion of your salary when you cannot work because of an accident, illness or pregnancy that is not work related. Salary protection is available for up to 6 months, after the elimination waiting period. You may use your accrued sick and/or vacation leave until the waiting period is met, then STD benefits begin if your claim has been approved by the insurance company.

This chapter briefly outlines information about the Short Term Disability coverage; however, for a more detailed explanation, refer to the insurance company handbook (Certificate of Insurance) available in the Employee Benefits Administration Office and online at www.mesaaz.gov/benefits.

Eligibility: Only full-time employees are eligible for this benefit.

Premiums: The STD premium is paid with after-tax dollars in the first two paychecks of each month. It cannot be claimed on your Health Flex Account or taken as a deduction off your personal income taxes. The actual weekly STD benefit received under this Plan is not taxable income to you. Premiums are payable through payroll deduction and are determined by the Plan elimination period that you choose and the amount of weekly benefit you would receive if an approved STD claim were paid to you. The weekly benefit is a percentage of your weekly base salary up to a maximum weekly benefit amount.

Benefits: There are three STD Plan options:

- 7-day elimination waiting period, or
- 29-day elimination waiting period, or
- 44-day elimination waiting period.

LONG TERM DISABILITY (LTD)

The City of Mesa provides or participates in three separate Long Term Disability (LTD) programs to cover employees who are totally disabled and unable to work: one for members of the Public Safety Personnel Retirement System (PSPRS), one for members of the PSPRS system (supplemental program) and Elected Officials and another for members of the Arizona State Retirement System (ASRS). This document highlights some of the key aspects of these long term disability plans; however, the disability carrier or third party administrator's certificate/policy dictates the exact benefits of the LTD Plan.

LTD Insurance helps protect a portion of your income when, due to a covered illness or injury, you become disabled and unable to work. The LTD programs described below cover disabilities occurring on or off the job. This important coverage helps to meet day to day living expenses during extended periods of disability, when your regular income has been discontinued and the need is greatest.

LTD benefits are taxable income to you and are subject to applicable tax laws, including Arizona State tax. LTD vendors are required by Federal law to withhold twenty (20) percent of your monthly benefit for federal taxes. A Form W-2 will be sent to you at the end of the year reflecting LTD income and taxes withheld for that year. **If you are exempt from taxes due to special circumstances, send a completed Form W-4 (to verify your exemption) to the LTD vendor each year.**

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM (PSPRS) MEMBERS – MEDICAL RETIREMENT DISABILITY BENEFITS

Employees who are members of the Public Safety Personnel Retirement System have Long Term Disability (LTD) benefits available upon an approved Medical Retirement, administered by the City of Mesa Clerk's Office. This benefit is designed to provide partial monthly income replacement following a medical retirement and during periods of total disability resulting from a covered injury, sickness or pregnancy.

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM (PSPRS) MEMBERS AND ELECTED OFFICIALS:
Employees enrolled in the Public Safety Personnel Retirement System and Elected Officials have fully insured Long Term Disability (LTD) coverage through a contracted disability carrier listed on the Quick Reference Chart in the Introduction chapter of this document. Eligible PSPRS employees and Elected Officials must satisfy a 6-month elimination (waiting) period while disabled, before any LTD benefits can be paid to you under this policy. Benefits payable equal 60% of your base monthly earnings when the disability commenced, **reduced** by income receipts from other sources if any (e.g. PSPRS Medical Retirement disability benefits, SS disability benefits), with a maximum monthly benefit of $5,000 and a minimum benefit of $100. This coverage is provided at no cost to you.

ARIZONA STATE RETIREMENT SYSTEM (ASRS) MEMBERS – MEDICAL RETIREMENT DISABILITY BENEFITS:

Employees who are members of the Arizona State Retirement System have Long Term Disability (LTD) benefits available through the State Retirement System, using a contracted disability vendor to administer the program. The name of this disability vendor is on the Quick Reference Chart in the Introduction chapter of this document. This coverage is designed to provide a monthly benefit upon a medical retirement, which partially replaces income lost during periods of total disability resulting from a covered injury, sickness or pregnancy. Eligible ASRS employees must satisfy a 6-month elimination (waiting) period while disabled, before any LTD benefits can be paid to you under this State Retirement System benefit. Benefits payable equal 66 2/3% of your base monthly earnings when the disability commenced, **reduced** by income receipts from other sources if any, and a minimum monthly benefit of $50. The cost of this coverage is determined by the Arizona State Retirement System and is deducted from your biweekly salary as a mandatory deduction. The City also contributes an equivalent amount to the cost of this coverage.

DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Abutment: A tooth or root that retains or supports a fixed or removable bridge. See also the definition of Double Abutment.

Accident: A sudden and unforeseen event as a result of an external or extrinsic source that is not work-related.

Active Course of Orthodontia Treatment: The period beginning when the first orthodontic appliance is installed and ending when the last active appliance is removed.

Actively At Work: You are considered to be actively at work when you are performing the regular duties of your employment in the customary manner either at one of the City's regular places of business or at some location to which the City's business requires you to travel. You are also considered to be actively at work on each day of a regular paid vacation, holiday, or non-working day on which you are not Totally Disabled, but only if you were performing the regular duties of your occupation in the customary manner on the regular work day immediately preceding that day. Note that this actively at work provision is not applicable to employees not at work due to a health condition.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, taking drugs or medicines that can be self-administered.

Acupuncture: A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow. When the services of an Acupuncturist is payable by this Plan, the Acupuncturist must be properly licensed by the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required be certified by the National Certification Commission for Acupuncturists (NCCA).

Adverse Benefit Determination: Denial of payment of a claim in whole or in part; denial of coverage through utilization management; rescission of coverage; or written notification that a benefit is not covered under the Plan.

Allowable Expense: A health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the Plans covering a Plan Participant, except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the Plans is not an Allowable Expense. Examples of expenses or services that are not Allowable Expenses appear in the Exclusions chapter of this document.

Allowed Charge/Allowed Amount/Allowable Charge: means the amount this Plan allows as payment to non-network providers for eligible medically necessary services or supplies. The allowed charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible medically necessary services or supplies performed by non-network providers. Allowable charges may be applied to any out-of-network services.

The Plan's allowed charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. See also the definition of Balance Billing in this chapter.

The Plan will not always pay benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the "allowed charge" amount for health care services or supplies.

Treatment errors that are clearly preventable are not allowable charges. The Plan will only pay for services or supplies necessary for treatment. Charges are not eligible for payment when they result from provider error preventable facility-acquired conditions. (See Definition of "Never Events" below.)

Any amount in excess of the "allowed charge" amount does not count toward a Plan's annual deductible or out-of-pocket maximums. Participants are responsible for amounts that exceed "allowed charge" amounts by this Plan. See also Contracted Amount.

With respect to **Non-network Emergency Room services**, the Plan allowed charges are the **greater** of:

- Billed charges, or

- the negotiated amount for in-network providers (the median amount if more than 1 amount to in-network providers), or
- 100% of the Plan's usual payment (Allowed Charge) formula (reduced for cost-sharing), or
- (if such database is available), the amount that Medicare Parts A or B would pay (reduced for cost-sharing).

Alternative Health Care Service: Refers to the following services acupuncture, homeopathy and naturopathy as those terms are defined in this Plan. Refer to the Schedule of Medical Benefits for coverage guidelines.

Ambulance: means a ground motor vehicle, helicopter (rotorcraft), airplane (fixed wing) or boat that is

1. licensed or certified for emergency patient transportation by the jurisdiction in which it operates; and
2. is specifically designed, constructed, modified and equipped with the intention to provide basic life support, intermediate life support, advanced life support, or mobile intensive care unit services by appropriately licensed and certified medical professionals; and
3. provides medical transport services for persons who are seriously ill, injured, wounded, or otherwise incapacitated
4. or helpless and in need of immediate medical transportation; or
5. are unable to be transported between health care facilities in other than an ambulance (such as transport of an inpatient between hospitals to obtain a radiology procedure or transport from a hospital to a skilled nursing facility).

Non-emergency medical services include transportation of individuals who cannot use public or private transportation because of their medically necessary requirement to be positioned in a wheelchair or stretcher. Non-emergency medical services are not payable by this Plan except when considered medically necessary.

Ambulatory Surgical Facility or Center: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

1. It is licensed as an Ambulatory Surgical Center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; **or**
2. Where licensing is not required, it meets all of the following requirements:
   - It is operated under the supervision of a licensed Physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.
   - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
   - It provides at least one operating room and at least one post-anesthesia recovery room.
   - It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
   - It has trained personnel and necessary equipment to handle emergency situations.
   - It has immediate access to a blood bank or blood supplies.
   - It provides the full-time services of one or more registered nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room.
   - It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays), an operative report and a discharge summary.
3. An Ambulatory Surgical Facility that is part of a Hospital, as defined in this chapter, will be considered an Ambulatory Surgical Facility/Center for the purposes of this Plan.

Ancillary Services: Services provided by a Hospital or other Specialized Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (local anesthesia). Anesthetics are commonly administered by injection or inhalation either by a Physician (anesthesiologist) or Nurse Anesthetist.

Appliance: A dental device to provide or restore function or provide therapeutic (healing) effect. Fixed Appliance is a device that is cemented to the teeth or attached by adhesive materials. Prosthetic Appliance is a removable device that replaces a missing tooth or teeth.

Applied Behavioral Analysis (ABA): ABA is the design, implementation, and evaluation of environmental modifications to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior to attempt to improve speech and social interaction

skills and reduce disruptive behavior. ABA is a technique used for individuals diagnosed with Autism Spectrum Disorders that refers to disorders defined in the DSM manual as autistic disorder, Asperger's syndrome or pervasive developmental disorder.

Appropriate: See the definition of Medically Necessary for the definition of appropriate as it applies to healthcare services that are Medically Necessary.

Assistant Surgeon: An assistant surgeon is also referred to as an assistant at surgery or first assistant. A person who functions as an assistant surgeon actively assists the physician in charge of a surgical case (the surgeon) in performing a surgical procedure. This Plan allows payment of an assistant surgeon under the following conditions:

1. the individual functioning as an assistant surgeon is properly licensed as a Physician, Nurse Practitioner, Certified Nurse Midwife, Physician Assistant, Registered Nurse First Assistant (RNFA), but not an employee of a hospital or surgical facility or a medical student, intern, or other trainee; and
2. the use of an assistant surgeon is determined by the Plan Administrator or its designee to be medically necessary; and
3. the assistant surgeon actively participated in the surgical procedure (was not stand-by).

Autologous Blood Transfusions: a procedure in which blood is removed from a donor and stored for a variable period before it is returned to the donor's circulation.

Balance Billing: A bill from a health care provider to a patient for the difference (or balance) between what this Plan pays and what the provider actually charged. Amounts associated with balance billing are not covered by this Plan, even if the Plan's Out-of-Pocket maximum limits are reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Allowed or Contracted Charge. Note that amounts over the Allowed Charge do not count toward the Plan's Out-of-Pocket maximum and may result in balance billing to you. Typically, In-Network providers do not balance bill except in situations of third party liability claims. **Out-of-Network Health Care Providers commonly engage in balance billing a Plan participant for any balance that may be due in addition to the amount payable by the Plan. Generally, you can avoid balance billing by using In-Network providers.**

Behavioral Health Disorder: A Behavioral Health Disorder is any Illness:

1. that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause, and, among other things, autism, depression, schizophrenia, and Substance Abuse.
2. where the treatment is primarily the use of psychotherapy or other psychotherapist methods, or is provided by Behavioral Health Practitioners as defined below.

Certain Behavioral Health Disorders, conditions and diseases are specifically excluded from coverage in the Exclusions chapter of this document. See also the definitions of Chemical Dependency and Substance Abuse.

Behavioral Health Practitioners: A psychiatrist, psychologist, or a certified mental health or substance abuse counselor or social worker who has a master's degree and who:

1. is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered; and
2. acts within the scope of his or her license; and
3. is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Behavioral Health Treatment: Behavioral Health Treatment includes all inpatient services, including Room and Board, given by a Behavioral Health Treatment Facility or area of a Hospital that provides behavioral or mental health or Substance Abuse treatment for an Illness identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), are considered to be Mental Disorder treatments, except in the cases of multiple diagnoses. If there are multiple diagnoses, only the treatment for the Illness that is identified under the DSM code is considered a Behavioral Health Treatment for the purposes of this Plan. Outpatient prescription drugs of any kind are **not** considered to be Behavioral Health Treatment for the purposes of this Plan, such medications are payable under the participant's medical plan.

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of providing a program for diagnosis, evaluation and effective treatment of Behavioral Health Disorders and which fully meets one of the following two tests:

1. It is licensed as a Behavioral Health Treatment Facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; **or**
2. Where licensing is not required, it meets all of the following requirements:
   - have at least one Physician on staff or on call; and

- provide skilled nursing care by licensed Nurses under the direction of a full-time Registered Nurse (RN); and
- prepare and maintain a written plan of treatment for each patient based on the medical, psychological and social needs of the patient.

3. Behavioral health treatment in either a free-standing Behavioral Health Facility or the Behavioral Health unit of a Hospital is payable under the Behavioral Health benefits of this Plan.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the allowable or contracted charge, after calculation of all Deductibles, Coinsurance, Copayments and Allowed or Contracted Charges, and after determination of the Plan's exclusions, limitations and maximums.

Benefits Administrator: See the definition of Plan Administrator.

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

1. It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements:
   - It is operated and equipped in accordance with any applicable state law for the purpose of providing prenatal care, delivery, immediate post-partum care, and care of a child born at the center.
   - It is equipped to perform routine diagnostic and laboratory examinations, including but not limited to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
   - It has available, trained personnel and necessary equipment to handle foreseeable emergencies, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
   - It provides at least 2 beds or 2 birthing rooms.
   - It is operated under the full-time supervision of a licensed Physician, Registered Nurse (RN) or Certified Nurse Midwife.
   - It has a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
   - It has trained personnel and necessary equipment to handle emergency situations.
   - It has immediate access to a blood bank or blood supplies.
   - It has the capacity to administer local Anesthetic and to perform minor Surgery.
   - It maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post-partum summary.
   - It is expected to discharge or transfer patients within 48 hours following delivery.
3. A Birth (or Birthing) Center that is part of a Hospital, as defined in this chapter, will be considered to be a Birth (or Birthing) Center for the purposes of this Plan.

Bitewing X-Rays: Dental x-rays showing the coronal (crown) halves of the upper and lower teeth when the mouth is closed.

Body Mass Index (BMI): BMI is calculated by dividing the individual's weight (in kilograms) by height (in meters) squared:

BMI = (weight in kilograms)
divided by (height in meters) times (height in meters)

or compute using the Obesity Education Initiative website: http://www.nhlbisupport.com/bmi/

To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by 0.0254.

Bridge, Bridgework: A fixed or removable prosthesis that replaces one or more teeth, is cemented in place to existing abutment teeth, consists of one or more pontics and one or more retainers (Crowns or Inlays), and cannot be removed by the patient. A removable prosthesis is held in place by clasps and can be removed by the patient.

Buccolingual: A dental term referring to the surfaces of a tooth facing the cheek or mouth (buccal) and the tongue (lingual).

Calendar Year: The 12-month period beginning January 1 and ending December 31. All annual Deductibles and Annual Maximum Plan Benefits are determined during the calendar year. See also the definitions of Contract Year and Plan Year.

Case Management: A process, administered by the Utilization Management Company, in which its medical professionals work with the patient, family, caregivers, Health Care Providers, and the Benefits Administrator to coordinate a timely and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers.

Certified Surgical Assistant (CSA, SA-C): A person who is at least a high school graduate and who has successfully passed a national surgical assistant program. A CSA does not typically hold a valid healthcare license as a RN, Nurse Practitioner (NP), Physician Assistant (PA), Nurse Midwife, Podiatrist, Dentist, MD or DO. A CSA may or may not be required to be licensed by a state agency. A CSA assists the primary surgeon with a surgical procedure in the operating room and is not an employee of a health care facility. Such individual may be payable by this Plan, including but not limited to designation as a Certified Surgical Assistant (CSA, SA-C), Certified Surgical Technologist (CST), Certified First Assistant (CFA), Certified Surgical Technologist (CST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT) **only IF** the use of an assistant surgeon is medically necessary.

Chemical Dependency: See the definitions of Behavioral Health Disorders and Substance Abuse.

Child(ren): See the definition of Dependent Child(ren) under the Dependent definitions heading.

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

City: The City of Mesa.

Claim Review Fiduciary: A person or company retained by the Plan and designated in the Plan documents to review and reconsider claims that have been denied in whole or in part if and when you or any similarly situated Plan participant requests such a review. See the Appeal Process in the Claim chapter of this document.

Claims Administrator/Appropriate Claims Administrator: A third party professional entity, person or committee (also known as a TPA) maintained or contracted by the Plan to administer the claims payment and appeals management responsibilities of the Plan. There may be more than one Claims Administrator/Appropriate Claims Administrator for this Plan because of the variety of benefits offered under this Plan. See the Quick Reference Chart in the Introduction section of this document for details.

Contract Year: The period of time designated in the contract between the City of Mesa and the vendor providing the service.

Contracted Charge/Contracted Amount: means the amount this Plan allows as payment for eligible medically necessary services or supplies to PPO network providers. With respect to a network provider (PPO network Health Care or Dental Care provider/facility), the Contracted Amount is the negotiated fee/rate set forth in the agreement between the participating network Health care or Dental care provider/facility and the PPO network or the Plan. For an In-Network health care provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Contracted Charge amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as an In-network claim; or the Health care or Dental care provider's/facility's actual billed charge.

The Plan will not always pay benefits equal to or based upon the Health care or Dental care provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible or Coinsurance. This is because the Plan covers only the "contracted charge" amount for health care services or supplies.

Any amount in excess of the "contracted charge" amount does not count toward the Plan's annual Out-of-pocket maximums. Participants are not responsible for amounts that exceed "contracted charges" amount by this Plan.

In the case where the PPO allowed charge amount on an eligible claim exceeds the actual billed charges, the participant will pay their coinsurance on the lesser amount, the billed charges, and the Plan will pay their coinsurance on the PPO allowed charge amount, plus, the Plan will pay the participant's additional coinsurance responsibility on the difference in the PPO allowed charge amount versus the actual billed charges. See also Allowed Charges.

Convalescent Care Facility: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan Benefits are payable when a person is covered by two or more employer-sponsored health care plans. See the chapter on Coordination of Benefits that sets forth the Plan's COB rules and procedures.

Copayment, Copay: The set dollar amount you are responsible for paying when you incur an Eligible Medical or Vision expense for certain services, generally those provided by in-network providers.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or reduction other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cost-Efficient: See the definition of Medical Necessity for the definition of Cost-Efficient as it applies to healthcare services that are Medically Necessary.

Covered Individual: Any employee, retiree, Elected Official or COBRA participant and that person's Spouse/Committed Partner or Dependent Child (as those terms are defined in this Plan) who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan.

Crown: The portion of a tooth covered by enamel. An artificial crown is a dental prosthesis used to return a tooth to proper occlusion, contact and contour, as used as a restoration or an abutment for a fixed prosthesis.

Custodial Care: Care and services (including room and board needed to provide that care or services) given mainly for personal hygiene or to perform the activities of daily living. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Some examples of Custodial Care are training or helping patients to get in and out of bed, as well as help with bathing, dressing, feeding or eating, use of the toilet, ambulating, or taking drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care.

Deductible: The amount of Eligible Medical or Dental Expenses you are responsible for paying before the Plan begins to pay benefits. **Individual Deductible:** The amount one covered person must pay before the Plan begins to pay benefits for that person. **Family Deductible:** The amount that an entire family must pay before the Plan begins to pay benefits for the family members. The family deductible is equal to three (3) individual deductibles but is calculated based upon the amounts applied to the deductible by all family members. See also the Medical Expense and Dental Expenses chapters in this document. There is also a separate deductible applied to non-network services and retail prescription drugs. See the Schedule of Medical Benefits in this document.

Dental: Dental services and supplies are **not** covered under the medical expense coverage of the Plan unless the Plan specifically indicates otherwise. As used in this document, Dental refers to any services performed by or under the supervision of a Dentist, or supplies, including Dental Prosthetics, but **not** including outpatient prescription drugs, prescribed by a Dentist, even if the services or supplies are necessary because of symptoms, illness or injury affecting another part of the body. Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection.

Dental Care Provider: A Dentist, or Dental Hygienist or other Health Care Practitioner or Nurse as those terms are specifically defined in this chapter of the document, who is legally licensed and who is a Dentist or performs services under the direction of a licensed Dentist; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Hygienist: A person who is trained and legally licensed and authorized to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed Dentist, and who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Subspecialty Areas:

Subspecialty	Diagnosis, Treatment or Prevention of Diseases Related To:
Endodontics	the dental pulp and its surrounding tissues.
Implantology	attachment of permanent artificial replacement of teeth directly to the jaw using artificial root structures.
Oral Surgery	extractions and surgical procedures of the mouth.

Subspecialty	Diagnosis, Treatment or Prevention of Diseases Related To:
Orthodontics	abnormally positioned or aligned teeth.
Pedodontics	treatment of dental problems of children.
Periodontics	structures that support teeth (gingivae, alveolar bone, periodontal membrane or ligament, cementum).
Prosthodontics	construction of artificial appliances for the mouth (Bridges, Dentures, Crowns).

Dentist: A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered; **and** acts within the scope of his or her license; **and** is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Denture: A removable device replacing missing teeth.

Dependent(s)
Dependent Child(ren): For the purposes of this Plan, a Dependent Child is any of the employee/retiree's children listed below who are **under the age of 26 whether married or unmarried**:

- natural children (son or daughter),
- foster children,
- stepchildren,
- legally adopted child(ren) or children placed for adoption,
- child(ren) for whom the employee or retiree is the legal guardian,
- child named in a qualified medical child support order (QMCSO) is also an eligible Dependent Child under this Plan.

A **Disabled Adult Child** may continue coverage if they are an **unmarried** Dependent Child (as defined above) **age 26 or older** who is **permanently and totally disabled** with a disability that existed prior to the attainment of the Plan's age limit. The Plan will require initial and periodic proof of disability. Proof of Social Security Disability is required for children over age 26. A Dependent Child who is not covered under the Plan but becomes disabled after reaching the Plan's Dependent age limit is not eligible to enroll as a Dependent under this Plan. "Disabled" means the inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise totally Disabled.

It is the employee's or retiree's obligation to inform the Plan promptly if any of the requirements set out in this definition of a Dependent Child are NOT met with respect to any child for whom coverage is sought or is being provided.

Coverage of a Dependent Child ends at the end of the month in which that child:

1. reaches his or her 26th birthday, unless the child is a Disabled Adult Child (as described above),**or**
2. fails to pay required contributions for coverage, or
3. no longer meets the definition of a Dependent child.

The following individuals are not eligible under the Plan: a spouse of a Dependent Child (e.g., the employee/retiree's son-in-law or daughter-in-law) and grandchild (unless the employee/retiree is the legal guardian of the grandchild).

Eligible Dependent: Your lawful Spouse (as defined in this Plan) and your Dependent Child(ren). An Eligible Dependent may be enrolled for coverage under the Plan by following the procedures required by the Plan. See the Eligibility chapter for further information. Once an Eligible Dependent is duly enrolled for coverage under the Plan, coverage begins in accordance with the terms and provisions of the Plan, as described in the Eligibility chapter, and that person is a covered Dependent, and remains a covered Dependent until his or her coverage ends in accordance with the terms and provisions of the Plan.

Spouse: The employee's lawful spouse as determined by Arizona State law.

Committed Partner effective 4/1/13 or later – see the section titled Committed Partner and Committed Partner child(ren) earlier in this document for definition and eligibility.

Disabled: A physical or mental impairment that substantially limits one or more of that person's major life activities. Major life activities typically refer to employment, caring for oneself, walking, learning, breathing, speaking, hearing, or seeing. See also the definition of Totally Disabled.

Disease Management (DM): A program of telephonic, email, or online services available to covered medical Plan members for education and support regarding chronic and lifestyle driven disease states. Disease Management services are provided by

licensed health care professionals employed by the Disease Management Company/Appropriate Claims Administrator operating under a contract(s) with the Plan.

Disease Management Company: An independent disease management organization, staffed with licensed health care professionals, operating under a contract(s) with the Plan to administer the Plan's Disease Management services. There may be more than one disease management organization under contract to the Plan at any time, to provide the range of services needed for the various benefits under the Plan. The Quick Reference Chart in the Introduction chapter of the document provides contact information about the disease management organizations used by the Plan.

Double Abutment: Tying two teeth together to help support a Bridge. If there is bone loss due to periodontal disease (pyorrhea), this will be considered a form of Periodontal Splinting. See the definition of Periodontal Splinting.

Durable Medical Equipment: Equipment that:
1. can withstand repeated use; and
2. is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness (except FDA approved breast feeding pump and supplies for breast feeding women are included in the definition of DME); and
3. is not disposable or non-durable.

Durable Medical Equipment includes, but is not limited to: apnea monitors, blood sugar monitors, commodes, electric hospital beds (with safety rails) electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the definitions of Corrective Appliances, Nondurable Supplies, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device).

Elected Officials: duly elected and sworn Mayor and City Council members.

Elective Hospital Admission, Service or Procedure: Any non-emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or Physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Dependent: See the definition under the **Dependent Definitions** heading.

Eligible Expenses: Expenses for healthcare services or supplies, but only to the extent that:
1. they are Medically Necessary, as defined in this Definitions chapter of the document; and
2. the charges for them are Allowed or Contracted Charges, as defined in this Definitions chapter of the document; and
3. coverage for the services or supplies is not excluded, as provided in the Exclusions and Definitions chapters of this document; and
4. the General Overall, Limited Overall, and/or Annual Maximum Plan Benefits for those services or supplies has not been reached.

Emergency Care: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Emergency Care. Medical or dental care and treatment provided after the sudden unexpected onset of a medical or dental condition manifesting itself by acute symptoms, which are severe enough that the lack of immediate medical or dental attention could reasonably be expected to result in any of the following:
1. The patient's life or health would be placed in serious jeopardy.
2. There would be a serious dysfunction or impairment of a bodily organ or part.
3. In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency Services: means with respect to an emergency medical condition (defined below), a medical screening examination within the **emergency department of a hospital** including ancillary services routinely available to the emergency department to evaluate the emergency medical condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

- The term "to 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, to deliver a newborn child (including the placenta).
- The term "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 serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

- The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

Employee (Benefit Eligible): Unless specifically indicated otherwise, when used in this document, Employee refers to a person employed by the City, receiving bi-weekly pay checks from the City (unless otherwise on an authorized unpaid leave of absence) and who is eligible to enroll for some or all of the coverage under the Plan.

Employee Benefits Administrator: Same as the Plan Administrator.

Employer: The City of Mesa.

Enroll, Enrollment: The process of completing and submitting a written enrollment election to the Plan Administrator (generally using online technology applications provided by the City, or certain paper forms as may apply), indicating that coverage by the Plan is requested by the Employee or Retiree. An Employee or Retiree may request coverage for an Eligible Dependent only if he or she is or will be covered by the Plan. See the Eligibility chapter for details regarding enrollment.

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the Medical and Dental Plan Exclusions chapters of this document, for which the Plan does **not** provide Plan Benefits.

Exhausted (in reference to COBRA Continuation Coverage): For the definition of Exhausted in connection with COBRA Continuation Coverage as it relates to entitlement to Special Enrollment for coverage, see the section on Special Enrollment in the Eligibility chapter of this document.

Experimental and/or Investigational:

1. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for pre-certification under the Plan's Utilization Management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:**
   A. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;
   B. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
   C. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; **and** written by experts in the field that shows that recognized medical, dental or scientific experts classify the service or supply as experimental and/or investigational; **or** indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
   D. With respect to services or supplies regulated by the Food and Drug Administration (FDA):
      - FDA approval is required in order for the service and supply to be lawfully marketed; **and** it has not been granted at the time the service or supply is prescribed or provided; **or**
      - A current investigational new drug or new device application has been submitted and filed with the FDA.
   E. However, a drug will **not** be considered Experimental and/or Investigational if it is:
      - approved by the FDA as an "investigational new drug for treatment use"; **or**
      - classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; **or**
      - approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was **not** approved for general use, **and** the FDA has **not** determined that such drug should not be prescribed for a given type of cancer.
   F. The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; **or** Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.
2. In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources **that are available at the time the service**

or supply was performed or provided, or the service or supply was considered for pre-certification under the Plan's Utilization Management program:

A. Medical or dental records of the covered person;
B. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
C. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
D. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to:
   - "United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";
   - The published opinions of:
     - the American Medical Association (AMA), clinical policy bulletins of major insurance companies in the US such as Aetna or CIGNA or Milliman Care Guidelines; or
     - specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies.
E. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
F. The latest edition of "The Medicare National Coverage Determinations Manual."

3. To determine how to obtain a Pre-certification of any procedure that might be deemed to be Experimental and/or Investigational, see the section on Pre-certification Review in the Utilization Management chapter of this document.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Federal Legend Drugs: See the definition of Prescription Drugs.

Fluoride: A solution applied to the surface of teeth or a prescription drug (usually in pill form) to prevent dental decay.

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

Foot Orthotics: A removable shoe insert prescribed by a doctor that is molded to the patient's foot to correct abnormal foot and lower extremity function.

Generic (drug): A generic drug is a copy of an FDA approved brand-name drug that contains the same active ingredients as the brand-name drug and is the same in terms of dosage, safety, purity, strength, how it is taken, quality, performance and intended use. Generic drugs work in the same way and in the same amount of time as brand-name drugs. Generic drugs typically provide substantial dollar savings as compared to brand name drugs.

Genetic Counseling: Counseling services provided before Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman to allow the patient to make an informed decision.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Gnathologic Recording: A measurement of force exerted in the closing of the jaws.

Handicap or Handicapped (Physically or Mentally): See the definition of Disabled and Totally Disabled.

Health Care Practitioner: A Physician, Behavioral Health Practitioner, Chiropractor, Dental Hygienist, Dentist, Nurse, Nurse Practitioner, Physician Assistant, Podiatrist, or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state

or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Health Care Provider: A Health Care Practitioner as defined above, or a Hospital, Ambulatory Surgical Facility, Behavioral Health Treatment Facility, Birthing Center, Home Health Care Agency, Hospice, Skilled Nursing Facility, or Sub-acute Care Facility, as those terms are defined in this Definitions chapter.

Home Health Care: Intermittent Skilled Nursing Care services provided by a licensed Home Health Care Agency as those terms are defined in this chapter.

Home Health Care Agency: An agency or organization that provides a program of home health care and meets one of the following tests:

1. It is approved by Medicare; or
2. It is licensed as a Behavioral Health Treatment Facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
3. If licensing is not required, it meets all of the following requirements:
    - It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or Registered Nurse (RN) to the home and
    - it has a full-time administrator and it is run according to rules established by a group of professional Health Care Providers including Physicians and Registered Nurses (RNs) and
    - it maintains written clinical records of services provided to all patients and
    - its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available and
    - its employees are bonded and
    - it maintains malpractice insurance coverage and
    - it is established and operated in accordance with applicable licensing and other laws.

Homeopathy: A school of medicine based on the theory that large doses of drugs that produce symptoms of an Illness in healthy people will cure the same symptoms when administered in small amounts. Homeopathy principles are designed to enhance the body's natural protective mechanisms based on a theory that "like cures like" or "treatment by similar." When the services of Homeopaths are payable by this Plan, the Homeopath must be properly licensed to practice Homeopathy in the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required, have successfully graduated with a diploma of Doctor of Medicine in Homeopathy from an institution which is approved by the American Institute of Homeopathy and completed at least 90 hours of formal post graduate courses or training in a program approved by the American Institute of Homeopathy.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home Hospice services) or in a home-like setting (Inpatient Hospice), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family. The agency must meet one of the following:

1. It is approved by Medicare; **or**
2. It is licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
3. If licensing is not required, it meets all of the following requirements:
    - It provides 24 hour-a-day, 7 day-a-week service;
    - It is under the direct supervision of a duly qualified Physician;
    - It has a full-time administrator;
    - It has a nurse coordinator who is a Registered Nurse (RN) with 4 years of full-time clinical experience. Two of these years must involve caring for terminally ill patients;
    - The main purpose of the agency is to provide Hospice services;
    - It maintains written records of services provided to the patient;
    - It maintains malpractice insurance coverage;
    - A Hospice that is part of a Hospital, as defined in this Chapter, will be considered a Hospice for the purposes of this Plan.

Hospital: A public or private facility or institution, other than one owned by the U.S. Government, licensed and operating according to law, that:

1. is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);
2. is approved by Medicare as a Hospital; and

3. provides care and treatment by Physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises.
4. A Hospital may include facilities for behavioral health treatment that are licensed and operated according to law.
5. Any portion of a Hospital used as an Ambulatory Surgical Facility, Birth (or Birthing) Center, Convalescent Care Facility, Extended Care Facility, Hospice, Skilled Nursing Facility, Sub-acute Care Facility, or other residential treatment facility or place for rest, Custodial Care, or for the aged will **not** be regarded as a hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition. Pregnancy of a covered member will be considered to be an Illness only for the purpose of coverage under this Plan. However, infertility is **not** an Illness for the purpose of coverage under this Plan.

Immediate Temporary Denture: A temporary Denture that is placed immediately after the extraction of teeth.

Implantology: The science of placing artificial root structures on or within the jawbones that will act to hold and support a dental prosthesis.

Impression: A negative reproduction of the teeth and gums, from which models of the jaws are made. These models are used to study certain conditions and to make dental appliances and prostheses.

Injury: Any damage to a body part resulting from trauma from an external source.

Injury to Teeth: An injury to the teeth caused by trauma from an external source or an intrinsic force, such as the force of biting or chewing. Benefits for Injury to Teeth are payable under the Medical Plan.

Inlay: A Restoration made to fit a prepared tooth cavity and then cemented into place.

In-Network Services: Services provided by a Health Care Provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Non-Network Services that are provided by a Health Care Provider that is **not** a member of (under contract with) the PPO.

Inpatient Services: Services provided in a Hospital or other Specialized Health Care Facility during the period when charges are made for room and board.

Intensive Outpatient Program (IOP): Intensive outpatient program (IOP) is a treatment program that includes extended periods of therapy sessions, several times a week for a minimum of three hours per day, a minimum of three days per week and a minimum of nine hours per week. It is an intermediate setting between traditional therapy sessions and partial hospitalization.

Investigational: See the definition of Experimental and/or Investigational.

Lifetime Benefit: This term **does not** denote, nor should it be construed to denote, any obligation by the Plan to pay any Benefits for the lifetime of the Plan Participant. Rather, it is a popular term that describes the maximum amount of Benefits payable by the Plan during the entire time a Plan Participant is covered under this Plan and any previous medical and/or dental expense Plan provided by the City. The term "per lifetime" may also be applied to unit or frequency limitations under the Plan. See the definitions of Maximum Plan Benefits.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result.

Mandibular Disorders: Disorders of the lower jaw.

Maxillary Disorders: Disorders of the upper jaw.

Maximum Plan Benefits: The maximum amount of Benefits payable by the Plan on account of medical and/or dental expenses incurred by any covered Plan Participant under this Plan and any previous medical and/or dental expense Plan provided by the City. The General and Limited Overall Maximum Plan Benefits are often referred to as "Annual" Benefits, but this reference **does not** denote, nor should it be construed to denote, any obligation by the Plan to pay any Benefits for the a full year for the Plan Participant.

- **Annual Maximum Plan Benefits** are the maximum amount of Benefits payable each Calendar Year on account of certain medical and/or dental expenses incurred by any covered Plan Participant or family of the Plan Participant under this Plan and any previous medical and/or dental expense Plan provided by the City during that calendar year.

Medically Necessary:

1. A medical, dental, vision or behavioral health service or supply will be determined to be "Medically Necessary" by the Plan Administrator or its designee (e.g. the City's contracted Utilization Management company) if it:
   - is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it or Dentist if a dental service or supply is involved; and
   - is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted medical standards in the community in which it is provided; and
   - is determined by the Plan Administrator or its designee to meet all of the following requirements:
     - It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
     - It is not provided solely for the convenience of the patient, Physician, Hospital, Health Care Provider, or Health Care Facility; and
     - It is an "Appropriate" service or supply given the patient's circumstances and condition; and
     - It is a "Cost-Efficient" supply or level of service that can be safely provided to the patient; and
     - It is safe and effective for the illness or injury for which it is used.
2. A service or supply will be considered to be "Appropriate" if:
   - It is a diagnostic procedure that is called for by the health status of the patient, and is:
     - as likely to result in information that could affect the course of treatment as; and
     - no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
   - It is care or treatment that is:
     - as likely to produce a significant positive outcome as; and
     - no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
3. A service or supply will be considered to be "**Cost-Efficient"** if it is no more costly than any alternative Appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.
4. The fact that your Physician, Healthcare Practitioner or Dentist may provide, order, recommend or approve a service or supply **does not mean** that the service or supply will be considered to be Medically Necessary for the coverage provided by the Plan.
5. A Hospitalization or confinement to a Specialized Health Care Facility will **not** be considered to be Medically Necessary if the patient's illness or injury could safely and Appropriately be diagnosed or treated while not confined.
6. A service or supply that can safely and Appropriately be furnished in a Physician's, Healthcare Practitioner's, or Dentist's office or other less costly facility will **not** be considered to be Medically Necessary if it is furnished in a Hospital or Specialized Health Care Facility or other more costly facility.
7. The non-availability of a bed in another Specialized Health Care Facility, or the non-availability of a Health Care Practitioner to provide medical services will **not** result in a determination that continued confinement in a Hospital or other Specialized Health Care Facility is Medically Necessary.
8. A service or supply will **not** be considered to be Medically Necessary if it **does not require** the technical skills of a Health Care Practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Health Care Practitioner, or any Hospital or Specialized Health Care Facility.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Midwife, Nurse Midwife: A person legally licensed as a certified nurse midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administering intravenous fluids and certain medications, providing emergency measures while awaiting aid, performing newborn evaluation, signing birth certificates, and billing and being paid in his or her own name, and who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient. A nurse midwife may not independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the definition of Nurse.

Naturopathy: A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage or herbal tea. When the services of Naturopaths are payable by this Plan, the Naturopath must be properly licensed to practice Naturopathy in the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required, must be a qualified Health Care

Practitioner or Physician or hold a degree as a Doctor of Naturopathic Medicine from a school approved by the Council on Naturopathic Medical Education, or have successfully graduated with a diploma of Doctor of Naturopathic Medicine and completed a post graduate clinical training program approved by the Council on Naturopathic Medical Education.

Never Events: Inexcusable outcomes in a health care setting or adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability. Never Events, as defined by the National Quality Forum Guidelines include but are not limited to:

1. Artificial insemination with the wrong donor sperm or donor egg
2. Unintended retention of a foreign object in a patient after surgery or other procedure
3. Patient death or serious disability associated with patient elopement (disappearance)
4. Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
5. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
6. Patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a healthcare facility
7. Patient death or serious disability associated with a fall while being cared for in a healthcare facility
8. Surgery performed on the wrong body part
9. Surgery performed on the wrong patient
10. Wrong surgical procedure performed on a patient
11. Intraoperative or immediately post-operative death in an ASA Class I patient
12. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
13. Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
14. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
15. Infant discharged to the wrong person
16. Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility
17. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility
18. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
19. Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates
20. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
21. Patient death or serious disability due to spinal manipulative therapy
22. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
23. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
24. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility
25. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
26. Abduction of a patient of any age
27. Sexual assault on a patient within or on the grounds of the healthcare facility
28. Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the healthcare facility.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic Appliance (or Device) and Prosthetic Appliance (or Device).

Non-Network (out-of-network): Services provided by a Health Care Provider that is **not** a member of the Plan's Preferred Provider Organization (PPO), as distinguished from In-Network Services that are provided by a Health Care Provider that is a member of the PPO.

Non-Participating Provider: A Health Care Provider who does not participate in the Plan's Preferred Provider Organization (PPO).

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA), and authorized to administer anesthesia in collaboration with a Physician, to bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP) or Registered Nurse Practitioner (RNP), and authorized, in collaboration with a Physician, to examine patients and establish medical diagnoses; admit patients into Health Care Facilities; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; and refer to and consult with appropriate Health Care Practitioners; and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; **and** is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of their license and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee, and acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living (such as eating, bathing, dressing) and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills in order to regain independence. Other occupational therapy services can include assessment of perceptual motor and sensory activity, the design, fabrication or application of selected support devices (orthotics) such as a wrist brace or ankle support, training on how to utilize prosthetic devices to maximize independence, guidance in the selection and use of adaptive equipment, teaching exercises to enhance functional performance and adaptation of environments for people with mental and physical disabilities.

Office Visit: A direct personal contact between a Physician or other Health Care Practitioner and a patient in the Health Care Practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association or the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CPT coding. Neither a telephone discussion with a Physician or other Health Care Practitioner nor a visit to a Health Care Practitioner's office **solely for** such services as blood drawing, leaving a specimen, or receiving a routine injection is considered to be an Office Visit for the purposes of this Plan.

Onlay: An Inlay Restoration that is extended to cover the biting surface of the tooth, but not the entire tooth. It is often used to restore lost and weakened tooth structure.

Open Enrollment Period: The period during which participants in the Plan may select among the health benefit programs that are offered by the Plan. The Plan's annual Open Enrollment Period is designated in advance by the Plan Administrator or its designee.

Orthodontics, Orthodontia: The science of the movement of teeth in order to correct a malocclusion or "crooked teeth".

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as to shorten or lengthen the horizontal, vertical or transverse dimensions of the jaw so that facial soft tissue, teeth and/or other facial structures are in aesthetic alignment/balance. Malposition can produce conditions such as Prognathism, Retrognathism, or TMJ syndrome/dysfunction. See the definitions of TMJ syndrome, Prognathism and Retrognathism.

Orthotic (Appliance or Device): A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this definition does **not** include Dental Orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic Appliance (or Device).

Out-of-Network Services: See Non-Network.

Out-of-Pocket Maximum: The maximum amount of Deductibles, Coinsurance and/or Copays, each covered person or family is responsible for paying during a Calendar Year before the Coinsurance required by the Plan ceases to apply. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of any additional Covered Expenses for the remainder of the Calendar Year. For a list of expenses that do not count toward the Out-of-Pocket Maximum, see the section on Out-of-Pocket Maximum in the Medical Benefits chapter of this document.

Outpatient Services: Services provided either outside of a Hospital or Specialized Health Care Facility setting or at a Hospital or Specialized Health Care Facility when room and board charges are **not** incurred.

Partial Denture: A Prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures. The Denture may be removable or fixed.

Participating Provider: A Health Care Provider who participates in the Plan's Preferred Provider Organization (PPO).

Periodontal Splinting: Tying two or more teeth together when there is bone loss. This is done to gain additional stability for teeth that can no longer stand alone.

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapist: A person legally licensed as a professional physical therapist who acts within the scope of their license and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee, and acts under the direction of a physician to perform physical therapy services including the evaluation, treatment and education of a person using physical measures, therapeutic exercise, thermal (hot/cold) techniques and/or electrical stimulation to correct or alleviate a physical functional disability/impairment. Physical therapists may also perform testing and retraining of muscle strength, joint motion, or sensory and neurological function along with balance, coordination, and flexibility in order to enhance mobility and independence.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Physician Assistant: A person legally licensed as a Physician Assistant and authorized, under the supervision of a Physician, to examine patients and establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; and refer to and consult with the supervising Physician; and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; **and** is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Placed for Adoption: For the definition of Placed for Adoption as it relates to coverage of adopted Dependent Children, see the definition in the section on Adopted Dependent Children in the Eligibility chapter of this document.

Plan Administrator: The person designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan. The City of Mesa Employee Benefits Administrator is the Plan Administrator.

Plan Participant: Any employee or retiree and that person's Spouse or Dependent Child (as those terms are defined in this Plan) who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan.

Plan, This Plan: The program, benefits and provisions described in this document.

Plan Year: The twelve-month period from January 1 to December 31 is designated to be the Plan Year. The Contract Year may not be the same as the Plan Year. See also the definitions of Calendar Year and Contract Year.

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) and authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license; **and** is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Pontic: The part of a fixed bridge that is suspended between two abutments and replaces a missing tooth.

Practitioner: See the definition of Health Care Practitioner.

Pre-Admission Testing: Laboratory tests and x-rays and other Medically Necessary tests performed on an outpatient basis prior to a scheduled Hospital admission or outpatient Surgery.

Pre-certification (also called prior authorization, preauthorization, pre-approval, pre-service review): A managed care program designed to assure that services are medically necessary before the service is provided. For example, under the Medical Plan, hospital admissions and certain other health care services are subject to review by the Utilization Management (UM) Company before services are provided (see the Utilization Management chapter for details) while the Prescription Drug Program reviews certain drugs/medications before the prescription is filled (contact the Prescription Drug Program at their phone number on the Quick Reference Chart in the front of this document).

Preferred Provider Organization (PPO): A group or network of Health Care Providers under contract with the Plan to provide health care services and supplies at agreed-upon discounted rates as payment in full, except with respect to a defined copayment or coinsurance for which the covered employee, retiree or dependent is responsible.

Prescription Drugs: For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend Drugs:** Any medicinal substance which the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. Drugs that require a prescription under state law but not under federal law.
3. **Compound Drugs:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Prophylaxis: The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth is performed by a Dentist or Dental Hygienist.

Prosthesis (Dental): An artificial replacement of one or more natural teeth and/or associated structures.

Prosthetic Appliance (or Device): A type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, corrective spectacle lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic Appliance (or Device).

Provider: See the definition of Health Care Provider.

Psychiatric: See Behavioral Health Disorder.

Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an employee to provide health care coverage for a Dependent Child, and requiring that Benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child.

Reasonable/Reasonableness: Reasonable and/or Reasonableness shall mean in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Provider.

1. Determination that fee(s) or services are reasonable will be made by the Appropriate Claims Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).
2. This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration.
3. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.
4. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable.
5. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator.
6. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable. Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions

deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

7. For providers in **the primary provider network** contracted by the City of Mesa, Reasonable Charges means the rates and terms for determining the Contracted Amounts for consideration of payment by the Plan, except for:
   A. High cost drugs, when not precluded by a provision within the current provider-payer agreement means charges not otherwise included within a DRG value or a Per Diem rate (in other words carved out of, or excluded from, the DRG or Per Diem rate or subject to a stop loss provision which alters the DRG or Per Diem rate) dispensed by a facility during an inpatient stay or outpatient service are limited to 125 % of AWP based on the most current edition of Red Book plus a dispensing fee allowance of 25 %. This limitation for high cost drugs shall also apply to drugs administered on an outpatient basis by a physician in an outpatient facility, clinic or office setting;
   B. Surgical implants, devices and prosthetics, when not precluded by a provision within the current provider-payer agreement, means charges not otherwise included within a DRG value or Per Diem rate (in other words carved out of, or excluded from, the DRG or Per Diem rate or subject to a stop loss provision which alters the DRG or Per Diem rate) dispensed by a facility during an inpatient stay or outpatient service are limited to 125 % of manufacturers invoice plus an acquisition and administration allowance of 25 %. This limitation for surgical implants, devices, and prosthetics shall also apply to such items dispensed on an outpatient basis by a physician in an outpatient facility, clinic, or office.
8. For providers **who are not in the primary provider network** contracted by the City of Mesa, Reasonable Charges also include:
   A. High cost drugs, dispensed by a facility during an inpatient stay or an outpatient facility during an outpatient service are limited to 125 % of AWP based on the most current edition of Red Book plus a dispensing fee allowance of 25 %. This limitation for high cost drugs shall also apply to drugs administered on an outpatient basis by a physician in an outpatient facility, clinic or office setting;
   B. Surgical implants, devices and prosthetics dispensed by a facility during an inpatient stay or outpatient service are limited to 125 % of manufacturers invoice plus an acquisition and administration allowance of 25 %. This limitation for surgical implants, devices, and prosthetics shall also apply to such items dispensed on an outpatient basis by a physician in an outpatient facility, clinic, or office;
   C. Reasonable Charges by a hospital facility for inpatient or outpatient services, or by a free standing outpatient facility or clinic shall be the **lesser of**: (a) charges billed by the facility or, (b) rates negotiated by the primary provider-payer network contracted by the Plan or, (c) , a maximum allowable amount not to exceed 200% of the Medicare Allowable amount (reduced by cost share amounts) for like services, procedures, drugs, and devices by licensed facilities and providers in the same general geographic area.

Reconstructive Surgery: A Medically Necessary Surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy on account of a malignancy.

Rehabilitation Therapy: Cardiac, occupational, physical, pulmonary or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed Therapist acting within the scope of his or her license. See the Schedule of Medical Benefits and the Exclusions chapter of this document to determine the extent to which Rehabilitation Therapies are covered.

1. **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, **actively participates** in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.
2. **Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. **Maintenance Rehabilitation is not covered by the Plan.**
3. **Passive Rehabilitation** refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of Hospitalization for acute care, and then only until the patient is capable of being discharged from the Hospital because Hospitalization for the condition requiring acute Hospital care is no longer Medically Necessary. Continued Hospitalization for the primary purpose of providing Passive Rehabilitation will not be considered to be Medically Necessary for the

purposes of this Plan. This plan does not provide payment for admission and confinement in an inpatient rehabilitation facility to provide rehab services to a person who currently has a cognitive deficit (that is, the person is unable to learn and remember the services being taught to them).

Restoration: A broad term applied to any filling, Crown, Bridge, Partial Denture or complete Denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape and function of part or all of the tooth or teeth.

Retail Medical Clinics: Walk-in clinics in retail stores like pharmacies and super markets, staffed by nurse practitioners and provide high-quality care for routine illnesses. These retail medical clinics are usually open on evenings and weekends offering one-time care and standard interventions to a limited range of health needs at low cost. Retail medical clinics are NOT equipped to diagnose or deal with complex cases. They are not doctors, nor are they structured to follow-up on treatment or offer many diagnostic tests.

Retiree: There are five groups of retirees:

- **Prior to November 1, 1991** retired employees of the City of Mesa who did not have to fulfill the requirement of having **at least 10 years** of service with the City of Mesa.
- **Beginning November 1, 1991**, and for those employees hired on or before **December 31, 2000,** retired employees of the City of Mesa with **10 or more years** of service in a benefits-eligible position with the City of Mesa and who qualify **and** begin receiving and continue to receive retirement benefits from the Arizona State Retirement System or Public Safety Personnel Retirement System (PSPRS), on the first of the month following retirement with the City of Mesa.
- **Effective January 1, 2001**, retired employees of the City of Mesa hired on or after January 1, 2001 through December 31, 2005 with **15 or more years** of service in a benefits-eligible position with the City of Mesa and who qualify **and** begin receiving and continue to receive retirement benefits from the Arizona State Retirement System or Public Safety Personnel Retirement System on the first of the month following retirement with the City of Mesa.
- **Effective January 1, 2006**, retired employees of the City of Mesa hired on or after January 1, 2006 through December 31, 2008 with **20 or more years** of service in a benefits-eligible position with the City of Mesa and who qualify and begin receiving and continue to receive retirement benefits from the Arizona State Retirement System or Public Safety Personnel Retirement System on the first of the month following retirement with the City of Mesa.

The retiree categories identified above may be eligible for various City contributions and subsidies towards the total cost of retiree coverage (based upon calculations related to hire date, length of service at retirement and whether or not the retiree or their covered family member are/become Medicare eligible). The City reserves the right to change or eliminate City contributions/subsidy amounts. In addition, retirees may be eligible for ASRS or PSPRS subsidies towards the retiree's cost of City Health Plan coverage (subject to change based upon ASRS and PSPRS rules/policies).

- **Beginning January 1, 2015, and for those employees** hired on or after **January 1, 2009,** retired employees of the City of Mesa with **20 or more years** of service in a benefits-eligible position with the City of Mesa and who qualify and begin receiving and continue to receive retirement benefits from the Arizona State Retirement System or Public Safety Personnel Retirement System, on the first of the month following retirement with the City of Mesa. Retired employees hired on or after January 1, 2009 are not eligible for any City contributions or discounts towards the cost of retiree coverage (but may be eligible for ASRS or PSPRS subsidies).

Retired employees (retirees) also include those individuals who have retired from City of Mesa employment due solely to a disability (totally disabled for a period of at least 6 months) **and** are receiving an LTD benefit **and** who continue to meet the requirements of Total Disability as defined in the Definitions chapter of this document.

If a retiree returns to work as a PT Active employee, he/she will remain as a retiree for health insurance purposes.

If a retiree returns to FT active employment, he/she will return to active status and pay active employee premiums. If the employee is an ASRS retiree, who retired prior to August 1, 2012, he/she can apply to receive a subsidy reimbursement for active health plan premiums from the retirement system, once every 6 months (subject to ASRS provisions that may change over time). PSPRS retirees who return to active status are not eligible for subsidy reimbursement for active health plan premiums. When the employee returns to retired status, he/she will do so without regard to this additional employment (i.e. his/her hire date will remain the same as before and he/she will not accrue any additional years of service for the purposes of determining City of Mesa Health Plan premium payment amounts).

If a person terminates employment with the City and at a later date is rehired by the City, the most recent hire date will be used for calculating the years of service required to continue benefits as a Retiree (and/or receive any City contributions or

subsidies). Previous years of services will not be used to calculate years of service for purposes of calculating eligibility or premium amounts. Seasonal employment and employment in a part-time position regularly scheduled to work less than 20 hours per week (non-benefits eligible positions) does not qualify toward active or retiree benefits eligibility under this Plan.

SPECIAL RETIREE ELIGIBILITY RULES PERTAINING TO REDUCTION IN WORK FORCE (RIWF):
Effective for RIWF's occurring on or after January 1, 2009, if an employee's position has been targeted for reduction, and as a result the employee occupying that position either accepts a severance package or early retirement, and if, within two years from the last day worked, said employee is rehired by the City of Mesa, the following will apply for purposes of determining retiree health insurance eligibility:

1. The employee's last prior employment effective date with the City of Mesa will be reinstated to determine the number of years of service required for that employee to qualify for retiree benefits upon retirement from the City.
2. The employee's prior years of service with the City of Mesa (including partial years) will be reinstated and used as credit toward the City's years of service requirement for determining eligibility and family premium amount.
3. These provisions do not apply to City of Mesa employees accepting voluntary severance whose positions were not targeted for reduction in work force (layoff).

Retirees eligible for Medicare must enroll in both Part A and Part B when first eligible; Part D is optional.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Retrospective Review: Review of health care services **after** they have been provided to determine if those services were Medically Necessary and/or if the charges for them are Allowed or Contracted Charges.

Root Canal (Endodontic) Therapy: Treatment of a tooth having a damaged pulp. The treatment is usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with a sealing material.

Scale: To remove calculus (tartar) and stains from the teeth with special instruments.

Second Opinion: A consultation and/or examination, preferably by a board certified Physician not affiliated with the primary attending Physician, to evaluate the Medical Necessity and advisability of undergoing a Surgery or receiving a medical service.

Skilled Nursing Care: Services performed by a licensed Nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a Physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a Nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a Nurse. Examples of Skilled Nursing Care services include, but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility: A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets **all** of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
2. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times; and
5. It maintains a daily medical record of each patient who is under the care of a licensed Physician; and
6. It is not (other than incidentally) a home for maternity care, rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis; and
7. It is not a hotel or motel.
8. A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Specialized Health Care Facilities: For the purposes of this Plan, Specialized Health Care Facilities include Ambulatory Surgical Facilities, Behavioral Health Treatment Facilities, Birthing Centers, Hospices, Skilled Nursing Facilities, and Sub-acute Care Facilities, as those terms are defined in this Definitions chapter.

Specialty Care Unit: A section, ward, or wing within a Hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered Nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Specialty Drugs: Generally refers to high-cost, low volume, biotechnology-engineered FDA approved, non-experimental medications used to treat complex, chronic or rare diseases. These medications may also have one or more of the following qualities: are injectable, require an infusion, must be administered by a health care practitioner, have side-effects or compliance issues that need monitoring, require substantial patient education/support before self-administration, and/or unique manufacturing, handling and distribution issues that make them unable to be purchased from a retail and/or regular mail order service. Specialty drugs are managed by the Prescription Drug Program under contract to the Plan. Examples of specialty drugs can include certain medications to treat hemophilia, immunity disorders, multiple sclerosis, rheumatoid arthritis, hepatitis or certain types of cancer.

Speech Therapist: A person legally licensed as a professional speech therapist who acts within the scope of their license and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee, and acts under the direction of a physician to perform speech therapy services including the application of principles, methods and procedures for the measurement, testing, evaluation, prediction, counseling, instruction, or rehabilitation related to disorders of speech, voice, language, swallowing or feeding.

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure.

Spinal Manipulation: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal Manipulation is commonly performed by Chiropractors, but it can be performed by a Physician.

Spouse: See the definition under **Dependent** heading.

Sub-acute Care Facility: A public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility, licensed and operated according to law and authorized to provide Sub-acute Care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement, generally not to exceed 60 days, to the patient's home or to a suitable Skilled Nursing Facility, and that meets **all** of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Sub-acute Care Facility or is recognized by Medicare as a Sub-Acute Care Facility; and
2. It maintains on its premises all facilities necessary for medical care and treatment; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse; and
5. It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
6. It is not a hotel or motel.

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of **Behavioral Health Disorders** and **Chemical Dependency**.

Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan Benefits. When the procedures will be considered to be separate procedures, the following percentages of the Allowed or Contracted Charge will be allowed as the Plan's Benefit:

1. Allowances for multiple surgeries through the same incision or operational field:

Primary procedure	100% of Allowed or Contracted Charge
Secondary and additional procedures	50% of Allowed or Contracted Charge per procedure

2. Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

First site primary procedure	100% of Allowed or Contracted Charge
First site secondary and additional procedures	50% of Allowed or Contracted Charge per procedure
Second site primary and additional procedures	50% of Allowed or Contracted Charge per procedure

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, severe aching pain in and about the TMJ (sometimes made worse by chewing), limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment, often associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly) or ill-fitting dentures.

Therapist: A person trained and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy who is legally licensed to perform such services (where licensing required by State law) and who works within the scope of his or her license and provides services under the direction of a Physician or Chiropractor, is allowed to bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, and is not the patient or the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee. For further information, see the definition of Occupational, Physical and Speech Therapy.

Third Opinion: A consultation and/or examination, preferably by a board certified Physician not affiliated with the primary attending Physician, to evaluate the Medical Necessity and advisability of undergoing Surgery or receiving a medical service, provided by the Plan when the Second Opinion indicates that the recommended Surgery or medical service is not Medically Necessary

Topical: Painting the surface of teeth as in a fluoride treatment or application of a cream-like anesthetic formula to the surface of the gum.

Total Disability, Totally Disabled: For an eligible employee, Total Disability means that during the first two years of disability the Eligible Employee is prevented, solely because of an injury or disease, from engaging in his/her regular or customary occupation and is performing no work of **any** kind for compensation or profit. After the first two years of disability, the eligible employee must be unable to engage in **any** occupation for which he is reasonably fitted by education, training or experience. The final determination as to whether or not Total Disability exists will be made by a Physician and approved by the appropriate Long Term Disability carrier. Any eligible employee not meeting the definition of disability who does not qualify as a retiree will not be eligible for benefits, unless under COBRA legislation. See also the definition of Disabled.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissues or cells (such as bone marrow or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted tissue in the recipient.

1. **Autologous** refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.
2. **Allogenic** refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are always allogenic.
3. **Xenographic** refers to transplants of organs, tissues or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Xenographic transplants are **not** covered by this Plan.

See the Schedule of Medical Benefits and the Exclusions chapter of this document for additional information regarding Transplants. See also the Utilization Management chapter of this document for information about pre-certification requirements for transplantation services.

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

Utilization Management (UM): A managed care procedure to determine the Medical Necessity, appropriateness, location, and cost-effectiveness of health care services or the medical necessity and appropriateness of certain prescription drugs. This

review can occur before, during or after the services are rendered and may include, but is not limited to Pre-certification and/or preauthorization; Concurrent and/or continued stay review; Discharge planning; Retrospective review; Case Management; Hospital or other Health Care Provider bill audits; and Health Care Provider fee negotiation.

Utilization Management services (sometimes referred to as UM services, UM program, Utilization Review services, UR services, Utilization Management and Review services, or UMR services) are provided by licensed health care professionals employed by the Utilization Management Company operating under a contract with the Plan. Pre-certification of certain prescription drugs is performed by the Prescription Drug Program.

Utilization Management Company: An independent utilization management organization, staffed with licensed health care professionals, operating under a contract(s) with the Plan to administer the Plan's Utilization Management services. There may be more than one utilization management organization under contract to the Plan at any time to provide the range of services needed for the various benefits under the Plan. The Quick Reference Chart in the Introduction chapter of the document provides contact information about the utilization management organizations used by the Plan.

Visit: See the definition of **Office Visit**.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child that are determined by the Plan to be Medically Necessary even though they are not provided as a result of illness, injury or congenital defect. The Plan's coverage of Well Baby Care is set forth in the Preventive Services Section of the Schedule of Medical Benefits chapter of this document.

You, Your: When used in this document, these words refer to the employee or retiree who is covered by the Plan. They do **not** refer to any Dependent of the employee or retiree.