PLAN DOCUMENT
SUMMARY PLAN DESCRIPTION

Benefits discussed in this document include:

Medical/Prescription Drug Plan Options	**Basic Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance**	**Short Term Disability Insurance (STD)**
Dental Plan Options	**Voluntary Life and Accidental Death and Dismemberment (AD&D) Insurance**	**Long Term Disability Insurance (LTD)**
Vision Plan Options	**Business Travel Accident/Commuter Travel Accident Insurance (BTA)**	**Flexible Spending Accounts – Health and Dependent Care (FSA)**
Employee Assistance Program (EAP)	**Health and Wellness Center & Mesa Wellness 360 Program**	**COBRA**
Legal Services/Identity Theft Protection Program – Voluntary Benefit	**Pet Care Membership Discount Program – Voluntary Benefit**	

Amended, Restated and Effective January 1, 2026

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INTRODUCTION

The City of Mesa offers a variety of health care and other benefit programs to eligible participants. This Plan Document describes: Medical/Prescription Drug, Dental, Vision Care, Flexible Spending Accounts (FSA), Employee Assistance Program (EAP), Group Term Life and Accidental Death and Dismemberment Insurance, Short and Long-Term Disability Insurance, Business Travel Accident/Commuter Travel Accident Insurance, Health and Wellness Center primary and preventive care medical services and Mesa Wellness 360 wellness programs and incentives. Also listed in the Quick Reference Chart section of this document is contact and enrollment information about individual voluntary benefit discount programs – Legal Services/Identity Theft Protection and United Pet Care Membership Network/Discounts.

The City self-insures and contracts with various third-party administrators (also known as Appropriate Claims Administrators in this document), and other vendors to administer the Medical/Behavioral Health/Prescription Drug and Dental Plans, the Flexible Spending Accounts program (including Health and Dependent Care Accounts) as well as the City of Mesa Health and Wellness Center and Wellness Programs and Initiatives, as may apply. The City has service agreements, contracts or insurance policies with various insurers and organizations to provide the following services: Specific Stop Loss Insurance for Medical/Behavioral Health/Prescription Drug programs, Employee Assistance Program services (EAP), Vision Care Plans, Basic and Voluntary Group Term Life/Accidental Death & Dismemberment (AD&D) Insurance, Business Travel Accident (BTA)/Commuter Travel Accident Insurance, and Short and Long-Term Disability Insurance coverage.

The Plan described in this document is effective January 1, 2026, 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. The medical and prescription drug benefits of this Plan are 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 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 for coverage 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, on the web sites, phone numbers and addresses located in the Quick Reference Chart in this document. As a courtesy to you, 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 enrollment application for new hire enrollments and Open Enrollment processing and Beneficiary Designations • 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 or Inside Mesa intranet home page direct links to Employee Benefits website Website online enrollment: New Hires: https://ebenmesa.mesaaz.gov/newhire Open Enrollment Active Employees: https://ebenmesa.mesaaz.gov/openenrollment Open Enrollment Retirees: https://ebenmesa.mesaaz.gov/retiree
City of Mesa Employee/Retiree Health and Wellness Center • On-site primary and preventive care medical services (including some virtual services for established members) • Active employees, retirees and respective dependents (aged 2 and above) covered in City active or retiree medical plans • Operated and managed by **Premise Health**	**Location:** 59 S. Hibbert St, Mesa AZ 85201 (enter from 1st Ave east of Hibbert) Phone #: 480-644-WELL (9355) – **make appointments** Hours: M-Thurs 7 a.m. to 5:30 p.m. MST, Fri 8 a.m. to 4:00 p.m. (except holidays) **Member portal: mypremisehealth.com** **Health and Wellness Website:** www.mesahealthandwellness.com Provider bios, classes and education, events, wellness communications, resources
City of Mesa Wellness 360 Program (MW360) • All active employees and their spouse/committed partners (SP/CP must be enrolled in City medical plans) • Wellness programs, coaching, events, activities, challenges, classes, demonstrations and health and wellness communications • Wellness points program to provide "cash" incentives/rewards/raffle entries and a medical plan premium discount reward for the following calendar year	**WebMD Health Services - Wellness Technology and Engagement Platform:** Program year runs from December 1 through November 30 of the following year Website: https://wellness360.mesaaz.gov/ Mobile App: Google Play Store or App Store – search for "WebMD Wellness At Your Side" and use connection code: mesawellness360 Customer Service: 1-888-258-9275 Hours: M-Th 9:00 am to 11:30 pm; Fri 9:00 am to 8:00 pm; Sat 9:30 am to 6:00 pm; Sun 1:00 pm to 11:30 pm (all ET)

QUICK REFERENCE CHART	
Information Needed About:	**Contact the following:**
Employee Assistance Program (EAP) • Up to eight (8) free counseling visits (in-person or telephone) per patient per problem per calendar year (including employee household members) • Up to thirty-six (36) free counseling visits for sworn police officers and firefighters (plus Public Safety 911 Operator, civilian EMT, civilian Paramedic and Crime Scene Specialists) following traumatic events in the line-of-duty • 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:
Medical/Behavioral Health Plan Benefits – Network, Claims Administration, Appeals, Member Services, Utilization Management, Case Management & Disease Management • Group #: 3341050 • Medical and Behavioral Health Claims/Explanation of Benefits (EOB) • Pre-Certification/Utilization/Case/Disease Management Administrator • Medical and Behavioral Health Provider Network – Open Access Plus (OAP) national network including Cigna Behavioral Health (CBH), and LifeSOURCE Transplant Network • Cigna Pathwell Specialty Medical Pharmaceuticals – personalized concierge support and Specialty Drug List for provider-based infusion services • Provider eligibility verification and benefits information • Medical ID Cards/Mobile ID Cards ("digital" with option for member initiated "physical" card through myCigna.com or by phone to Member Customer Service • Cigna One Guide services • Telehealth Connection Services (including MDLive) • Website member portal • Mobile App • Health and Wellness Information and Links • Appeals Administration	**Cigna Healthcare (Cigna)** **OAP Plus Provider Network** Member Customer Care Center and Health Information Line: 1-800-244-6224 Hours: 24x7x365 Member Portal/website: www.myCigna.com Mobile App: Google Play Store or App Store – search for "mycigna" Pre-enrollment customer service line (for new hires and pre-Open Enrollment customer service) – 1-888-806-5042 Cigna Virtual Care Services: (1-888-726-3171) - access through mycigna.com for MDLIVEforCigna.com for medical, behavioral health, wellness screening and dermatology online screening purposes. Other Virtual or App based services thru mycigna.com for Women's Health, Nutritional Counseling, Physical Therapy/Musculosketal, Speech Therapy, Sleep Apnea, Cardiac Health, Chronic Pain Management Digestive Health, LGBTQIA+ care and Mental Health and Wellbeing thru: Visana, Allara, Wildflower, Aeroflow Health, MIDI Health, Gennev, Hey Jane, Nourish, Foodsmart, Kroger, AshCare, Airrosti, Joint Academy, Great Speech, Gem Sleep, Heartbeat, Override, Oshi Health, Folx and the Headspace for Cigna Healthcare app Cigna Pathwell Specialty Medical Pharmaceuticals Care Manager: 1-877-505-3681 Hours: Monday to Friday 8 am to 7 pm (leave a message if after hours) Pre-certification phone #: 1-800-244-6224 Provider electronic claims to Cigna: EDI# 62308 Out-of-Network and Paper Claims to: Cigna Healthcare P. O. Box 188050 Chattanooga, TN 37422-8050 Submit Appeals to: Cigna Healthcare P. O. Box 188050 Chattanooga, TN 37422-8050

QUICK REFERENCE CHART

Information Needed About:	Contact the following:
MDLIVE for Cigna® • Active employees, retirees and respective dependents covered in City active or retiree medical plans • Easy Access to Urgent Care (no co-pay!) – for all three City of Mesa Cigna Health Insurance Plans • **Primary Care** - Easy, fast appointments, referrals, prescriptions, lab work and diagnostic tests • **Dermatology** - Fast, customized care for skin, hair, and nail conditions – no appointment required • **Urgent Care** - Available via E-Treatment, phone or video • **Behavioral Care** - Talk therapy and psychiatry from the privacy of home, with no waiting rooms	**Visit myCigna.com** or **call MDLIVE at 888.726.3171** when you need virtual care. 24/7 care team available. **Head-to-toe virtual care from MDLIVE** It's easy to connect to care. Virtual care visits are convenient and easy, whether you choose on-demand care or to schedule an appointment. And you can select an appointment in English or Spanish. **Basic Plan:** MDLive Telehealth Connection virtual services: ➢ Medical and Behavioral health, Urgent Care and Virtual Wellness Screenings are covered at 100% ➢ Virtual primary care services for routine and chronic condition management and virtual dermatology care at $20 copay **Choice Plan:** MDLive Telehealth Connection virtual services: ➢ Medical and Behavioral health, Urgent Care and Virtual Wellness Screenings are covered at 100% ➢ Virtual primary care services for routine and chronic condition management and virtual dermatology care at 80% after deductible. **Copay Plan:** MDLive Telehealth Connection virtual services: ➢ Medical and Behavioral health, Urgent Care and Virtual Wellness Screenings are covered at 100% ➢ Virtual primary care services for routine and chronic condition management at $20 copay ➢ Virtual dermatology care at $40 copay.

QUICK REFERENCE CHART

Information Needed About:	Contact the following:
Prescription Drug Benefits/Program for Medical Plan Participants (Active Employees, Non-Medicare Eligible Retirees and Eligible covered dependents) • Rx ID Cards (plus online and mobile app ID) • In-Network Retail Pharmacy network nationwide • Mail Order Pharmacy services • Up to 90-day supply services at all network retail pharmacy locations • Non-network outpatient retail pharmacy claims • Utilization management services and appeals; preauthorization, step-therapy, or quantity limits on certain prescription drugs • Formulary Management • Outpatient Specialty Drug Pharmacy services/authorizations • Member Website • Mobile App + MedEmpower Fuel™ app • **MedAssist**- high-cost Non-Specialty Drug Program – referrals to copay assistance and plan cost containment services available for a list of approximately 70 drugs (subject to change at any time)	**MedImpact Healthcare Systems, Inc. (MI)** **Member Services Address**: Attn: Customer Service 10181 Scripps Gateway Ct., San Diego, CA 92131 **Member Services Phone**: 1-866-387-3537 Hours: 24/7/365 (Also used for Pharmacy and Physician Provider Services, Coverage Determinations and Appeals/Grievances, Paper Claims Service) **Member Portal**: www.medimpact.com **Mobile App (member portal) or MedEmpower Fuel™ App**: Google Play Store or App Store – search for "MedImpact" or "MedEmpower Fuel™ " *First time users of Member/Consumer Portal or Mobile Apps must register using your Member ID # on your MedImpact ID card* **Appeals**: Mail: Attn: Appeals and Grievances Department (at Member Services address above) Phone: 1-866-387-3537 Fax: 1-858-790-6060 **Coverage Determinations (PA's):** Mail: Attn: Prior Authorization Department (at Member Services address above) Phone: 1-866-387-3537 Fax: 1-858-790-7100 **Birdi Mail Order**: Phone: 1-855-873-8739 Fax: 1-888-783-1773 Hours: M-F 5 a.m. to 5 p.m. and Sat. 6 a.m. to 2 p.m. MST Website: www.medimpact.com (first time users must register) Email: customerservice@birdirx.com **MedImpact Direct Specialty services**: Address: 8060 South Kyrene Rd, Tempe, AZ 85284-2115 Phone: 1-877-391-1103 Fax: 1-888-807-5716 Hours: M-F 6 a.m. to 6 p.m. MST Website: www.medimpact.com (first time users must register) Email: specialtyservicecenter@medimpactdirect.com **Submit non-network retail pharmacy up to 30-day "paper" claims** with claim form to: MedImpact Healthcare Systems, Inc. Attn: Claims Department P.O. Box 509098, San Diego, CA 92150-9098 Phone: 1-866-387-3537 Fax: 1-858-549-1569 Email: Claims@Medimpact.com

QUICK REFERENCE CHART

Information Needed About:	Contact the following:
Prescription Drug Benefits/Program for Medicare Eligible Retiree Medical Plan Participants (EGWP Medicare Part D Prescription Drug Program and Wrap Program) • Rx ID Cards (plus online and mobile app ID) • In-Network Retail Pharmacy network nationwide • Mail Order Pharmacy services • Up to 90-day supply services at all network retail pharmacy locations • Non-network outpatient retail pharmacy claims • Utilization management services and appeals/grievances: preauthorization, step-therapy, or quantity limits on certain prescription drugs • Formulary Management • Specialty Drug Pharmacy services/authorizations • Member Website • Mobile App • MPPP Program – spread out-of-pocket pharmacy costs over a calendar year – enrollment needed to activate	**VibrantRx (PDP)** **Member Services Address**: VibrantRx P.O. Box 509097, San Diego, CA 92150 **Member Services Phone**: 1-844-826-3451 Hours: 24/7/365 (Also used for Pharmacy and Physician Provider Services, Coverage Determinations and Appeals/Grievances, Paper Claims service) **Member/Consumer Portal**: www.MyVibrantRx.com/mesaaz **Mobile App**: Google Play Store or App Store – search for "MyRxInfo" Alternatively, go to www.MyVibrantRx.com/mesaaz on mobile device, scroll down log in page to "Download Our Mobile App" and click on the link to MyRxInfo app *First time users of Member/Consumer Portal or Mobile App must register using your Member ID # on your VibrantRx ID card* **Appeals and Grievances**: Mail: Attn: Appeals or Grievances Department as applicable (at Member Services address above) Phone: 1-844-826-3451 Fax: Appeals 1-858-790-6060; Grievances 1-858-790-6000 **Coverage Determinations (PA's):** Mail: Attn: Prior Authorization Department VibrantRx 10181 Scripps Gateway Court San Diego, CA 92131 Phone: 1-844-826-3451 Fax: 1-858-790-7100 **Birdi Mail Order**: Phone: 1-855-873-8739 Fax: 1-888-783-1773 Hours: M-F 5 a.m. to 5 p.m. and Sat. 6 a.m. to 2 p.m. MST Email: customerservice@birdirx.com Website: www.MyVibrantRx.com/mesaaz (first time users must register) **Specialty Drug services**: Address: MedImpact Direct Specialty 8060 South Kyrene Rd, Tempe, AZ 85284-2115 Phone: 1-877-391-1103 Fax: 1-888-807-5716 Hours: M-F 6 a.m. to 6 p.m. MST Website: www.MyVibrantRx.com/mesaaz (first time users must register) Email: specialtyservicecenter@medimpactdirect.com **Submit non-network retail pharmacy "paper" claims** with claim form to: Mail: VibrantRx Attn: Claims Department P.O. Box 509097, San Diego, CA 92150-9098 Phone: 1-844-826-3451 Fax: 1-858-549-1569

QUICK REFERENCE CHART	
Information Needed About:	**Contact the following:**
Specialty Drug Advocacy Services for Prescription Drug Plan Participants in City Medical Plans (Employees/Covered Dependents and Non-Medicare Eligible Retirees/Covered Dependents) • Mandatory participation in financial case management/advocacy services to help identify/facilitate member enrollment in publicly available financial assistance programs for prescribed specialty drug otherwise covered in City prescription drug programs • Select Drugs and Products list management – subject to change at any time • Coordinate qualified Specialty Drug delivery and claims processing	**Select Drugs and Products℠ Program/List administered by PaydHealth LLC (PH)** Toll-free 1-877-422-1776 Hours: 8 a.m. to 8 p.m. M – F CST (except holidays)
Flexible Spending Accounts (FSA) Third Party Administration • Health FSA claims processing • Dependent Care FSA claims processing • Health and Dependent Care FSA Debit Cards • Direct Deposit claims reimbursements • Account balances • Website member portal • Mobile App • FlexConnect – opt-in auto connect to health plan EOBs for claims submission and reimbursement automation • Kinside Dependent Care Referral and Discount service • Health and Wellness Information and Links • Navia GlicRx Compass Card for RX discounts - from navia.glicrx.com + mobile app	**Navia Benefit Solutions** Customer Service: 1-800-669-3539 Hours: 5 am to 5 pm Monday - Friday E-mail Address: customerservice@naviabenefits.com Member Portal/Website: www.naviabenefits.com; employer code – CM9 Mobile App: Google Play Store or App Store – search for “MyNavia” Claims Submittal: Claims may be submitted and adjudicated/substantiated by Navia debit card or online in member portal/mobile app, including FlexConnect (no separate claim form required) Claims submittal with a claim form by email, fax or mail: E-mail: claims@naviabenefits.com Fax: 1-866-535-9227 Mail: P.O. Box 53250, Bellevue, WA 98015

QUICK REFERENCE CHART

Information Needed About:	Contact the following:
Dental Plan Benefits/Third Party Claims Administration/Member Services and Dental Provider Network Access • Group #: 4760 • Delta Dental PPO + Premier Provider 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: 1-800-352-6132 or 602-588-3981 Hearing Impaired: TTY/TDD users may call 711 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/member Mobile App: Google Play Store or App Store – search for "Delta Dental" E-mail Address: customerservice@deltadentalaz.com Submit claims to: Delta Dental of Arizona Attn: Claims Department P.O. Box 9092 Farmington Hill, MI 48333-9092 Payer ID #: 86027
Vision Care Plan - Routine Eye 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 • Essential Medical Eye Care Exam benefit	**Vision Service Plan (VSP)** Member Services: 1-800-877-7195 Hours: M – Fri 5am to 7pm PST Member portal/website: www.vsp.com or access from Smart Phone; print ID card if desired (not required) VSP ID # is your employee ID # with 4 or 5 preceding zeroes to make 9 digits Automatic processing for in-network and affiliate vendor claims Submit non-network claims to: VSP Member Claims P. O. Box 495933 Cincinnati, OH 45249 Submit appeals to: VSP Member Appeals 3333 Quality Drive Rancho Cordova, CA 95670
Business Travel Accident/Commuter Travel Accident Insurance Policy #: ABL 963116 Full-time employees only.	**Life Insurance Company of North America administered by New York Life Group Benefit Solutions (NYL GBS)** Contact Employee Benefits Administration Office at 480-644-2299 for questions, certificates/policy information, beneficiary designations or to file a claim. **Secure Travel** – offers emergency assistance, emergency medical transportation and pre-trip planning 24/7/365 - call 347-708-1824

QUICK REFERENCE CHART

Information Needed About:	Contact the following:
Basic and Voluntary Group Term Life and Accidental Death & Dismemberment Insurance Policy #: 174429-A **Standard Life Insurance Company – The Standard** 1100 SW Sixth Ave, Portland, OR 97204 Phone: 800-378-2395 Website: www.standard.com	Contact Employee Benefits Administration Office for questions, certificates/policy information, beneficiary designations and to file a life/insurance and/or accidental death and dismemberment claim: Phone: 480-644-4421 Email: benefits.info@mesaaz.gov The Standard also has available "The Life Services Toolkit" through Health Advocate for active employees and their beneficiaries: • Estate Planning Assistance • Financia Assistance • Contact The Standard at 800-378-2395 for use of other services available to covered members: Will Preparation, Estate Resolution and Probate Services Travel Assistance services with Assist America, Inc. for life insurance covered employees when you travel more than 100 miles from home for up to 180 days for business or pleasure, and pleasure travel for covered spouse/committed partner and up to age 25 children: • Call 800-872-1414 (US, Canada, Puerto Rico, US Virgin Islands & Bermuda) or +1-609-986-1234 or text +1-609-334-0807 everywhere else • Email: medservices@assistamerica.com • Mobile App: 01-AA-STD-5201
Short Term Disability (STD) Insurance – Voluntary Program Policy #: 174429-B	**Standard Life Insurance Company (The Standard)** Member Services: 800-378-2395 Hours: 5 am to 5 pm Pacific Time Claims: Member portal/website: www.standard.com , go to File a Claim for Insurance Benefits Through Work (login and create an account), then continue to submit claim online or alternatively click on "Paper Claims Forms" and select Short Term Disability Claim Packet to complete and mail a claim. Can also check 800-378-2395 for phone claim filing services after February 1, 2026. While receiving short-term disability insurance benefits from The Standard you can access **Health Advocacy Select** at 844-450-5543 M – F, 8 am to 11 pm ET to be assigned a Personal Health Advocate (Registered Nurse) for help navigating your temporary disability healthcare needs – make sense of your diagnosis and treatment options, find and schedule appointments, locate specialists for high-risk pregnancies and pediatricians, manage out-of-pocket expenses, resolve claims and billing issues and find resources for services that are not covered by your health benefits program.

QUICK REFERENCE CHART	
Information Needed About:	**Contact the following:**
Medical Retirement and Long-Term Disability Benefits for Public Safety (Sworn Police Officers and Firefighters) and Elected Officials – For Full-time Sworn and Elected Official employees only.	• **Primary disability benefits from Public Safety Personnel Retirement System and Elected Officials Retirement Plan** • PSPRS and EORP medical retirement benefits - mandatory automatic enrollment for eligible employees; partial taxability on benefits • For questions and to file a claim under PSPRS or EORP contact City Clerk's Office at 480-644-5293 **The Standard LTD policy** is a secondary policy offset by primary disability benefits from PSPRS or EORP Medical Retirement benefits – described above: • **Fully insured policy # 174429-C** – insured and administered by Standard Life Insurance Company – The Standard • Mandatory automatic enrollment for PSPRS and EORP eligible employees (employer paid insurance premiums; taxable benefits) • For questions and to file a Standard LTD disability claim contact Employee Benefits Administration Office at 480-644-2299
ASRS Retirement System – Medical Retirement and Long-Term Disability Benefits	• Arizona State Retirement System covered employees - administered by **Broadspire Services Inc.** • Mandatory automatic enrollment for eligible employees • For questions and to file a claim contact Employee Benefits Administration Office at 480-644-2299

QUICK REFERENCE CHART

Information Needed About:	Contact the following:
LegalShield Legal Services Membership **Voluntary Benefit**: for active employees and immediate family and retired employees and immediate family; direct pay – no City payroll deductions/billing. **Includes:** **Legal Advice/Consultation** on unlimited personal issues **Dedicated Law Firm – Direct access, no call center** **Letters/Calls** made on your behalf **Contracts/Documents Reviewed** up to 15 pages **Residential Loan Document Assistance** for the purchase of your primary residence **Will Preparation** - Will/Living Will/Health Care Power of Attorney **Traffic Ticket Consultation** **IRS Audit Assistance** (begins with the tax return due April 15th of the year you enroll) **Trial Defense** (if named defendant/respondent in a covered civil action suit) **Uncontested Divorce, Separation, Adoption and/or Name Change Representation** (available 90 days after enrollment) **25% Preferred Member Discount** (bankruptcy, criminal charges, DUI, personal injury, etc.) **24/7 Emergency Access** for covered situations **IDShield Identity Protection Membership** **Includes:** **Continuous Credit Monitoring** IDShield continuously monitors your credit report. If changes occur, you'll receive an instant alert. **Auto-Monitoring** Provides monitoring services directly upon enrollment using member-provided Personally Identifiable Information (PII) such as name, Social Security number and date of birth. **Hard Credit Inquiry Alerts** Monitors your credit report for new hard inquiries. When an inquiry is made by the creditor, a notification is triggered in real-time, and you will receive an alert. **Credit Freeze and Fraud Alert Assistance** We help in placing a credit freeze and/or fraud alert on your credit reports. **Unlimited Consultation** On any cyber security issue. **Full-Service Restoration** Our Licensed Private Investigators will work tirelessly to restore your identity to its pre-theft status. **IDShield Mobile App** Features include identity threat and credit inquiry alerts, the ability to track and edit monitored information and direct access to IDShield Licensed Private Investigators. **24/7 Emergency Access** We're here in the event of an identity theft emergency.	**LegalShield/IDShield (trade name of Pre-Paid Legal Services, Inc.)** One Pre-Paid Way Ada, OK 74820 Customer Service Phone: 1-800-654-7757 M – Fri 7 am to 7 pm Central Time Group #: 92249 City of Mesa enrollment link/Website: www.legalshield.com/info/cityofmesa Enrollment Phone: 480-695-0501 Associate Name: Jerry Loffredo Email: jerry@bjloffredo.com

QUICK REFERENCE CHART

Information Needed About:	Contact the following:
United Pet Care – Pet Healthcare Membership Discount/Network Program **Voluntary Benefit**: for active and retired employees; direct pay – no City payroll deductions/billing. **Includes:** • Operating since 1996 • Member portal for enrollment, payment authorization, provider look-up by zip code and 24 x 7 chat, call, and video access to Pet Helpline • Per pet monthly membership fees • Membership card – digital • Vet Spending Card – Fido, by MedZERO virtual Mastercard with O% interest and no fees, $500 in on-demand funds usable at any US vet • National network of veterinary providers with 20% to 50% off all in-house services • Preventive and primary care for most animal breeds • Discount veterinary generic and brand drugs • whiskerDocs – 24/7 Pet Helpline with call, chat, and video features • No pre-existing condition exclusions • No breed/age restrictions (including rescue animals) • No waiting periods, deductibles, claim forms	**United Pet Care LLC** Address: 350 W. Washington St, Suite B101, Tempe, AZ 85288 Phone: 877-872-8800 M – F (except holidays) 8 am to 5 pm MST Email: Info@unitedpetcare.com Website: www.unitedpetcare.com To enroll: www.unitedpetcare.com/enroll (when enrolling select City of Mesa in the affiliation drop down) whiskerDocs: call, chat, and video contact information inside member portal after enrollment Fido by medZERO Vet Spending Card: available for UPC members at no additional cost. How it works: • Enroll in UPC • Download the FIDO by medZERO mobile app • Enter your information and repayment method • Instantly receive your virtual Mastercard • Use at any US vet or vet clinic

ELIGIBILITY AND ENROLLMENT

	OVERVIEW OF ELIGIBILITY FOR COVERAGE/ENROLLMENT IN PLAN BENEFITS					
Benefit Options	**Full-time Employees**	**Benefit Eligible Part-time Employees**	**Active Elected Officials**	**COBRA Qualified Beneficiaries**	**Retirees**	**Medical Retirement Retirees with Disability**
Medical/Behavioral Health/Prescription Drug Plans	YES	YES	YES	YES	YES	YES
Dental Plans	YES	YES	YES	YES	YES	YES
Vision Plans	YES	YES	YES	YES	YES	YES
EAP	YES	YES	YES	YES*	YES*	YES*
Employee & Retiree Health and Wellness Center (Primary & Preventive Care)	YES	YES	YES	YES – if COBRA medical plan participant	YES	YES
Mesa Wellness 360 Challenges and Rewards Program	YES	YES	YES	NO	NO – except for Retiree medical plan participant - limited wellness webinar and education participation	NO – except for Retiree medical plan participant - limited wellness webinar and education participation
Long Term Disability (LTD) Insurance	YES	YES	YES	NO	NO	NO
Voluntary Short-Term Disability (STD) Insurance	YES	YES	NO	NO	NO	NO
Basic Life and AD&D Insurance	YES	NO	YES	May port or convert active coverage to an individual policy at time of termination from a full-time status	May port or convert active coverage to an individual policy at time of retirement from a 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 a full-time status
Voluntary Life and AD&D Insurance (for Employee, Spouse/Committed Partner, and/or eligible Child(ren)	YES	YES	YES	May port or convert active coverage to an individual policy at time of termination	May port or convert active coverage 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 Travel Accident Insurance (BTA)	YES	NO	YES	NO	NO	NO
Flexible Spending Accounts (FSA)	YES	YES	YES	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	May continue Health FSA through COBRA for remainder of calendar year after last day worked, with post-tax contributions

*EAP coverage during first 18 months following termination of employment or loss of eligibility for active Plan coverage, for COBRA beneficiaries, Retirees or Medical Retirement Retirees, who are also enrolled in either COBRA medical or Retiree medical coverage with the City.

1. Full-time employees of the City of Mesa (regularly scheduled to work at least 40 hours or more each week) and **Part-time benefit eligible 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/classification), who receive a bi-weekly paycheck directly from the City of Mesa (unless not receiving a paycheck during an authorized unpaid leave of absence), are eligible for the benefits listed in the chart above, as of the **first day of the month following your date of hire**. All eligible employees are required to actively enroll/elect medical coverage through the City or specifically opt-out of City medical coverage, as may apply.

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 for these programs (all or none of these benefits), to be the date of hire, instead of the standard City eligibility default of first of month following hire date.

Benefit Effective Date	Comments
Option 1: First of the month following the date of hire	• Enrollment processes/forms and any required verification documentation for dependents, such as marriage/birth certificate, legal certifications, divorce decree, etc. must be uploaded to the online enrollment system or physically presented 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 defaulted automatically to the City's Basic Medical/Prescription Drug Plan with employee only coverage and a required wait until the next 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 – all or none)	• Enrollment processes/forms and any required verification documentation for dependents, such as marriage/birth certificate, legal certifications, divorce decree, etc. must be uploaded or physically presented in the Employee Benefits Administration Office as soon as administratively practical but no later than 5 days from the hire date. If this deadline is missed, coverage will be effective on the first of the month following the date of hire providing that enrollment processes/forms and verification documentation have been uploaded/received no later than 31 days from the hire date. Please note the Employee Benefits Office hours of operation/location and email address in the Quick Reference Chart.

The benefits enrollment process for medical/prescription drug, dental, vision, flexible spending accounts, voluntary life/AD&D insurance and short-term disability insurance includes completion of online enrollment processes by eligible employees using the City's eBenMesa enrollment application, upload or submission of any required forms/verification documentation to the Employee Benefits Administration Office, and payment of any required premium contributions as they come due (generally the first two paychecks of each month or every paycheck for flexible spending account contributions).

"Automatic" enrollment processes for eligible employees applies to the following benefit programs: EAP services for all active employes as of date of hire, and, as of the first of the month following the date of hire, automatic enrollment for Basic Life/AD&D, BTA and secondary LTD insurance for Sworn Personnel and Elected Officials These automatic enrollment processes are administered by the Employee Benefits Administration office in conjunction with the City's HRIS payroll system as may apply for the specific programs. LTD coverage under the Public Safety Personnel Retirement System (PSPRS) or the Arizona State Retirement System (ASRS), is an automatic enrollment process effective on the date of hire for eligible employees (see Long Term Disability section of this Plan Document for additional information) and administered in the City's HRIS payroll system.

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. Eligibility for these benefits starts on the day on which the elected official is sworn into office, and coverage for each program is effective as described in 1. above provided online enrollment processes/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 when due.

3. Retired employees of the City of Mesa (Retirees) who meet the length of service requirements as stated in the Definitions section of this Plan Document (under "Retiree"), and other requirements described below, are eligible for the Retiree benefits listed in the chart describing the Overview of Eligibility for Plan Benefits section.

When you retire, active employee health coverage terminates on the last day of the month in which your retirement date occurs. Retiree coverage begins on the first day of the month following your retirement date, provided any required enrollment processes and premium payments are completed/paid, and you are eligible for and activate a monthly retirement pension from either the ASRS or PSPRS state retirement system. You will be offered the City's retiree healthcare coverage for the same plan

type options (medical, dental and/or vision coverage), that you had as an active employee immediately prior to your retirement. At initial retirement, you may change coverage tier in each retiree health plan from family to single but not from single to family (that must wait until the next Open Enrollment period). You **must be enrolled** in active medical, dental or vision plan coverage with the City immediately prior to, or on your retirement date to elect retiree medical, dental or vision plans upon retirement (or alternatively, elect COBRA for any or all of these plans). Plan for this requirement ahead of your retirement date, during Special/Qualifying Event Enrollment or Open Enrollment periods, as described later in this chapter to be sure you are enrolled in the active plan options that you want immediately upon retirement.

Monthly premiums paid by the retiree during retirement, are determined by a number of factors including: plan/tier of medical, dental and/or vision coverage(s) selected or continued from year to year; annually evaluated total monthly retiree premium costs; annually evaluated maximum City contribution amounts by plan; Medicare eligibility; continuing eligibility for monthly pension system benefits from either the Arizona State Retirement System (ASRS) or Public Safety Personnel Retirement System (PSPRS) and, ASRS or PSPRS healthcare premium subsidies for which the retiree is eligible. The City reserves the right to change or eliminate City contributions and any Medicare discounts that may apply to retiree enrollments. ASRS or PSPRS subsidies applied to offset the retiree's cost of City health plan coverage are subject to change based upon ASRS and PSPRS rules/policies.

Upon retiring from the City of Mesa (if already eligible for Medicare at that time) or upon aging into Medicare or becoming eligible for Medicare due to disability, after retirement, retired employees, and their eligible covered dependents (eligible for Medicare) who are enrolled in City retiree medical plans, **must** also enroll in Medicare Parts A and B directly with Medicare. This Medicare enrollment is required if you otherwise want to continue your enrollment in City retiree medical plans (including even if you are employed with another employer during retirement from the City). You must pay any required Medicare premiums for Part B coverage directly to Medicare and must opt-in to the City sponsored Medicare Part D Prescription Drug Program (PDP) with no additional premiums.

If a Retiree returns to work with the City, as a **PT or seasonal non-benefit eligible employee**, he/she will remain as a retiree for medical, dental or vision plan purposes. If a retiree returns to **FT or PT benefit eligible active employment** with the City, he/she will return to active employee coverage status and become eligible for and pay active employee benefit premiums. If the returned employee is an ASRS retiree, who retired prior to August 1, 2012, he/she can apply to receive a healthcare subsidy reimbursement from the retirement system to help offset the costs of active health plan premiums, once every 6 months (subject to ASRS provisions that may change over time). PSPRS retirees who return to active status with the City in a PSPRS position are not eligible for healthcare subsidy reimbursement for active health plan premiums. PSPRS retirees who return to active status in a benefited position that is also an ASRS position (with approval of the PSPRS board), are eligible to receive a monthly reimbursement in their City paycheck, of their eligible retirement system healthcare subsidy. When the ASRS or PSPRS employee returns to retired status, he/she will do so without regard to this additional employment and return to standard retirement system healthcare subsidy eligibility and City retiree healthcare plan eligibility, then applicable.

4. Retired Employees with a Medical Retirement Due to Disability (Medical Retirees): Retired employees, other than those described in 3. above, who medically retire from the City due solely to a Total Disability **and** are receiving an ASRS/PSPRS disability (LTD) pension benefit on the first of the month following or coincident to medical retirement from the City **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 medical, dental and vision plan coverage as retired employees without a medical retirement/disability, regardless of the length of service completed immediately prior to the medical retirement/disability. An employee will be eligible to retire under this provision if totally disabled for a period of at least six months prior, and the Total Disability and ASRS/PSPRS disability (LTD) pension benefit continues thereafter.

Retiree medical, dental or vision plan coverage begins on the first day of the month following the medical retirement date and will continue while the medical retiree is receiving disability pension benefits, completes any enrollment processes, and any required premium contributions are paid. Individuals who retire due to a disability must enroll in Medicare Parts A and B directly with Medicare when first eligible (due to a Social Security Disability Award or regular Medicare eligibility) and must opt-in to the City sponsored Medicare Part D prescription drug program, upon becoming eligible for Medicare.

When/if disability pension benefits end, the medical retiree may be eligible to continue coverage as a retired employee without a medical retirement/disability, IF the length of service and other eligibility requirements described in 3. above and in the Definitions section, were met **prior** to the medical retirement/disability commencement. City service does not continue to accrue while medically retired and receiving disability pension benefits.

Seasonal employment and employment in a part-time non-benefits eligible position do not qualify toward active or retiree benefits eligibility under this Plan. ***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.***

IMPORTANT NOTICE ABOUT EMPLOYEE, RETIREE AND DEPENDENT INFORMATION

You and/or your Dependents must promptly furnish to the Employee Benefits Administration office (See Quick Reference Chart section), information regarding change of name, address, marriage, divorce, death of any covered family member, change in status of a Dependent Child or Medicare eligibility/status.

You must notify the Medical, Prescription Drug or Dental Plan Appropriate Claims Administrator of Medicare enrollment or disenrollment or the existence/cessation of other health insurance coverage or Medicare coverage for yourself or any covered dependents (so that primary and secondary claims adjudication can be effectively administered in accordance with Plan Document provisions for such).

FAILURE TO PROVIDE ANY OF THE ABOVE INFORMATION MAY CAUSE YOU OR YOUR DEPENDENTS TO LOSE CERTAIN RIGHTS UNDER THE PLAN, MAY CAUSE CLAIMS ADJUDICATION DELAYS, ERRORS, OR DENIALS AND/OR MAY RESULT IN YOUR LIABILITY TO THE PLAN (REQUIREMENT TO REIMBURSE THE PLAN) IF ANY BENEFITS ARE PAID ON BEHALF OF AN INELIGIBLE PERSON.

IMPORTANT NOTICE ABOUT COORDINATION OF INFORMATION AND BENEFITS WITH MEDICARE

To comply with federal Medicare coordination of benefit regulations, you must promptly provide to the Plan Administrator or its designee, including Appropriate Claims Administrators, the Social Security Number (SSN) of you and your Eligible Dependents for which you have elected, or are electing Plan coverage, along with 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 after that date. Failure to provide this information will result in claims processing delays and/or coverage denials.

Retired employees and/or their dependents (including Disabled Dependents) enrolled in one of the City's retiree medical plans, MUST enroll in Medicare Parts A and B directly with Medicare when first enrolled in a City retiree medical plan if also eligible for Medicare at that time, or subsequently, if Medicare eligibility occurs after initial enrollment in a City Retiree medical plan (i.e. age-in to Medicare eligibility or become eligible for Social Security Medicare Disability post-retirement). Please provide proof of Medicare coverage to the City's Employee Benefits Administration office when received. Medicare eligible Retirees and Medicare eligible dependents **must also opt-in to the City's Medicare Part D Prescription Drug Plan (PDP),** upon becoming eligible and enrolled in Medicare Parts A and B. A retired employee or their Medicare eligible dependent enrolled in a City retiree medical plan, may only elect Medicare Part D through the City's Medicare Part D Prescription Drug Plan (PDP) and not any other third-party Medicare Part D Prescription Drug Plan.

Enrollment in Medicare (including Medicare Parts A, B, C and D directly with Medicare), is optional for active employees and their dependents (including disabled dependents), but if enrolled in both a City medical plan and Medicare while an active employee, the City's plan will be primary coverage, and Medicare will be secondary insurance coverage. See the COBRA section for information about the effect of Medicare eligibility on COBRA eligibility and primary or secondary coverage status for COBRA medical claims.

DEPENDENTS' ELIGIBILITY FOR COVERAGE

If you elect coverage for yourself, you are also eligible for benefit coverage for your Eligible Dependents in the medical, dental, vision and voluntary life and AD&D 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 Definitions 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 and Surviving Lawful Spouse/Dependents of Law Enforcement eligibility section).

PROOF OF DEPENDENT STATUS

Specific documentation to substantiate Dependent status is required by the Plan (upon initial enrollment, qualifying event, and open enrollment additions and at other times based upon routine audit processes) and may include any of the following:

For Legal Spouse verification:

- **Marriage:** copy of the certified marriage certificate (signed and dated on or after the marriage date and appropriately recorded in the applicable legal jurisdiction).

For Child(ren) verification:

- **Birth:** copy of the certified birth certificate or hospital issued birth notification (if parent names are included).
- **Natural son or daughter (to age 26):** certified birth certificate listing employee/retiree as parent, child's marriage certificate or legal documentation certifying a name change (if child is married or has had a name change since the birth certificate was issued).
- **Adoption or placement for adoption (to age 26)**: certified birth certificate; legal adoption or placement documentation (either legal representation or court issued) listing employee/retiree or spouse as adoptive parent or intended adoptive parent; if child is married or has had a name change, child's marriage certificate or legal documentation certifying the name change.
- **Stepchildren (to age 26)**: birth certificate showing the employee's/retiree's spouse as the parent; if child is married or has had a name change, child's certified marriage certificate or legal documentation certifying the name change; employee/retiree's certified marriage certificate documenting marriage to stepchild's parent.
- **Foster Children (to age 26):** birth certificate; if child is married or has had a name change, child's certified marriage certificate or legal documentation certifying the name change; foster care license & placement documentation listing employee/retiree or spouse and foster child.
- **Legal Guardianship Children (to age 18):** a copy of legal guardianship documents and a copy of the certified birth certificate.
- **Grandchildren: not eligible** unless adoption, placement for adoption, stepchildren or foster children (to age 26); or legal guardianship children (to age 18); follow proof of dependent status guidelines described in this section for each applicable dependent category.
- **Disabled Dependent Child (age 26 or older, or age 18 or older if a legal guardianship 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.

For Legal Spouse or Child(ren) Loss of Coverage Verification:

- **Involuntary Loss of Dependent coverage:** Certificate of loss or end of coverage from previous employer or insurance carrier and marriage certificate and/or birth certificate(s) as applicable to the event and if not already on file.

SURVIVING LAWFUL SPOUSE AND SURVIVING DEPENDENT(S) OF SWORN OFFICER (LAW ENFORCEMENT OFFICER) EMPLOYEES KILLED IN THE LINE OF DUTY

The surviving lawful spouse and surviving dependent(s) of a deceased City Law Enforcement Officer are entitled to continue health coverage (medical, dental and/or vision) under the Plan. The following terms apply:

1. "Law Enforcement Officer" means a peace/police officer, detention/corrections officer (other than juvenile detention officer), or a fire fighter employed by the City of Mesa.
2. Surviving dependent coverage means coverage for a Child or Disabled Adult Child of a deceased law enforcement officer, as defined in the Definitions Dependent Children section of this document.

3. Disabled Adult Child dependent is also eligible for coverage providing the disability began before age 26 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 suffered in the line of duty. For purposes of this document, "injuries suffered in the line of duty" includes presumptive illnesses defined under Arizona state law;** and
5. The law enforcement officer must have been enrolled in a City-sponsored active or retiree Medical Plan at the time of death; and
6. The surviving lawful spouse and surviving dependents must have been covered by a City-sponsored active or retiree 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, subject to change on an annual basis; and
8. Survivor spouse/dependent continued health coverage at active rates will be offered as long as the City of Mesa offers such coverage to active employees; and
9. Continued coverage will be discontinued if the surviving lawful spouse remarries, becomes Medicare eligible or dies, or if a dependent otherwise becomes ineligible for coverage under the terms of City Medical Plans.
10. Upon termination of coverage due to the discontinuation reasons described above, the surviving lawful spouse and/or surviving dependent(s) will have the opportunity to elect standard COBRA continuation of coverage for 18 to 36 months (depending upon the discontinuation reason and except for "becomes Medicare eligible") and, paying full COBRA premiums.

COMMITTED PARTNER ELIGIBILITY

An employee/retiree who is newly eligible for medical/prescription drug, dental, vision care or voluntary life/AD&D insurance coverage under this Plan, has the option of enrolling an eligible Committed Partner and Committed Partner children, or during a subsequent Open Enrollment period. Note, Committed Partner or Committed Partner Children are not eligible for reimbursement for health FSA claims in the employee's Health FSA account with the City (if applicable).

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).

How to Enroll 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 the employee is first eligible to enroll, during a subsequent Open Enrollment period, or when requested annually to re-verify Committed Partner status):

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 documentation of Committed Partner child(ren) 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 **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 provide 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 (unless the child is also the natural, adopted or legal guardianship child of the employee/retiree).

Tax Implications of Enrolling a Committed Partner
The Plan will automatically default 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 monthly employer contributions towards family coverage provided to a Committed Partner and Committed Partner children will result in taxable imputed income to the employee every paycheck in which applicable employer benefit contributions occur**. The employee (or retiree) is responsible for seeking tax advice to determine the qualified tax dependent status of their Committed Partner or Committed Partner children, for purposes of adjusting annual federal and/or state income tax returns if applicable.

- **Post-Tax Elections Only**

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

- **Imputed Income Attribution**

If the employee has Committed Partner only coverage (i.e. no CP children or dependent children), the monthly Imputed Income Attribution for Medical Plan coverage will be the value of the monthly City (employer) contribution for single coverage. If the employee has Committed Partner and Committed Partner children (and/or dependent children) coverage, the Imputed Income Attribution will be the value of the monthly City (employer) contribution for family coverage minus the value of the monthly City (employer) contribution for the employee only tier of that coverage. Imputed Income Attribution for dental and vision coverage will be the respective plan values of the City (employer) contributions for family coverage minus the values of the City (employer) contributions for single coverage. All of these Imputed Income Attribution amounts are subject to additional federal, state and FICA tax withholding each paycheck in which the Imputed Income Attribution occurs for each individual employee and will result in a reduction in the employee's net paycheck amount. The Plan reserves the right to change the methodology for post-tax and Imputed Income processing as may be required by regulatory guidelines or other plan related circumstances.

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 (except if the COBRA qualifying event is the death of the employee or retiree). Re-enrollment after a drop of Committed Partner coverage is subject to satisfaction of eligibility and enrollment provisions during Open Enrollment periods.

Primary/Secondary Claims Payment Status for 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).

ENROLLMENT AND START OF COVERAGE

There are three opportunities to enroll for coverage under this Plan: Initial Enrollment (when first hired), Special/Qualifying Event Enrollment (including when first eligible upon a move into a benefit eligible position), and Open Enrollment (annually). These opportunities are described further in this chapter.

Procedure to Request Enrollment:
Generally, an individual must enroll in the Plan using online enrollment processes (called eBenMesa, with New Hire and Open Enrollment modules). For Special/Qualifying Event Enrollment call, fax, e-mail or visit the Employee Benefits Administration Office to complete enrollment/change processes or be directed/assisted in eBenMesa usage if appropriate.

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

a) Online enrollment selections (or submission of an Enrollment/Change form if applicable), and
b) Upload/submit proof of Dependent status (see Dependent Eligibility and Committed Partner Eligibility sections for details), and
c) Pay any required contributions for coverage (either through payroll deduction or invoice/SurePay processes while on unpaid authorized leave of absence, as applicable), and
d) Perform steps a. through c. above, in a timely manner per 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 enrollment processes including upload/submission of any required documentation such as birth or marriage certificates, 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 that require these processes and payments 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 using the online enrollment processes for each of the plans you wish to waive coverage. Note, no additional compensation is paid to you if you opt out of any benefit coverage. If you decline coverage for yourself, you cannot enroll your spouse or dependent children in the coverage you decline (does not apply to voluntary life/AD&D insurance coverage for spouse/committed partner or child(ren) although there may be limitations on the amount of available coverage for these family members).

If you later want to enroll in 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/change form to the Employee Benefits Administration Office with the optout 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/committed partner 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 retiree 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, as long as this coverage is otherwise available to retirees in general. Note, 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 due to termination of employment and then within thirty 30 days return to work with the City in a benefits-eligible position**, you will be required to re-enroll in the same benefit elections as you had before you terminated for the remaining portion of the Plan year. Participation will be effective the first of the month following such re-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.

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 (medical retirements),** your coverage starts on the first day of the month following your retirement date with the City. 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 (with a following January 1st effective date).

SPECIAL/QUALIFYING EVENT 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 you have a new Spouse by marriage, or if you have any Dependent Children by birth, adoption or placement for adoption, stepchildren, foster or legal guardianship children, you may request enrollment for your new Spouse and/or any Dependent Child(ren), **no later than 31 days** after the effective date of marriage, birth, adoption or placement for adoption, step-children status, foster or legal guardianship status.
   - 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 have a Dependent Child by birth, adoption or placement for adoption, foster or legal guardianship children you may request enrollment for your Spouse together with your new Dependent Child (and any other Dependent Children that are not already enrolled) no later than 31 days after the date of your new Dependent Child's birth, adoption or placement for adoption, foster or legal guardianship status.
   - To request Special/Qualifying Event Enrollment, follow the Enrollment procedures described earlier in this chapter. Supporting documentation (described in the earlier Proof of Dependent Status section), must be uploaded/submitted. If verification documentation is not available within 31 days after the event date, do not delay the submission of your change enrollment and notify Employee Benefits Administration of the documentation circumstances. To obtain more information about Special/Qualifying Event Enrollment, contact the Employee Benefits Administration Office.
   - **Special/Qualifying Event 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 of your initial eligibility for the Plan, 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, Spouse and/or Dependent Child(ren) within 31 days after the termination of yours or their coverage under that other health insurance policy or plan if that other coverage terminated due to:
   - loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause); or
   - termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
   - the health insurance was provided under COBRA Continuation Coverage, and COBRA coverage was "exhausted"; or
   - moving out of a HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
   - the other plan ceases to offer coverage to a group of similarly situated individuals; or
   - the loss of dependent status under the other plan's terms; or
   - the termination of a benefit package option under the other plan, unless substitute coverage offered

See also the Enrollment Procedures section of this chapter for more information. **Proof of loss of other 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 connected 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 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 providing you complete enrollment processes within 5 days of the marriage date.
   - 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 (or later, if the employee already has family tier coverage for the respective plans in which coverage is desired for the newborn or newly adopted Dependent Child), 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/Qualifying Event 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/Qualifying Event Enrollment opportunity, the employee will be permitted to change benefit plan options if desired.
5. **Failure to Enroll During Special/Qualifying Event Enrollment:** If you fail to request enrollment for yourself or any of your Eligible Dependents within 31 days (or as applicable, 60 days) after the date on which you or they first become eligible for Special/Qualifying Event Enrollment, you will not be able to enroll yourself or them until the next annual Open Enrollment period (or during a subsequent Special/Qualifying Event, also known as a mid-year status change).

NEWBORN DEPENDENT CHILDREN (Special Rule for Coverage)

Your newborn Dependent Child(ren) can 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. Exception: if you already have family tier of coverage for the respective plans in which you want coverage for newborn Dependent Child(ren), and you complete enrollment processes later than 31 days after the newborn's date of birth, the newborn can be covered with a retroactive effective date of date of birth.

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/PLACED FOR ADOPTION DEPENDENT CHILDREN (Special Rule for Coverage)

Your adopted Dependent Child can 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 (majority) 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 (unless the "exception" described above in Newborn Dependent Children applies), 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 individual 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 to complete a Qualifying Event enrollment in the spouse's coverage. 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 become 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 with the City or has a reduction in hours to a non-benefits eligible status, either of which would otherwise result in a termination of coverage, and still qualifies as a Dependent Child, the employee-child can be covered under the employee parent's coverage as a Special/Qualifying Event and if enrollment processes are 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 (at the same or different times) from the City of Mesa**, you may each elect your own individual (single) plan retiree coverage or one family plan, as described in #1 above (with one of the retirees being the designated retiree for purposes of this eligibility rule). During **one** subsequent Open Enrollment period, designated retiree, and spouse, may make a different election as to who is the designated retiree or a different election for individual or family coverage than the respective elections made upon the initial retirement of one or both the parties. Additionally, if the individual designated as the retiree precedes the spouse in death, the spouse will become the designated retiree at that time and may enroll in his/her own single coverage retiree plan at that time, (or family coverage if other eligible dependents are to continue 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. Per 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 acknowledge the child as a dependent even though the child may not otherwise meet the Plan's definition of dependent.
2. A QMCSO usually results from a divorce or legal separation and typically:
   - Designates one parent to enroll and 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;

- States the period from which or to which the QMCSO applies; and
- Identifies each health care plan type 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 eligible to be 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/Designee or Appropriate Claims Administrator 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/Designee or Appropriate Claims Administrator will 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 (but otherwise eligible to participate) 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.
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 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. Note that as long as the QMCSO is in force and the employee-parent is eligible for and enrolled in any applicable coverage that is required by the QMCSO, the employee-parent cannot voluntarily terminate the Dependent Child's coverage, even during Open Enrollment periods, absent a court or administrative order that allows the voluntary drop to occur. 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.

OPEN ENROLLMENT

1. Open Enrollment is a period during the fall (generally two weeks in 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 rates, 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 (except Voluntary Life/AD&D Insurance for spouse/Committed partner or dependent children).
   - You and all your covered Eligible Dependents must be enrolled in the same medical, dental or vision 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 for newly added Dependents (including birth/marriage certificates, adoption/placement, foster and legal guardianship paperwork etc.) must be uploaded/submitted to the Employee Benefits Administration Office on or before the close of the Open Enrollment period (or within a one-week "grace period" thereafter). Failure to upload/submit such documentation will result in the dependent NOT being enrolled even if otherwise eligible.
   - Retirees or COBRA participants who have opted out (or were never enrolled in) a specific coverage type 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 (January 1). Similarly, 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 any of medical, dental, vision, voluntary life/AD&D or STD coverage, and who choose or are not required to make a new coverage election during Open Enrollment (passive 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, all covered persons remain eligible for that coverage, and if the Plan Administrator has not designated that the Open Enrollment is an active enrollment for some or all the benefit plans offered by the City. **This provision does not apply to Flexible Spending Account elections, which must be designated/enrolled every year, i.e. active FSA enrollments every year.**
5. **Failure to Enroll Dependents during Open Enrollment:** If you fail to enroll new Eligible Dependents (or remove Dependents for whom you no longer want coverage but are otherwise eligible) within the Open Enrollment period, you will not be able to enroll/drop them until the next Open Enrollment period, unless your Eligible Dependents qualify for Special/Qualifying Event Enrollment/Drop described in previous/later sections.

SPECIAL/QUALIFYING EVENT OR MID-YEAR ENROLLMENT OR CHANGES

Federal IRS regulations for pre-tax premium benefit plans generally require that your Plan coverage remains 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 you have a Special Enrollment/Qualifying Event 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, foster or legal guardianship status 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 non-benefit eligible 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 that impacts the benefit plans for which you are eligible;
4. Change in Dependent status under the terms of this Plan that satisfies or ceases to satisfy the Plan's eligibility requirements (or changes the type of plan in which you and your family members may be enrolled), including changes due to attainment of age (age 18 for legal guardianship children; age 26 for natural, adopted/placed for adoption, foster or stepchildren) 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 e.g. change in HMO geographic area residency requirements;
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 due to a change in the cost of coverage for all Plan participants, or because 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 due to 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 situation, you may revoke coverage in the current plan and 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 be necessary, appropriate and consistent with the change in status (for example, if mid-year, the employee and spouse deliver a newborn child they can add that child to this Plan, but it would be inconsistent with a birth event to drop the spouse from coverage at that time); and
2. You must notify the Plan in writing (or completing applicable online processes) within 31 days of the qualifying change in status (except for "exception" noted in the section about Newborn dependents), otherwise, the request will not be considered made because of your change of status and you must 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 due to 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;
    - New spouse due to marriage with date of marriage as effective date of coverage provided you notify of the event within 5 days of the marriage date.
5. Except in situations where there is a change in plan costs, or a Special/Qualifying Event Enrollment opportunity, employees cannot change from one plan option to another plan option mid-year and must wait until Open Enrollment to change plans.

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 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

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 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...
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 and eligible individuals
Gain a child due to birth or adoption/placement for adoption, gain a stepchild, foster or legal guardianship child	• 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 their relationship status 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 not drop health coverage for yourself or any other covered and eligible 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 another plan coverage • Remove your children from your health coverage, with proof of another 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.

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.

PAYMENT FOR YOUR COVERAGE

Your contributions pay part of the cost of coverage for yourself and your dependents (generally payroll deductions for active employees and direct billing for retired employees or employees on unpaid leave of absence or dock status). The City (or retirement system subsidies for eligible retirees) 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 the people that it covers with variations for the types of coverage chosen and whether you cover your dependents. 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 in the first two paychecks of the month or in direct billing cycle(s) for the month, etc.

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 medical, dental or vision care plan offered by the City may elect COBRA, and the first six months of COBRA coverage will be provided by the City at the then current active employee-contribution rate for either single or family coverage.
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 pension 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 voluntarily drop 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 retiree 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 then current active employee-contribution rate for either single or family coverage.
4. **Surviving Lawful Spouse and Surviving Dependents of Sworn Officers 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 (except for any COBRA continuation privileges at that time); or
   - the surviving lawful spouse and surviving dependents cease to make the contributions required for coverage; or
   - the City terminates the Plan.

REQUIRED PLAN NOTIFICATION

You, your Spouse/Committed Partner, 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 (regardless of any legal or personal obligations you may have to provide health insurance coverage to your former spouse) or cessation of a Committed Partnership; or
- a Dependent Child becomes physically or mentally disabled; or ceases to have any physical or mental Disability; or

- Death of any covered person

Failure to timely notify the Plan of the above noted events will eliminate future COBRA rights that might otherwise apply to affected individuals who lose coverage and may subject the employee or retiree to repayment obligations for any overpayment of Plan benefits that may have occurred during a period of time when the affected individuals were ineligible for coverage under the Plan. 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

The Plan Administrator or its designee may process a termination of 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 to obtain coverage, services, or benefits under the Plan; or
b. **allow anyone else to use the identification credentials or card** that entitles you or your covered Dependent to coverage, services, or benefits under the Plan; or
c. **change (or fraudulently design) any prescription** furnished by a Physician or other Health Care Practitioner.

If your coverage is terminated for any of the above cause reasons, it may be terminated retroactively to the date that you or your covered Dependent performed or permitted the acts described above and you will be responsible for direct payment or repayment of any claims incurred/paid after the effective date of the termination of coverage.

The Plan Administrator or its designee may also 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 end of the month through which you have made appropriate premium payments. In addition, your coverage may be suspended during the 15-day notice period, and you will be responsible for repaying the Plan for any claims incurred/paid after the effective date of the termination of coverage.

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, adoption of a child, or starting legal responsibility of a step-child, foster child or legal guardianship 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 employee or dependent premium payments for insurance coverage that is continued while on FMLA Leave.
2. Since you **may not be paid** while you are on Family or Medical Leave, you may pay your contributions by the due dates specified in a direct billing invoice process (generally twice a month); your direct billing contributions will be made on an after-tax basis.
3. If you drop your coverage (or coverage is terminated due to lack of payment) while you are on Family or Medical Leave, you are still responsible to pay for the coverage that was active until the termination date of coverage and upon your return to work promptly at the end of that Leave, your benefit coverage can be re-activated (upon your request within 31 days from the end of that Leave) without any additional limits or restrictions imposed because 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 to which you may be entitled, contact Human Resources/Leave of Absence Administration.

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 to make 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 continue to receive paychecks from the City, or in response to twice monthly, direct billing invoices 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 specified period thereafter at your full expense. See the COBRA chapter of this document.

Questions regarding your entitlement to USERRA leave should be referred to Human Resources/Leave of Absence Administration or refer to Management Policy #338 Military Leave. Questions regarding 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.

Medical or Special Leave of Absence

If you are authorized a Medical or Special Leave of Absence, the City will continue Plan contributions for the benefit plans in which you are enrolled and choose to continue while on leave, on the same basis as prior to the beginning of the leave. 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 during your leave you must continue to pay your short-term disability premiums while on leave. In addition, you will be responsible for making any required employee contributions for all benefit coverages you choose to continue (e.g. medical, dental, vision and Voluntary Life/AD&D premiums) by the due dates specified in a direct billing invoice process (generally twice a month); your direct billing contributions will be made on an after-tax basis.

REACTIVATION 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 can be re-activated on the first of the month following your return to active service, if you return immediately after your authorized leave of absence ends and provided you notify Employee Benefits Administration within 31 days of your return to work. If your coverage was terminated due to lack of payment while on leave of absence, but is subsequently reactivated in accordance with this process, you will still owe any past due premiums for the period during which your coverage was active while on leave, but the reactivation of coverage and related premium responsibility will be prospective from the effective date of the reactivated coverage.

EMPLOYEE ASSISTANCE PROGRAM (EAP) ELIGIBILITY

Active employees (as of date of hire), COBRA medical plan participants and retirees enrolled in one of the City's retiree medical plans (during the first 18-months of retiree medical plan coverage) and their family/household members, are eligible to use the EAP program sponsored and paid by the City of Mesa. Active employees 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. The EAP is described in the EAP chapter of this document.

MESA HEALTH AND WELLNESS CENTER/MESA WELLNESS 360 PROGRAM

This section describes the City of Mesa Health and Wellness Program (also see the Quick Reference Chart):

- **Employee and Retiree Health and Wellness Center** (Mesa location) staffed by contracted third-party administered medical professionals for primary and preventive care medical services for adults and children aged two (2) and above, dermatology screenings, and youth sports physicals:
    - Available by appointment only, free of charge to all active and retiree medical plan subscribers and their eligible covered family members (from effective date of medical plan coverage)
    - Health and Wellness Center also provides employment related DOT physicals for eligible active employees whose job description requires them to complete these activities on an annual, or less frequent basis.
- **Mesa Wellness 360 Program**: wellness engagement platform (WebMD) for events, challenges, preventive screenings rewards, webinars/education, communications, health coaching, nutrition education, life/work management, Citywide events etc., wellness points recording and rewards processing:
    - Available to all active employees, spouses/committed partners enrolled in medical plans
    - Non-medical plan members who are active employees can also participate but with different rewards incentives
    - Some retiree participation is available in webinar/education activities (no rewards processing)

MEDICAL/PRESCRIPTION DRUG PLANS

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/Designee or Appropriate Claims Administrator (e.g., the City's contracted Appropriate Claims Administrator or Utilization Management services providers) to be "Medically Necessary" and "Contracted Charges" or "Allowed Charges**"**, 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 or other sections of this document; **and**
3. not greater than any applicable General Overall or Limited Overall Plan Benefits that are shown in the Schedule of Medical/Prescription Drug 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 even if they are considered Medically Necessary; that are determined to be greater than the Allowed or Contracted Charges; that are not covered by the Plan; that are determined to be due to non-compliance with the plan's prior authorization/pre-certification criteria for prescription drugs or that are determined to be greater than any applicable General Overall or Limited Overall Plan Benefits. Plan exclusions apply regardless of whether services are medically necessary.

PROVIDER NETWORK ORGANIZATION SERVICES

If you receive medical services or supplies from a Health Care Provider that is a member of the Plan's contracted Provider Network Organization (medical and behavioral health networks), you will be responsible for less money out of your pocket than if you use non-network (also known as "out-of-network") providers.

Medical Plan network providers are available in all 50 states and have agreed to accept only the amounts the Plan pays for covered services (Contracted or Allowed Charges), plus any additional amounts you must pay (i.e., deductible, copay, coinsurance), as designated by the Plan and described in the Schedule of Medical/Prescription Drug Benefits or in the Medical Network chapter of this document. There are generally no "balance billing" opportunities for network providers.

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

Generally, **the Plan will not reimburse you (or pay benefits on your behalf) for all Eligible Medical Expenses**. Usually, you must 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 for eligible, covered in-network medical expenses, no further Coinsurance or copayments will be applied during that Plan year.

In addition, there may be an Annual Maximum Plan Benefit or frequency limitation applicable to each Plan Participant with respect to certain Eligible Medical Expenses. You may also be required to meet prior authorization/pre-certification criteria prior to your benefit being payable. These features are described in the following sections of this chapter.

DEDUCTIBLES

The medical deductible is the amount you must pay each calendar year before the Plan begins to pay 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 your Eligible Medical Expenses (except out-patient Prescription Drug 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 pays before Plan medical benefits begin for that person. 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 medical benefits begin. The Plan's Family Deductible also varies depending on the plan selected and the use of network or non-network providers.
- There are no separate per person prescription drug deductibles for any of the medical plan options.
- Only eligible medical expenses can be used to satisfy the Plan's deductible. Non-eligible medical expenses do not apply to the deductible, including non-compliance penalties. Services paid with a copay are not subject to the deductible, unless otherwise specified in the Schedule of Medical/Prescription Drug Benefits. Deductibles are applied to eligible

medical expenses in the order in which the claims are received by the Plan, not necessarily the order in which the services were rendered by providers.

- 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/Prescription Drug 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 Coinsurance. Unless the Schedule of Medical/Prescription Drug Benefits indicates otherwise, this Plan generally pays a greater percentage of the Eligible Medical Expenses after the Deductible is satisfied for in-network services, and you are responsible for the remaining lesser percentage. The reverse can be true for out-of-network services.

Coinsurance When You Use Network Health Care Providers: The plan pays the same or a greater percentage of benefits as you do, 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 and if the services are subsequently deemed to be non-medically necessary, the Plan will not pay any benefits for those services, and you must pay for all those costs. In addition, if you fail to follow Pre-Certification requirements for certain out-of-network services, you may be subject to a penalty cost per claim (see the Schedule of Medical/Prescription Drug Benefits for details) in addition to any denial consequences of failing to satisfy medical necessity guidelines, as may apply. 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) is a set dollar amount you (and **not** the Plan) are responsible for paying when you incur certain Eligible Medical Expenses. The Plan pays the balance of allowable charges after your Copay amount. 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/Prescription Drug 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 (and In-Network deductibles also accumulate to meet Out-of-Pocket Maximums).

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

Maximum Out-of-Pocket (MOOP) Explained: Out-of-pocket costs are the in-network eligible expenses (deductibles, coinsurance and/or copays) which must be paid by the plan participant **before** the 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/Prescription Drug Benefits, no further coinsurance or copays will apply to covered Eligible In-Network Medical Expenses for the rest of that calendar year for that individual. 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 the expenses described in the section below.**

Expenses Not Included in the Maximum Out-of-Pocket: 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/supplies that are not covered by the Plan.
2. All charges greater than the Allowed or Contracted Charge for out-of-network expenses as determined by the Plan.
3. All charges greater than the Limited Overall Maximum Plan Benefits, Specific Annual Maximum or Lifetime Plan Benefits for certain Eligible Medical Expenses and/or more than 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 non-integrated Prescription Drug Out-of-Pocket Maximum expenses – see Schedule of Medical/Prescription Drug Benefits).
5. All non-medically necessary expenses incurred because of failure to follow the Utilization Management provisions of this Plan.

6. Specialty Prescription Drug costs under the Prescription Drug benefits of the Plan when a member has failed to engage in the Plan's Specialty Drug Advocacy Services program.

ANNUAL MAXIMUM PLAN BENEFITS: Limited Overall ("Annual") Maximum Plan Benefits and Specific Annual Maximum or Lifetime Plan Benefits: on a few occasions, Plan Benefits for **certain medical or prescription drug expenses** are subject to Limited Overall ("Annual"), Specific or Annual Maximums for each Covered Individual. These limits may be dollars, units, days, frequency, or quantity limitations. Once the Plan has paid these maximums or covered a prescription drug up to applicable quantity limitations on behalf of any Covered Individual or family, it will not pay any further Plan Benefits for those services or supplies for that individual or family for the balance of the Calendar Year (or in the case of quantity limitations, until a new prescription is filled in the applicable and allowed timeframe). The services or supplies that are subject to these Maximum Plan Benefits are identified in the Schedule of Medical/Prescription Drug Benefits.

MEDICAL/PRESCRIPTION DRUG PLAN OPTIONS

The City of Mesa offers three Preferred Provider Organization (PPO) Medical Plan options described below and each administered by the same Appropriate Claims Administrators. You and all your family members who are enrolled for medical coverage must all be enrolled in the same plan option.

- **Basic Medical Plan**: This plan option is a deductible and coinsurance PPO plan, allowing you to use either in-network or out-of-network providers with different benefit levels for network and non-network usage. The in-network coinsurance for the Basic Medical Plan is generally 50% paid by the Plan and 50% paid by the member, after a $550 individual (and $1,650 family) deductible (except that in-network preventive care services may be covered at 100%, no deductible, and in-network provider office visits are a $20 PCP copay and $30 Specialist copay, no deductible). In-network providers are contracted with the Provider Network Organization listed in the Quick Reference Chart found at the beginning of this Plan Document. Covered in-network medical benefits are subject to maximum calendar year out-of-pocket expense (including deductible) - MOOP: $4,500 per individual to a maximum family out-of-pocket of $9,000. Out-of-network benefits are subject to a $1,500 individual deductible (and $4,500 family deductible) and then the Plan pays 25% coinsurance with 75% coinsurance paid by the member (plus any balance billing obligation of the difference between billed charges and Allowed or Contracted charges).

  Effective January 1, 2026, outpatient prescription drug benefits and coverage for the Basic Medical Plan are the same as for the Choice and Copay Medical Plans ("one Rx plan for all"). Prescription drug plan benefits have separate copay/coinsurance amounts based on drug classification/tier (generic, preferred brand, non-preferred brand, and Specialty drugs) and drug delivery channel (Retail 30, Retail/Mail Order 90 and Specialty) with no deductibles. There are separate annual out of-pocket maximums (Rx MOOP's) of $4,000 per individual to a maximum family Rx MOOP of $8,000. The Medicare Part D Prescription Drug Plan for retiree Medicare eligible individuals has an annual out-of-pocket maximum for Part D prescription drugs of $2,100 per individual. This Part D MOOP is also included in the Prescription Drug Wrap plan benefits' annual out of-pocket maximum (Rx MOOP) which is $4,000 per individual for non-Medicare Part D and non-formulary Medicare drugs that are otherwise covered under the Plan.

- **Choice Medical Plan:** This plan option is a deductible and coinsurance PPO plan, allowing you to use either in-network or out-of-network providers with different benefit levels for network and non-network usage. The in-network coinsurance for the Choice Medical Plan is generally 80% paid by the Plan and 20% paid by the member, after a $300 individual (and $900 family) deductible (except that in-network preventive care services may be covered at 100%, no deductible). In-network providers are contracted with the Provider Network Organization listed in the Quick Reference Chart found at the beginning of this Plan Document. Covered in-network medical benefits are subject to maximum calendar year out-of-pocket expense (including deductible) - MOOP: $3,000 per individual to a maximum family out-of-pocket of $6,000. Out-of-network benefits are subject to a $1,500 individual deductible (and $4,500 family deductible) and then the Plan pays 50% coinsurance with 50% coinsurance paid by the member (plus any balance billing obligation of the difference between billed charges and Allowed or Contracted charges). Outpatient prescription drug benefits are the same as the Basic and Copay Medical Plans ("one RX Plan for all") – see above description for Basic Plan.

- **Copay Medical Plan**: This plan option is a PPO plan that has no in-network deductibles and applies copayments by major service types (primary care office visits $25, specialist office visits $50, rehabilitation therapy services $30 (PT, OT, ST and Chiropractic), urgent care services $60, emergency room services $200, outpatient surgery/procedure events $250 and inpatient hospitalization events $400) provided by in-network providers (except that preventive care services may be covered at 100%, no copayments). In-network providers are contracted with the Provider Network Organization listed in

the Quick Reference Chart found at the beginning of this Plan Document. Covered in-network benefits are subject to maximum calendar year out-of-pocket expense for the member (MOOP): $4,600 per individual to a maximum family out-of-pocket of $9,200. Out-of-network benefits are subject to a $1,500 individual deductible (and $4,500 family deductible) and then the Plan pays 50% coinsurance with 50% coinsurance paid by the member (plus any balance billing obligation of the difference between billed charges and Allowed or Contracted charges). Outpatient prescription drug benefits are the same as the Basic and Choice Medical Plans ("one RX Plan for all") – see above description for Basic Plan.

PRESCRIPTION DRUG PROGRAM

The Prescription Drug Program (included in Medical Plan coverage) is administered by the Appropriate Claims Administrators (also known as PBM's) shown in the Quick Reference section of this Plan Document and is "carved out" from the Medical Plan Appropriate Claims Administrators. 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 network pharmacies or the Prescription Drug Plan's Home Delivery (Mail Order) Service. Use mail order or purchase mail order quantities at network retail pharmacies, to receive up to a 90-day supply of non-emergency, maintenance, generic and brand medications. Specialty drugs are only available through Appropriate Claims Administrator's Specialty Pharmacies (except Medicare Part D retirees may be eligible for Specialty drugs through preferred retail pharmacies that stock those medications).

Coverage for prescription drugs is provided only for drugs that are pharmaceuticals approved by the US Food & Drug Administration (FDA), requiring a prescription, approved for the condition, dose, route, duration, and frequency, and prescribed by a Physician or other Health Care Practitioner (including a Pharmacist) authorized by law to prescribe them and not otherwise excluded from coverage in any other section of this Plan Document. Drugs not yet approved by the FDA are not covered. Coverage for prescription drugs is also subject to Utilization Management processes as described in the Drugs and Medicines section of the Schedule of Medical/Prescription Drug Benefits (preferred and non-preferred formulary drugs, excluded drugs or classifications, quantity limitations, step therapy requirements and prior authorization requirements).

Network Retail Pharmacy: Use a network retail pharmacy to fill prescriptions (with a negotiated discount) for up to a 30-day supply of generic or brand name medications (or up to an 83-day supply of same), or to receive up to a 90-day supply of generic and brand name maintenance medications. To fill a prescription at a Retail Network pharmacy, obtain a prescription from your physician and present it (either direct/electronically from the provider's office or a paper script), along with your prescription drug ID card/RX ID information, to any participating retail pharmacy. The prescription will be adjudicated through the Appropriate Claims Administrator's pricing system for discounts and benefit levels (coinsurance and/or copays) described in the Schedule of Medical/Prescription Drug Benefits – Drugs and Medicines section.

For employees and non-Medicare eligible retirees and eligible covered dependents, the prescription will also be automatically evaluated and coordinated for any better pricing and discounts (generally for generic and some brand name drugs), through any connected commercially available discount programs that the Appropriate Claims Administrator may engage with. If the commercially available discount program provides a better pricing outcome for the member, the resulting out-of-pocket expenses under that discount program (if any), will be applied to member out-of-pocket maximums under the City's prescription drug programs as well.

Non-Network 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 copay, or coinsurance. Claim forms are available at the Prescription Drug Program's website or by calling Member Services.

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.

High-Cost Non-Specialty Drug Copay Assist Program (MedAssist with MedImpact): Effective January 1, 2026, when notified by MedImpact after a first courtesy fill that your high-cost non-Specialty brand drug prescription may be eligible for copay assistance through the drug manufacturer (or other funding entity), you must follow the direction to apply for the eligible

assistance. Not only will complying with this process keep your medication fill/refill timing on track but it will save you money for your high-cost non-Specialty drug purchases, that would otherwise be subject to copays/coinsurance described in the Drugs and Medicines section of the Schedule of Medical/Prescription Drug Benefits and you may save the Plan money too.

Prescription Drug Utilization Management Requirements: Certain drugs and medications may be subject to Utilization Management requirements before coverage is provided under the Prescription Drug program for eligible members:

- Step therapy requirements
- Quantity limitations
- Prior authorization (PA) requirements
- Specialty Drug PA and Preferred Drug requirements
- Mandatory Specialty Drug Advocacy Program services engagement for Specialty Drugs on the Select Drugs and Products List of the Plan's prescription drug benefit program
- New-to-Market Drug Exclusions and Limitations
- Changes to exclusions and limitations for existing drugs that are covered under the Plan
- Changes to Formulary content and preferred or non-preferred status

Note: formularies (the list of drugs that may be covered under the Plan) and whether a brand name drug is a preferred or non-preferred brand name drug, are subject to change without notice at any time, including on a regular quarterly basis. 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 drug or medication, and whether a brand name drug is a preferred or non-preferred brand name drug, contact the Prescription Drug Program Appropriate Claims Administrator listed in the Quick Reference Chart.

Note: coinsurance, copays, or expenses associated with drugs under the Prescription Drug Program do not accumulate to the medical plan 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/Prescription Drug Benefits for more information and limitations on the Prescription Drug Program, coinsurance, copays, minimums and maximums and out-of-pocket maximums.

Specialty Select Drugs and Products Program List for Specialty Advocacy Program Services (SDA) with PaydHealth: the Prescription Drug Program provides non-Medicare eligible members with copay reduction/elimination opportunities for certain prescribed Specialty Drugs and products on the Select Drugs and Products Program List administered by PaydHealth (see Quick Reference Chart). This program provides financial advocacy services to find and qualify alternate partial and full funding sources for members utilizing drugs on the Select Drugs and Products Program List (see Definitions section), while at the same time reducing Plan funding for those drugs and products and helping the Plan continue to offer valuable, sustainable prescription drug benefits to all members. Participation in the program is mandatory. **Once a member participates and completes the enrollment and qualification process for any drug or product dispensed under the Select Drugs and Products Program List and becomes eligible for full alternate funding administered by PaydHealth, you are no longer eligible for funding under this Plan for that drug or product except and if you become no longer qualified for full alternate funding.**

All Specialty Drugs (and many high-cost non-specialty drugs or products) require clinical prior authorization for medical necessity and must meet administrative review – through your prescription drug program service administered by the City's Appropriate Claims Administrator or Pharmacy Benefit Administrator (PBM), MedImpact (see Quick Reference Chart section for contact details). MedImpact will advise PaydHealth if you are authorized to receive a Specialty Drug that is also included in the Select Drugs and Products Program List. Thereafter, a PaydHealth case coordinator will reach out to assist you with making these high-cost Specialty Drugs you are prescribed, more affordable to both you and the Plan. The Plan is sponsoring this program and as a person covered under the Plan, you are not responsible for any payments to PaydHealth. If you need a drug on the Plan's Select Drugs and Products List (which is subject to change at any time), you are required to engage with PaydHealth, and an alternative funding entity as may apply for the specific drug or product. "Engage" may mean respond telephonically or by email, provide information, provide follow-up documentation, and seek provider cooperation if requested by the alternative funding entity. **If you do not engage and complete the process with a PaydHealth case coordinator, you will not have funding for those specific drugs under the City's prescription drug program and will be responsible for the full cost of those drugs.** Should a member be **denied alternate funding for any reason** (even though you have engaged and completed the required process for the specific drug or product on the Select Drugs and Products List), your claim will be automatically submitted for **benefit reconsideration and coverage under the Plan through**

MedImpact and become subject to the copay/coinsurance described in the Drugs and Medicines section of the Schedule of Medical/Prescription Drug Benefits.

INFORMATION ABOUT MEDICARE PART D PRESCRIPTION DRUG PLANS FOR *ACTIVE* EMPLOYEES WITH MEDICARE COVERAGE (AND COVERED DEPENDENTS)

If you are an active employee and you and/or your Dependent(s) are enrolled in either Medicare Part A or B, you are also eligible for Medicare Part D Prescription Drug benefits. It has been determined that the City's 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 or more than the standard Medicare Part D Prescription Drug coverage will pay.

Because this Plan's prescription drug coverage is as good as or better than Medicare, you are not required to enroll in a Medicare Prescription Drug Part D Plan while you are actively employed, to avoid a late penalty under Medicare upon a later enrollment. You remain eligible in the future to enroll in a Medicare Part D Prescription Drug Plan during Medicare's annual enrollment period each year with no late penalties. However, **this Plan does not coordinate benefits with Medicare Part D for active employees and their covered dependents**. If you enroll in a Medicare Part D prescription drug plan you may not use prescription drug coverage under this Plan. You will be dis-enrolled from the prescription drug coverage under this Plan if you are enrolled in a Medicare Part D prescription drug plan while actively employed or the covered spouse or dependent of an active employee.

The Medicare program has arranged to let employer-sponsored Plans know if their participants have tried to enroll in a Medicare Part D Prescription Drug Plan. This is because many people with Medicare may not understand that they can 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 Part D Prescription Drug Plan, we will contact you to see if that is your final decision or just an error.

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 or the City's employee benefits website at www.mesaaz.gov/benefits). See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

INFORMATION ABOUT MEDICARE PART D PRESCRIPTION DRUG PLANS FOR *RETIREES WITH MEDICARE COVERAGE* (AND COVERED DEPENDENTS)

Effective as of January 1, 2017, the City of Mesa Health Plan replaced the outpatient prescription drug benefits available to Medicare eligible retirees and covered individuals enrolled in City retiree medical plans, with a Medicare Part D Prescription Drug benefit (and additional City provided prescription drug "wrap" benefits). Effective January 1, 2022, this Medicare Part D program for retirees is called **MedImpact/VibrantRx Employer PDP sponsored by City of Mesa**. You will have the same coinsurance and/or copayments, but effective as of January 1, 2026, lower annual individual out-of-pocket prescription drug maximums than are available to non-Medicare-eligible retirees. See section titled Medical/Prescription Drug Plan Options, Schedule of Benefits Annual Maximum Out-of-Pocket (MOOP) and Drugs and Medicines sections for details about this coverage.

The Plan is required to allow Medicare eligible retirees (and individuals) the opportunity to opt out of Medicare Part D coverage when first eligible. Please note that if you do opt-out however, you will also opt out of **both** your medical and prescription drug coverage from the City of Mesa Health Plan and may never re-enroll in the future. The same applies to covered spouse and children (if any) even if they are not otherwise Medicare eligible, since family members may only be enrolled in a City Retiree Plan if you are enrolled.

MEDICAL AND PRESCRIPTION DRUG 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 (but no actual network) 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 the Schedule of Medical/Prescription Drug Benefits. For claims incurred outside the United States, you must generally pay for services directly and submit a claim to the Appropriate Claims Administrator for available reimbursement/coverage:

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

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG BENEFITS CHART

A chart describing the Plan's medical, behavioral health and prescription drug benefits (with explanations and limitations of those benefits) appears on the following pages. This Schedule of Medical /Prescription Drug Benefits outlines the Plan's Deductibles, Coinsurance, Copayments, Annual Out-of-Pocket Maximums, and any limitations or exceptions that may apply. Each of the Plan's medical, behavioral health or prescription drug benefits is listed in the first column of the chart, with Maximum Out of Pocket Expenses, Deductibles, Hospital Services (Inpatient) and Physician and Health Care Practitioner Services appearing first. These categories cover most (but not all) healthcare services covered by the Plan. They are followed by descriptions of all other benefits for specific health care services and supplies, listed in **alphabetical** order (except Prescription Drugs and Medicines categories, which are at the end of the Schedule of Medical/Prescription Drug Benefits Chart).

Explanations and limitations that apply to all Benefits are shown in the second column of the Schedule of Medical/Prescription Drug Benefits. Specific differences in the Benefits when they are provided In-Network (when you use contracted Network Providers) and Out-of-Network (when you use providers who are not contracted with the Appropriate Claims Administrators' networks) are shown in the subsequent columns. Payment of out-of-network claims is per the Allowed or Contracted Charge reimbursement as defined in this Plan, as described in the Schedule of Medical/Prescription Drug Benefits and as further defined in the Reasonable/Reasonableness section of the Definitions section of this Plan Document and may be based on an amount less than billed charges, and as a result **balance billing obligations for the covered member may apply** for out-of-network services.

Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty, a denial of coverage (if an otherwise covered benefit under the Plan is subsequently deemed not Medically Necessary or Experimental/Investigational), and an increased out-of-pocket cost (up to 100% of the cost of the medical or prescription drug service/product). Refer to the Utilization Management section of this document and the Drugs and Medicines page of the Schedule of Medical/Prescription Drug Benefits section and the Prescription Drugs section of this Medical Plans chapter for a description of these services and prior authorization procedures.

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG 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 Allowed or Contracted Charges as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
Annual Maximum Out-of-Pocket (MOOP) **Medical MOOP** • Medical Out-of-Pocket costs are the eligible **in-network expenses** (including deductibles, coinsurance and copayments) you must pay **before** this Plan will pay medical benefits at up to 100% of Allowed or Contracted Charges for the rest of that calendar year. **Prescription Drug MOOP** • Outpatient retail, mail order or specialty prescription drug expenses you must pay before prescription drug copays or coinsurance are eliminated for the rest of that calendar year.	Some expenses **do not accumulate** to meet annual **Medical MOOP** (out-of-pocket maximums): • Expenses not covered by the Plan • Charges greater than the Allowed or Contracted Charge • Any amounts above Plan benefit maximums • Penalties for failure to follow Utilization Management (UM) requirements • Out-of-Network Expenses • Outpatient prescription drug expenses (except these do contribute to separate Prescription Drug MOOP described to the right)	**Medical MOOP**: $3,000 per person $6,000 per family **Prescription Drug MOOP**: Same as Basic Medical Plan **Retiree Medicare Part D Prescription Drug MOOP:** Same as Basic Medical Plan	Not applicable	**Medical MOOP**: $4,500 per person $9,000 per family **Prescription Drug MOOP**: $4,000 per person $8,000 per family **Retiree Medicare Part D Prescription Drug MOOP:** $2,100 per individual (included in above Prescription Drug MOOP for non-Medicare Part D and non-formulary Medicare drugs otherwise covered)	Not applicable	**Medical MOOP**: $4,600 per person $9,200 per family **Prescription Drug MOOP**: Same as Basic Medical Plan **Retiree Medicare Part D Prescription Drug MOOP:** Same as Basic Medical Plan	Not applicable
Deductibles The medical plan deductible is the amount you must pay each calendar year before the Plan pays benefits for covered services.	In-Network and Out-of-Network deductibles are NOT interchangeable or commingled. **Deductibles do not apply to outpatient carved out prescription drug benefits.**	$300 per person to a maximum of $900 per family	$1,500 per person to a maximum of $4,500 per family	$550 per person to a maximum of $1,650 per family	$1,500 per person to a maximum of $4,500 per family	None	$1,500 per person to a maximum of $4,500 per family

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG 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 Allowed or Contracted Charges as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
Hospital Services (Inpatient) • Room & board with general nursing services • Specialty care units (e.g., intensive care, cardiac care unit) • Inpatient Lab, x-ray, diagnostic services • Related Medically Necessary ancillary services (e.g., prescriptions, supplies). • Newborn care; male newborn circumcision (child must be enrolled in the plan within 31 days of birth – 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. See Emergency Services for Observations up to 72 hours without in-patient admission; after 72 hours Observation Stays with or without in-patient admission require inpatient copay/coinsurance and pre-certification requirements. **Newborn hospital charges: both mother & baby incur separate deductibles, coinsurances, or copays as applicable.**	80% after deductible	50% after deductible and balance billing to you	50% after deductible	25% after deductible and balance billing to you	100% after $400 copay per admission	50% after deductible and balance billing to you

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG 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 Allowed or Contracted Charges as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
Physician and Health Care Practitioner Services **Office visits:** (see Definitions chapter), hospital, emergency room & other health care facility visits by Physicians & Health Care Practitioners (in-person or virtual, online, video, or telephonic settings) MD, OD, Physician Assistant, Nurse Practitioner and Nurse Midwife fees Surgeon and Assistant Surgeon or Certified Surgical Assistant (CSA) or related designation fees (if Medically Necessary); Anesthesia fees for Physicians, Certified Registered Nurse Anesthetists (CRNA); Certified Perfusionist for heart-lung surgical procedures; Pathologist and Radiologist professional fees Psychological and neuropsychiatric testing by a Physician/Psychologist/licensed Behavioral Health provider Retail Medical Clinics (see Definitions chapter) Audiology/Hearing Exams **Virtual services**: MDLive (registration through myCigna.com portal) virtual medical and behavioral health urgent care services, routine primary care, wellness screening services and dermatology care; see Quick Reference Chart for other virtual services and providers	**See Preventive Care Services/Screenings in this Schedule of Medical/Prescription Drug Benefits for preventive services benefits.** Some surgical services are 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** are reimbursed for services to a **maximum** of 25% of allowed or contracted expenses payable to the primary Surgeon. Prior authorizations for certain services may be required, following a pre-approved treatment plan, or there may be procedures for making referrals. **For purposes of office visit/virtual care copays or coinsurance, PCP is defined as General Practice, Family Practice, Internal Medicine, Pediatrician, Obstetrician, Gynecologist, Behavioral Health Provider (all levels), Physician Assistant, Nurse Practitioner, Registered Nurse (all other Professional classifications defined as Specialist).** See Quick Reference Chart in front sections of this Plan Document for more details on MDLive with Cigna.	**Office Visits for Behavioral Health primary diagnosis services:** (in-person or virtual) 100% no deductible **All Other Office Visits:** (in-person or virtual) 80% after deductible **MDLive virtual services:** 1) Medical and behavioral health urgent care and virtual wellness screenings at 100%, no deductible 2) Virtual primary care services for routine and chronic condition management and virtual dermatology care at 80% after deductible **All other services**: 80% after deductible	50% after deductible and balance billing to you	**Office Visits for Behavioral Health primary diagnosis services:** (in-person or virtual) 100% no copay **All Other Office Visits**: (in-person or virtual) 100% after $20 PCP copay or $30 Specialist copay), no deductible **MDLive virtual services:** 1) Medical and behavioral health urgent care and virtual wellness screenings at 100%, no deductible 2) Virtual primary care services for routine and chronic condition management at $20 copay 3) Virtual dermatology care at $20 copay, no deductible **All other services**: 50% after deductible	25% after deductible and balance billing to you	**Office Visits for Behavioral Health primary diagnosis services:** (in-person or virtual) 100% no copay **All Other Office Visits**: (in-person or virtual) 100% after $25 PCP copay or $50 Specialist copay **MDLive virtual services:** 1) Medical and behavioral health urgent care and virtual wellness screenings at 100%, no copay 2) Virtual primary care services for routine and chronic condition management at $20 copay 3) Virtual dermatology care at $40 copay **All other services**: 100%, no copay	50% after deductible and balance billing to you

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG 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 Allowed or Contracted Charges as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
Allergy Services • Allergy sensitivity testing, including skin patch or Rast/Mast blood tests; Desensitization and hyposensitization (allergy shots given at periodic intervals); Allergy antigen solution	Allergy services are 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	50% after deductible and balance billing to you	50% after deductible	25% after deductible and balance billing to you	Physician services: 100% after $25 PCP office visit copay; $50 office visit copay for Specialist Allergy shots only: 100% after $15 copay; Antigen: 100%, no copay	50% after deductible and balance billing to you
Alternative Health Care • Office visits with a licensed Homeopathy or Naturopathy provider in the jurisdiction in which services are provided • Acupuncture services	**Homeopathic and Naturopathic** coverage is limited to Office Visit charges/services that are standard service codes covered within a PCP or Specialist office visit in the **Choice Plan only.** Homeopathic and Naturopathic supplies and medications are not covered. Acupuncturist office visits are not covered but **Acupuncture treatment services** are covered to a maximum of $1,000 per person, per year, in or out-of-network in the **Choice Plan only** and may be subject to medical necessity review.	80% after deductible	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.						
Anesthesia Services	See the Physicians and Health Care Practitioner Services row.						

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG BENEFITS

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

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
Audiology/Hearing Services • Audiology/hearing exams • Hearing aids, devices, batteries, hearing aid repairs and implantable hearing aids	See the Physician and Health Care Practitioner Services row or Corrective Appliances row for benefits and limitations.						
Behavioral Health Services **Behavioral Health and Substance Abuse Services:** • **Cigna Behavioral Health designated EAP outpatient counseling visits:** three (3) per person, per plan year • **Outpatient Visits:** In-office or virtual outpatient behavioral health therapy sessions • **Outpatient Applied Behavioral Analysis (ABA)/Therapeutic Behavioral (TBT) therapies** • **Intensive outpatient, day treatment and partial day treatment behavioral health services** • **In-Patient Admission:** Hospital and residential treatment center services	Behavioral Health day treatment, partial day treatment, hospitalization 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. See Physician and Health Care Practitioner Services row for Psychological and Neuropsychiatric testing and Behavioral Health services provided as a primary diagnosis by PCP and Specialist medical providers. **Employee Assistance Program (EAP):** See section titled "Employee Assistance Program (EAP) Benefits" with ComPsych for separate stand-alone EAP services and benefits including virtual behavioral health care.	Outpatient and Inpatient Services: 100%, no deductible Virtual Behavioral Health services (MDLive); virtual or EAP three visits; virtual or in-person (Cigna Behavioral Health); Headspace for Cigna app: 100%, no deductible	Outpatient and Inpatient Services: 50% after deductible and balance billing to you	Outpatient and Inpatient Services: 100%, no deductible Virtual Behavioral Health services (MDLive); virtual or EAP three visits; virtual or in-person (Cigna Behavioral Health); Headspace for Cigna app: 100%, no deductible	Outpatient and Inpatient Services: 25% after deductible and balance billing to you	Outpatient and Inpatient Services: 100%, no copay Virtual Behavioral Health services (MDLive); virtual or EAP three visits; virtual or in-person (Cigna Behavioral Health); Headspace for Cigna app: 100%, no deductible	Outpatient and Inpatient Services: 50% after deductible and balance billing to you
Birthing Center	See the Specialized Health Care Facility row.						

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG BENEFITS

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

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
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 covered only when medically necessary.	80% after deductible	50% after deductible and balance billing to you	50% after deductible	25% after deductible and balance billing to you	100%, no copay	50% after deductible and balance billing to you
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 – requires pre-certification	Medically necessary Wig/Toupee cranial prothesis prescribed by a Physician, if required to replace hair loss due to chemotherapy (in or out-of-network, up to one per person).	80% after deductible	Wig/Toupee/: covered as in-network benefit All other services: 50% after deductible and balance billing to you	50% after deductible	Wig/Toupee: covered as in-network benefit All other services: 25% after deductible and balance billing to you	100%, no copay	Wig/Toupee: covered as in-network benefit All other services: 50% after deductible and balance billing to you

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG BENEFITS

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

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
Chiropractic Services • **Limited to 25 visits/person/per year**: including Office Visit, Manipulations(s), Modalities and Physical Therapy (PT) performed by a Chiropractor • Chiropractic visits above 25 visits (per calendar year for in-network and per rolling 12-months for out-of-network visits), subject to medical necessity review/pre-certification process	Physical Therapy (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 pre-certified with Licensed Physical Therapist for coverage; see Rehabilitation Services row for coverage and limitations.	80% after deductible	50% after deductible and balance billing to you	50% after deductible	25% after deductible and balance billing to you	100% after $30 copay	50% after deductible and balance billing to you

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG BENEFITS

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

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
Corrective Appliances (Prosthetic & Orthotic Devices, Other Than Dental) • See Reconstructive Services, Breast Reconstruction after Mastectomy and Chemotherapy sections • Prosthetic coverage for rental (up to Allowed/Contracted purchase price) or purchase of medically necessary models/devices including 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 • 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 for one pair/person/year from **in-network providers only**	See the specific exclusions for Corrective Appliances in the Exclusions chapter. For Appliances coverage see definitions of "Prosthetics" and "Orthotics" in the Definitions chapter. Corrective Appliances are covered only when ordered by a Physician or Health Care Practitioner. Occupational therapy orthotic supplies needed to assist in performing activities of daily living are **not** covered. Cranial remolding devices covered in-network for infants and children and post-operatively for synostic plagiocephaly. **Hearing aids/devices**: one set (2 hearing aids and medically necessary amplification equipment) every five years from **in-network providers only.** **Implantable Hearing Devices** such as cochlear implants: a) Pre-certification required - see Utilization Management section; b) In-network providers only; c) Complications related to Implantable Hearing Devices are covered.	80% after deductible Batteries and repairs for hearing aids covered 100% no deductible in or out-of-network Colostomy/ ostomy supplies 100%, no deductible	50% after deductible and balance billing to you No coverage for hearing aids, Implantable Hearing Devices, foot orthotics or cranial remolding devices	50% after deductible Batteries and repairs for hearing aids covered 100% no deductible in or out-of-network Colostomy/ ostomy supplies 100%, no deductible	25% after deductible and balance billing to you No coverage for hearing aids, Implantable Hearing Devices, foot orthotics or cranial remolding devices	$200 copay for each Outpatient Implantable Hearing Device event $400 copay for each Inpatient Implantable Hearing Device event All other services, 100% no copay	50% after deductible and balance billing to you No coverage for hearing aids, Implantable Hearing Devices, foot orthotics or cranial remolding devices

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG 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 Allowed or Contracted Charges as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
Diagnostic Procedures Procedures performed to make a medical diagnosis: • Non-invasive and invasive diagnostic procedures: exams, x-rays, ultrasounds, high-tech radiology services (including MRI/MRA, CT/CTA, PET, Nuclear Cardiology Imaging and Cardiology Stress Echoes), diagnostic clinical observation, body fluid tests, needle biopsy, Endoscopy services	See Endoscopy Services section for Gastroscopy, Bronchoscopy and Colonoscopy services.	Outpatient high-tech radiology services including related professional services 100%, no deductible All other services (including in-patient high-tech radiology) 80% after deductible	50% after deductible and balance billing to you	Outpatient high-tech radiology services including related professional services 100%, no deductible All other services (including in-patient high-tech radiology) 50% after deductible	25% after deductible and balance billing to you	100%, no copay unless combined with Office Visit, then PCP or Specialist office visit copay applies	50% after deductible and balance billing to you
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	50% after deductible and balance billing to you	50% after deductible	25% after deductible and balance billing to you	100%, no copay	50% after deductible and balance billing to you
Disease Management (DM) Services (nutrition and lifestyle management services for medical management of documented organic diseases including, but not limited to Obesity/Morbid Obesity and Diabetes) Out-patient DM services in- network at licensed facility or with licensed Nutritionist, related to Weight Loss Surgery or with diagnosis of Obesity/ Morbid Obesity, Diabetes Diagnosis or documented organic disease.	See the chapter on Disease Management (DM) programs for other diseases/disorders programs, available at no charge through the Appropriate Claims Administrator. Covered when authorized by a Physician.	80%, after deductible	Not covered	50%, after deductible	Not covered	100%, after $50 copay per class, session, or visit	Not covered

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG BENEFITS

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

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network 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 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 birth	See the specific exclusions related to DME in the Exclusions chapter. To help determine DME coverage see definition of "Durable Medical Equipment" in Definitions chapter. DME is covered only when Medically Necessary, ordered by Physician or Health Care Practitioner, and purchased through a DME provider or supplier; items purchased directly online are not covered. Coverage is provided for Medically Necessary Oxygen, along with Medically Necessary equipment & supplies required for administration.	80% after deductible	50% after deductible and balance billing to you	50% after deductible	25% after deductible and balance billing to you	100%, no copay	50% after deductible and balance billing to you

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG BENEFITS

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

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network 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 medically necessary facility transfer; air transportation only as Medically Necessary due to inaccessibility/medical detriment if ground transport used	Expenses for use of Hospital emergency room and/or Ambulance are covered only when services are for Emergency Services. Observations up to 72 hours, without inpatient admission, are covered under emergency room copay/coinsurance; if inpatient admitted after 72 hours, inpatient copay/ coinsurance applies. See the definition of "Emergency Services" in the Definitions chapter. The Utilization Management Company must be **notified** of an emergency in-patient hospital admission within 48 hours after admission; see Utilization Management chapter.	**ER, Urgent Care facilities, Physician Office and Ambulance**: 80% after deductible	Covered as In-Network	**Physician Office Visit $20 copay PCP or $30 copay Specialist** **All other services and ER, Urgent Care facilities, and Ambulance**: 50% after deductible	Covered as In-Network visit	**ER**: 100% after $200 copay. If admitted, then $400 inpatient copay applies **All other Physician Office**: 100% after $25 PCP office visit or $50 Specialist office visit copay **All other Urgent Care facilities**: 100% after $60 copay **Ambulance**: 100%, no copay	Covered as In-Network

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG BENEFITS

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

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
Endoscopy Services (outpatient) • Facility, technical and professional fees associated with outpatient Endoscopic procedures such as Gastroscopy, Colonoscopy and Bronchoscopy procedures	Gastroscopy and Bronchoscopy services are covered when medically necessary & ordered by a Physician or Health Care Practitioner. Colonoscopy procedures are covered for in-network preventive screening reasons and in or out-of-network medically necessary diagnostic reasons, when ordered by a Physician or Health Care Practitioner.	Gastroscopy and Bronchoscopy: 80% after deductible Colonoscopy: 100%, no deductible	Preventive screening Colonoscopy – not covered Medically necessary Endoscopy services: 50% after deductible and balance billing to you	Gastroscopy and Bronchoscopy: 50% after deductible Colonoscopy: 100%, no deductible	Preventive screening Colonoscopy – not covered Medically necessary Endoscopy services: 25% after deductible and balance billing to you	Gastroscopy, Bronchoscopy: $250 copay for outpatient facility; 100% professional services Colonoscopy: 100%, no copay	Preventive screening Colonoscopy – not covered Medically necessary Endoscopy services: 50% after deductible and balance billing to you
Fertility, Genetic, Reproductive, Family Planning, Sexual Dysfunction Services • Fertility and Infertility services or treatments are not covered. See Medical Exclusions and Definitions Sections for more information. • Prescription contraceptive devices (such as diaphragm, intrauterine devices) and voluntary surgical sterilization (e.g., vasectomy, tubal ligation, Essure) covered • Prescription oral contraceptives covered under Drugs and Medicines section • Family Planning counseling services for women covered at 100% (in-network physicians only). • See the Preventive Services section for BRCA testing and counseling coverage.	Voluntary Sterilization services performed outside a physician's office require Pre-certification. Birth control devices, injectable drugs (e.g., Depo-Provera), intrauterine devices (IUD), diaphragms and implantable birth control devices/services (e.g., Norplant) are covered under this Schedule of Medical/Prescription Drug Benefits. See the specific exclusions related to Fertility, Genetic, Reproductive and Sexual Dysfunction Services in that section. Diagnosis and medically necessary treatment of sexual dysfunction is covered. No coverage for genetic services/tests/ procedures except when performed for detecting/evaluating/ treating chromosomal abnormalities or genetically transmitted characteristics in pregnant women & high-risk individuals, subject to medical necessity; requires Pre-certification.	**Voluntary Sterilization** Vasectomy: 100% no deductible Tubal Ligation: 100% no deductible **RX Oral Contraceptives** See Drugs & Medicines Birth control devices and injectable drugs for women covered 100%	**Voluntary Sterilization** Not covered **RX Oral Contraceptives** See Drugs & Medicines Birth control devices and injectable drugs for women not covered	**Voluntary Sterilization** Vasectomy: 100% no deductible Tubal Ligation: 100% no deductible **RX Oral Contraceptives** See Drugs & Medicines Birth control devices and injectable drugs for women covered 100%	**Voluntary Sterilization** Not covered **RX Oral Contraceptives** See Drugs & Medicines Birth control devices and injectable drugs for women Not covered	**Voluntary Sterilization** Vasectomy: 100% no deductible Tubal Ligation: 100%, no copay **RX Oral Contraceptives** See Drugs & Medicines Birth control devices and injectable drugs for women covered 100%	**Voluntary Sterilization** Not covered **RX Oral Contraceptives** See Drugs & Medicines Birth control devices and injectable drugs for women Not covered

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG 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 Allowed or Contracted Charges as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network 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 (see Utilization Management chapter). Covered only when ordered by a Physician and then to a maximum of 60 days per person per calendar year. Home health visit is defined as a period of 2 hours or less, subject to a maximum of 16 hours per day. See Exclusions related to Home Health Care and Custodial Care (including personal care and childcare). **Home Physical Therapy** is payable as described below under Rehabilitation Services benefits. **Outpatient prescription drugs** payable as described above under Drug and Medicine benefits.	80% after deductible	50% after deductible and balance billing to you	50% after deductible	25% after deductible and balance billing to you	100%, no copay	50% after deductible and balance billing to you
Hospice Services • Applies to Facility or Home Hospice care	**Hospice Services** require pre-certification. Length of coverage is based on medical necessity.	80% after deductible	50% after deductible and balance billing to you	50% after deductible	25% after deductible and balance billing to you	100%, no copay	50% after deductible and balance billing to you
Laboratory Services (Outpatient) • Technical and professional fees • See Hospital Services section of this schedule for inpatient laboratory services **See Preventive Care Program sections of this schedule for in-network 100% covered lab services and screenings.**	Covered only when ordered by a Physician or Health Care Practitioner (except Covid-19 testing services). Covid-19 antigen and anti-body testing lab services covered 100% in-network.	80% after deductible	50% after deductible and balance billing to you	50% after deductible	25% after deductible and balance billing to you	100% no copay	50% after deductible and balance billing to you

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG 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 Allowed or Contracted Charges as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
Maternity Services • Hospital, Birthing Center, Physician & Nurse Midwife professional fees for Medically Necessary maternity services. • **Preventive Care Screening for gestational diabetes** covered 100% in-network, between 24-28 weeks gestation & at first prenatal visit (and thereafter for high-risk patients) • **Preventive Care** FDA approved manual or electric breast pump, supplies, & lactation counseling covered 100%, in-network only, one breast pump per birth (see DME section) • **IMPORTANT**: For a newborn to be covered by this Plan, you must follow the Newborn enrollment requirements in the Eligibility section of this document	Utilization Management Company notification is requested when pregnancy is confirmed. Pre-certification is required (see Utilization management section) for hospital stays **greater** than 48 hours for vaginal delivery or greater than 96 hours for cesarean delivery. Newborn hospital charges and professional fees are billed separately for mother and baby (separate deductibles, coinsurances, or copays). See Fertility & Reproductive Care in Exclusions section. Expenses for elective induced abortion are excluded unless a physician certifies the health of the woman is endangered or there are medical complications arising from a pregnancy or abortion. See Laboratory Services (Outpatient), Radiology Services (Outpatient) and Physicians Services rows of this Schedule for lab, pathology, radiology and anesthesia services related to Maternity.	Initial Office Visit to confirm Pregnancy: 80% after deductible Pre-natal and Post-partum professional services and Delivery professional services (Global Fee): 100% after $400 copay Outpatient or in-patient hospital or birthing center: 80% after deductible Breast Pump, supplies and lactation counseling: 100%, no deductible	50% after deductible and balance billing to you Breast Pump, supplies, and lactation counseling: not covered	Initial Office Visit to confirm Pregnancy: 100% after $20 copay Pre-natal and Post-partum professional services and Delivery professional services (Global Fee): 100% after $400 copay Outpatient or in-patient hospital or birthing center: 50% after deductible Breast Pump, supplies and lactation counseling: 100%, no deductible	25% after deductible and balance billing to you Breast Pump, supplies, and lactation counseling: not covered	Initial Office Visit to confirm Pregnancy: 100% after $25 copay Pre-natal and Post-partum professional services and Delivery professional services (Global Fee): 100% after $400 copay Outpatient or in-patient hospital or birthing center: 100% after $250 Out-patient copay or $400 In-patient copay Breast Pump, supplies and lactation counseling: 100%, no copay	50% after deductible and balance billing to you Breast Pump, supplies, and lactation counseling: not covered
Medical Pharmaceuticals (Specialty Drugs) Delivered by Infusion	Cigna Pathwell Specialty Care Management and Utilization Services	80% after deductible	Not covered	50% after deductible	Not covered	100%, no copay	Not covered

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG 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 Allowed or Contracted Charges as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
Nondurable Supplies • Sterile surgical supplies used immediately after surgery • Supplies needed for operation/use covered Durable Medical Equipment (DME) or Corrective Appliances • Supplies needed for use by skilled home health or home infusion staff for their covered and 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 in-network at 100%	See the definition of "Nondurable Supplies" in the Definitions chapter. Pre-certification is **not required** for Nondurable Supplies when used in conjunction with DME or Corrective Appliances	80% after deductible Breast feeding pump supplies covered 100%	50% after deductible and balance billing to you	50% after deductible Breast feeding pump supplies covered 100%	25% after deductible and balance billing to you	100% no copay Breast feeding pump supplies covered 100%	50% after deductible and balance billing to you

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG 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 Allowed or Contracted Charges as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network 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 (or congenital or disease state malformations) to teeth, roof of mouth and jaws if the following conditions are met: If 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 (or non-congenital or pre-disease state) level of health and function **See definition of Injury to Teeth in the Definitions chapter: Oral and Craniofacial Surgery**	See the exclusions related to Dental Services in the Exclusions chapter. Medically necessary Oral and Craniofacial Surgery for the treatment of TMJ syndrome or dysfunction (as defined in Definitions chapter) is covered. Medically necessary Oral, Maxillofacial or Craniofacial surgery and appliances that includes cutting procedures to remove tumors or cysts, treat abscesses or acute injury or malformation of gums, cheek, lip, tongue, hard or soft palate or, due to arthritic deterioration are covered. No coverage under the medical plan for treatment/removal of impacted teeth, root canal, gingivectomy or dental abscess (see Schedule of Dental Benefits for coverage under Dental Plan). Orthognathic procedures payable only when Medically Necessary per the Plan – see Definitions section.	80% after deductible	50% after deductible and balance billing to you	50% after deductible	25% after deductible and balance billing to you	See the Hospital and Physician services row of this Schedule	50% after deductible and balance billing to you
Out-patient Surgery Facility	See the Specialized Health Care Facility row in this schedule.						
Pre-Certification Penalty	Penalty applies to covered **out-of-network** medically necessary services that are not pre-certified before the services are received (but otherwise require Pre-certification under the Utilization Management section).	None	$750 per event	None	$750 per event	None	$750 per event

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG BENEFITS

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

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
Preventive Care Services/Screenings Services and screenings recommended under US Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention and Health Resources and Services Administration (including PPACA/CARE mandates) (1) Evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (2) Immunizations/vaccines (including FDA approved or EUA approved COVID-19 vaccines) that have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved (adult man or woman, adolescent, child, infant) (3) For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines of the Health Resources and Services Administration (4) For women, additional preventive care and screenings not described in (1), as provided for in comprehensive guidelines supported by the Health Resources and Services Administration	**Preventive Care and Screenings are covered in-network only.** Services and screenings include Supplemental Preventive Services as defined in the Definitions section of this document. Detailed information at: www.healthcare.gov/coverage/preventive-care-benefits/ . **Telehealth Connection** services through MDLive: virtual wellness screenings and in-network lab tests and biometrics for adults age 18+.	100% Covered	Not covered	100% Covered	Not covered	100% covered	Not covered

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG BENEFITS

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

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
Radiology (X-Ray), Nuclear Medicine and Radiation Therapy Services (Outpatient) • Technical and professional fees associated with preventive, diagnostic and curative services • Technical and professional fees associated with Radiation Therapy (require pre-certification)	Diagnostic and curative services are covered only when medically necessary and ordered by a Physician/Health Care Practitioner. See the Hospital Services section of this Schedule for inpatient radiology services. Preventive and diagnostic Mammogram and preventive DEXA (bone density) screening services covered 100% in-network; preventive not covered out-of-network.	Preventive and diagnostic Mammogram, Preventive DEXA screenings and all out-patient High-Tech Radiology services (including related professional services, equipment and supplies): 100% no deductible All other Services: 80% after deductible	Preventive Mammogram and DEXA screenings: not covered All other services: 50% after deductible and balance billing to you	Preventive and diagnostic Mammogram, Preventive DEXA screenings and all out-patient High-Tech Radiology services (including related professional services, equipment and supplies): 100% no deductible All other Services: 50% after deductible	Preventive Mammogram and DEXA screenings: not covered All other services: 25% after deductible and balance billing to you	100% no copay	Preventive Mammogram and DEXA screenings: not covered All other services: 50% after deductible and balance billing to you
Reconstructive Services and Breast Reconstruction after Mastectomy • Includes expenses for Reconstructive Surgery or procedures to correct a deformity resulting from disease, infection, trauma, congenital anomaly that causes a functional defect, or prior covered therapeutic procedures • Most Cosmetic and Dental services are excluded from coverage • Post-mastectomy bras are payable as medically necessary	See specific exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions chapter. Mastectomy and subsequent breast reconstruction coverage: reconstruction of the mastectomy breast(s); surgery to produce a symmetrical appearance; prosthesis and physical complications for all stages of mastectomy, including lymphedemas; post-Mastectomy reconstruction tattooing; external silicone, fabric, foam, or fiber-filled breast prosthesis, payable as medically necessary.	80% after deductible	50% after deductible and balance billing to you	Office Visits: 100% after $20 copay All other services: 50% after deductible	25% after deductible and balance billing to you	Office Visits: 100% after $25 PCP office visit copay or $50 Specialist office visit copay Hospital: 100% after $400 copay (per admission) All other services: 100%, no copay	50% after deductible and balance billing to you

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG 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 Allowed or Contracted Charges as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
Rehabilitation/Habilitative Services (Physical, Occupational, Speech, Cardiac and Pulmonary Therapies) • **Outpatient Rehabilitation/Habilitative Services** - short-term, active, progressive or maintenance (to prevent regression) Rehabilitation Services performed by licensed therapists as ordered by a Physician in an outpatient facility or under Home Health Care Services • **Inpatient Rehabilitation/Habilitative Services** in an acute Hospital, rehabilitation unit/facility or Skilled Nursing Facility - short-term, active, progressive or maintenance (to prevent regression) Rehabilitation Services that cannot be provided in an outpatient or home health care setting • **Cardiac Rehabilitation** after cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.) • **Pulmonary rehabilitation** • **Non-spinal manipulation chiropractic modalities**	All Rehabilitation/Habilitative services are covered only when ordered by a Physician. **Annual visit limitation for Outpatient Physical, Occupational or Speech Therapies - 90 combined visits per person, per year, in or out-of-network; no annual visit limitation for these therapies performed for a behavioral health condition.** **In-patient** Rehabilitation/Habilitative admissions **require pre-certification** – see the Utilization Management section. **Out-patient** Physical, Occupational or Speech Therapies **require pre-certification** – except Physical Therapy provided by a Chiropractor during 25-visit annual limitation (see Chiropractic Services section and Utilization Management chapter). **Speech therapy:** covered if directly associated with medical illness or injury or associated with a developmental delay & services are provided by a licensed 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 stuttering, stammering and conditions of psychoneurotic origin, is not covered, except as secondary to a specific medical condition. Coma stimulation services are **not** covered.	80% after deductible	50% after deductible and balance billing to you	50% after deductible	25% after deductible and balance billing to you	Outpatient Rehabilitation/ Habilitative Services: 100% after a $30 copay Inpatient Rehabilitation/ Habilitative admission: 100% after $400 copay	50% after deductible and balance billing to you

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG BENEFITS

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

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
Skilled Nursing Facility	See the Specialized Health Care Facility row.						
Specialized Health Care Facilities • Outpatient Surgery Center Facility or Hospital based Outpatient Facility specializing in same day surgery or procedures where an overnight hospital stay is not required • Birthing Center • Skilled Nursing Facility (SNF). • Sub-Acute Care Facility (also called Long Term Acute Care – LTAC – facility) • Wound care procedures and management in Outpatient Hyperbaric Chamber	**Use of Specialized Health Care Facility requires pre-certification;** see Utilization Management section for details. Specialized Health Care Facility services must be ordered by a Physician; see Definitions chapter. Benefits for use of **Skilled Nursing** or **Sub Acute Care Facility** or any combination of either type of confinement are payable for **up to 60 days per calendar year.** **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 the hospital which maintains the birthing center.	80% after deductible	50% after deductible and balance billing to you	50% after deductible	25% after deductible and balance billing to you	Outpatient Surgery Center Facility or Birthing Center: 100% after $250 copay Wound Care procedures and management (including Outpatient Hyperbaric Chamber procedures): 100% after $50 copay SNF/LTAC Facility: 100% after: $400 Copay per inpatient admission	50% after deductible and balance billing to you
Spinal Manipulation Services • Spinal Manipulation Services from a Physician (MD or DO) or Chiropractor	See the Chiropractic Services row.						
Sub-Acute Care Facility	See the Specialized Health Care Facility row.						

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG BENEFITS

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

Benefit Description	Explanations and Limitations	Choice Medical Plan		Basic Medical Plan		Copay Medical Plan	
		In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers	In-Network Providers	Out-of-Network Providers
Virtual Healthcare Services	See the Physician and Health Care Practitioner Services, Mental/Behavioral Health Services and Preventive Care Services rows.						
Transplantation (Organ & Tissue) • Coverage provided only for eligible services directly related to **Transplantation of human organs or tissue** (including 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 are subject to pre-certification** - see the Utilization Management section. Benefits are payable **only if** services are provided in a Hospital or Specialized Health Care Facility. **No coverage for travel & lodging expenses** except when using in-network LifeSOURCE Transplant Network providers and facilities that are greater than 60 miles from patient home; up to $10,000 covered travel (air, train, ferry, bus, taxi/shuttle, car rental, personal vehicle, gas, tolls & parking) and lodging ($50 per person to a max. of $100 per night or actual cost if less) per transplantation event for patient and one companion or caregiver (two caregivers for dependent minor); no coverage for meals, personal items or expenses, entertainment, deposits, car repairs/maintenance etc.	LifeSOURCE Transplant Network: (Facility and Professional): 100%, no deductible All other in-network Providers: 80% after deductible	50% after deductible up to following Transplant maximums: Bone Marrow - $130,000; Heart - $150,000; Heart/Lung - $185,000; Kidney - $80,000; Kidney/Pancreas - $80,000; Liver - $230,000; Lung - $185,000; Pancreas - $50,000 and balance billing to you	LifeSOURCE Transplant Network (Facility and Professional): 100%, no deductible All other in-network Providers: 50% after deductible	25% after deductible up to following Transplant maximums: Bone Marrow - $130,000; Heart - $150,000; Heart/Lung - $185,000; Kidney - $80,000; Kidney/Pancreas - $80,000; Liver - $230,000; Lung - $185,000; Pancreas - $50,000 and balance billing to you	LifeSOURCE Transplant Network (Facility and Professional): 100%, no copay All other in-network Providers: $400 copay per In-patient Admission; $250 copay per Out-patient Surgical Facility; $25 copay PCP office visit; $50 copay Specialist office visit	50% after deductible up to following Transplant maximums: Bone Marrow - $130,000; Heart - $150,000; Heart/Lung - $185,000; Kidney - $80,000; Kidney/Pancreas - $80,000; Liver - $230,000; Lung - $185,000; Pancreas - $50,000 and balance billing to you

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG 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 Allowed or Contracted Charges as defined in the Definitions chapter and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Choice Medical Plan In-Network Providers	Choice Medical Plan Out-of-Network Providers	Basic Medical Plan In-Network Providers	Basic Medical Plan Out-of-Network	Copay Medical Plan In-Network Providers	Copay Medical Plan Out-of-Network
Vision (Eye Care) Services • Medical services for disease or injury of the eyes (not including routine vision care or refractions except as medically necessary due to an underlying medical condition, illness, or injury) • Eyeglasses or corrective lenses only as described in Explanations and Limitations column • See separate Vision Care Plan described in this document for routine vision care and refractions coverage	Eyeglasses (including lenses and standard/basic frames) or contact lenses are covered as medically necessary for certain diseases or injuries of the eye (e.g., keratoconus, cataract surgery, corneal and retinal conditions etc.) Additional medically necessary corrective eyeglasses/lenses or contact lenses for convenience, replacement, or cosmetic enhancement reasons, may be available through the Vision Care Plan (see Vision Plan Benefits chapter). Vision therapy, such as orthoptic or pleoptic services is not covered.	80% after deductible	50% after deductible and balance billing to you	Office Visits: 100% after $30 Specialist copay All other services: 50% after deductible	25% after deductible and balance billing to you	Office Visits: 100% after $50 Specialist copay $20 copay for medically necessary lenses/frames purchase	50% after deductible and balance billing to you

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG BENEFITS

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

Benefit Description	Explanations and Limitations	Choice Medical Plan In-Network Providers	Choice Medical Plan Out-of-Network Providers	Basic Medical Plan In-Network Providers	Basic Medical Plan Out-of-Network	Copay Medical Plan In-Network Providers	Copay Medical Plan Out-of-Network
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 • See Drug Coverage section of this Schedule for coverage of weight loss prescription medication • See Disease Management Services (for Obesity/Morbid Obesity Diagnosis) row of this Schedule for coverage of nutritional/life-style classes, sessions or visits • 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 **No coverage for post-weight loss skin reduction surgery/treatment, except as medically necessary to alleviate significant complications of weight loss.**	**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 enough, 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 • Defined pre-operative & post-operative weight management program to ensure best outcome; and 3. 6-months physician supervised diet prior to surgery with nutritional consultations; and 4. Behavioral Health Evaluation within last 12 months recommending approval of bariatric surgery and behavioral outcomes expected to warrant Surgery (see Behavioral Health benefit) 5. Cardiac/Pulmonary Clearance; and 6. Basic Labs (within the last 6 months)	80% after deductible	No coverage	Office Visits: 100% after a $20 copay for PCP or $30 copay Specialist All other services: 50% after deductible	No coverage	Office Visits: 100% after $25 copay for PCP office visit or $50 copay Specialist office visit Hospital: $400 copay per in-patient admission or $250 copay per out-patient admission, then plan pays 100% All other services: 100%	No coverage

SCHEDULE OF MEDICAL/PRESCRIPTION DRUG BENEFITS

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

Benefit Description	Explanations and Limitations	One Plan for All: Basic, Choice and Copay Medical Plans In-Network Providers
Drugs and Medicines: **(Outpatient Retail, Mail Order and Specialty Drugs)** • Preventive vaccinations (including Covid-19 vaccines) covered 100% in-network only (travel related vaccinations not covered) • Preventive bowel preparation medications covered 100% in–network, for adults 45 – 74 • Preventive Generic Statin Drugs (low to moderate doses) covered 100% in-network, for adults 40-75 • 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 >35 age women at low risk of adverse medication effects covered at 100% • Emergency contraceptives: two kits per 30-day period; Fertility drugs payable if prescribed for non-fertility therapy only • **VibrantRx Medicare Part D** drug benefits/formularies may be different from MedImpact Commercial benefits and formularies that apply to active and non-Medicare eligible retiree members. **Effective 1/1/25: VibrantRx Medicare Prescription Payment Plan – MPPP available (enrollment required with the pharmacy benefit administrator to activate).**	**See sections on Quick Reference Chart and Prescription Drugs** for Appropriate Claims Administrator and benefit details. See **Out-of-Pocket Maximums** section of this Schedule for in-network Prescription Drugs. See **Drug Exclusions** in Exclusions chapter. No coverage for certain dental drugs, non-prescription contraceptives and over the counter (OTC) drugs (**except** preventive Aspirin and Covid-19 OTC self-test kits). M**andatory engagement** required for **Specialty Drug Advocacy Services** (PaydHealth) for Select Drugs and Products Program List (for non-Medicare Part D members); and voluntary engagement in **MedAssist** (MedImpact) **High-Cost Non-Specialty Drug Advocacy Services** (effective 1/1/26). **Compound medications** subject to prior authorization medical necessity review above $500 per script. **Dispense As Written (DAW) Penalty**: fill a brand name drug when generic substitution authorized = pay the price difference plus the applicable brand copay or coinsurance. **Diabetic Insulin (in-network only): Tier 1 and 2 Generic and Preferred Brand Insulin paid under Tier 1 Generic copay or coinsurance rules for Retail or Mail Order (with default maximums if better, of $35 for a 30-day supply or $105 for a 90-day supply. Tier 1 and 2 diabetic supplies, products, sensors, monitors, delivery equipment etc. - 100% covered; Diabetic supplies standard copays/coinsurance if Tier 3.** Some drug classifications and all Specialty Drugs, subject to **Utilization Management** including step therapy, quantity limitations or Prior Authorization requirements; Formulary placement/deletion - subject to change at any time. **All plans - Out-of-Network benefits:** no discounts apply; coverage limited to amount Plan would have paid if a network pharmacy was used (plus applicable deductibles, copays, or co-insurance); 90-day supplies not covered out-of-network.	**No deductible** **Network Retail Pharmacy:** (up to a 30-day supply) ***Tier 1*** *(Generic):* Greater of $10 copay or 20% (max $60); Insulin: same except max is $35 ***Tier 2*** *(Preferred Brand)*: Greater of $35 copay or 30% (max $110); Insulin: same as Tier 1 ***Tier 3*** *(Non-Preferred Brand)*: Greater of $60 copay or 50% (max $170); Insulin: 50% to a max of $35 **Network Pharmacy Retail-90 and Mail Order Pharmacy:** (up to 90-day supply) ***Tier 1*** *(Generic): G*reater of $20 copay or 20% (max $120); Insulin: same except max is $105 ***Tier 2*** *(Preferred Brand): G*reater of $70 copay or 30% (max $220); Insulin: same as Tier 1 ***Tier 3*** *(Non-Preferred Brand)*: Greater of $120 copay or 50% (max $340); Insulin: same except max is $105 **Specialty Pharmacy:** (up to a 30-day supply) ***Tier 4*** *(Specialty Generic or Specialty Preferred for Medicare Part D):* Greater of $15 copay or 20% (max $90) ***Tier 5*** *(Specialty Preferred Brand)*: Greater of $55 copay or 30% (max $165) ***Tier 5 (D) Medicare Part D only:*** *(Specialty Non-Preferred):* Greater of $55 copay or 30% (max $165) ***Tier 6*** *(Specialty Non-Preferred Brand for Commercial non-Medicare Part D)*: Greater of $90 copay or 50% (max $255)

MEDICAL/PRESCRIPTION DRUG 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/Designee or Appropriate Claims Administrator.
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 (except as provided under Telehealth Connection services and Virtual Office Visit services), mailing charges, disabled/handicapped plates/automotive forms/interest charges, late fees and mileage costs, service provider administration fees, concierge/retainer agreement/membership fees or photocopying fees.
3. **Educational Services:** Even if they are needed 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 or Annual 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/Designee or Appropriate Claims Administrator 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 (not including third party medical liability coverage from home or motor vehicle insurance).
9. **Expenses used to satisfy Plan Deductibles, copays, coinsurance amounts** 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/Designee or Appropriate Claims Administrator to be Experimental and/or Investigational as defined in the Definitions chapter of this document.
14. **Failure to Comply with Medically Appropriate Treatment:** Expenses incurred by any Covered Individual due to failure to comply with medically appropriate treatment, as determined by the Plan Administrator/Designee or Appropriate Claims Administrator.
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 due to 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/Designee or Appropriate Claims Administrator determines in their 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 related to the injury or illness resulting from or sustained in the alleged illegal act. Such appeal should be directed to the Appropriate Claims Administrator who will submit it through the Appeal Process outlined in the Claims Information chapter of this plan document.

17. **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.
18. **Medically Unnecessary Services:** Services or supplies determined by the Appropriate Claims Administrator not to be Medically Necessary as defined in the Definitions chapter of this document.
19. **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 Appropriate Claims Administrator.
20. **Never Events (i.e., Services for which reimbursement will never be made)**: Expenses for services performed because 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/Designee or Appropriate Claims Administrator 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 provided supplies 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 (and unless otherwise indicated in Schedule of Medical/Prescription Drug Benefits section or Utilization Management chapter).
23. **Non-Emergency Travel and Related Expenses**: Expenses 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 Appropriate Claims Administrator.
24. **Occupational Illness/Injury Expenses:** All expenses incurred by you or any of your covered Dependents arising out 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. See the Coordination of Benefits Chapter for more information.
25. **Personal Comfort/Preference 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, streaming services, 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 accommodation for the types of services provided or unless the use of a private room is certified as Medically Necessary by the Plan Administrator/Designee or Appropriate Claims Administrator.
28. **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.
29. **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.

30. **Telephone Calls:** 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;
    - Providing advice to a new or established patient;
    - Providing counseling to anxious or distraught patients or family members

    - **Exception to Telephone Calls exclusion from coverage:** for specifically contracted Virtual Care service providers under the Plan, and "virtual" office visit calls, video-conferencing and other electronic communications as may apply with independent Physicians and Health Care Practitioners for the provision of medical or behavioral health services, are covered.

31. **War or Similar Event:** Expenses incurred for 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

32**. 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 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/Prescription Drug Benefits for certain Plans.
    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).

33. **Behavioral Health Care Exclusions**
    a. Expenses for diagnosis, treatment, and prevention of Behavioral Health Disorders, including substance abuse, except as provided under Behavioral Health in the Schedule of Medical/Prescription Drug Benefits.
    b. 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.
    c. Expenses for biofeedback or hypnosis/hypnotherapy.
    d. Expenses for Behavioral Health Care services related to:
        - Learning disorders/developmental delays/Dyslexia (initial diagnostic testing for these conditions is covered);
        - Vocational disabilities;
        - Mental retardation
        - Court-ordered Behavioral Health Care services or custody counseling (unless the services are determined by the Plan Administrator/Designee or Appropriate Claims Administrator, to be medically necessary in the absence of court order and such services are otherwise a covered benefit under the Plan);
        - Family planning counseling/pregnancy counseling/adoption counseling

    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/Prescription Drug Benefits.

34. **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 unless medically necessary.
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 unless an in-network provider and with a physician's prescription or orders.

35. **Cosmetic Services Exclusions**
    a. Expenses for surgery or medical treatment to improve, preserve or return physical appearance, but not physical function (except that physician recommended cranial remolding devices for infants and children or when used post-operatively for synostic plagiocephaly, shall be covered). 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/Designee or Appropriate Claims Administrator. 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/Prescription Drug 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.
36. **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/Designee or Appropriate Claims Administrator 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.
37. **Dental Services Exclusions (from the Medical/Prescription Drug Plans)**
    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 as described in the Oral and Craniofacial Services section of the Schedule of Medical/Prescription Drug Benefits as being included and 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 medically necessary repair or replacement of an injury to teeth or restoration of the jaw, mouth, or palate if damaged by an external object in an accident, or if they are incurred as a result of a disease state or congenital malformation. See Oral and Craniofacial Services in the Schedule of Medical/Prescription Drug Benefits and the Definitions chapter for additional information regarding these services.
    c. 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/Designee or Appropriate Claims Administrator.
    d. Expenses for **Oral Surgery** to remove impacted teeth, gingivectomies, treatment of dental abscess, and Root Canal (Endodontic) Therapy.
    e. Expenses covered under the Dental Plan, and all expenses excluded under the Dental Plan unless coverage is specifically provided under the Schedule of Medical/Prescription Drug Benefits.
    f. 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.
    g. 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/Designee or Appropriate Claims Administrator.

38. **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. Gene and Cellular Therapy Products and any related medical, surgical, laboratory, professional and facility services directly related to the administration or production of the Gene and Cellular Therapy Product, except as otherwise approved by Appropriate Claims Administrators' medical and case management processes to establish medical necessity, safe and effective outcomes, non-experimental and requirements to participate in case management, advocacy services, pre-authorization, step therapy and other utilization processes, as may apply. **Plan participants may use the Plan's Pre-certification procedures to determine if proposed Gene and Cellular Therapy is covered or excluded.**
    c. Non-prescription or non-legend or over the counter (OTC) drugs or medicines, **except** as otherwise described for coverage in Schedule of Medical/Prescription Drug Benefits sections on Drugs and Medicines, Nondurable Supplies and Preventive Care Programs e.g., OTC insulin, diabetic supplies, 81mg aspirin, OTC Covid-19 Test Kits.
    d. 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 or primary nutritional intake for a child or adult when prescribed by a Physician).
    e. Naturopathic or Homeopathic remedies and substances.
    f. 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);
        - OTC topical fluoride preparations for dental purposes;
        - hair growth and hair removal products used for cosmetic purposes (*i.e.,* Propecia, Rogaine, Vaniqa); (except for medically necessary treatments for hair loss due to a medical condition for children under the age of 18)
        - drugs for anti-aging, bodybuilding/athletic enhancement or to improve physical performance including but not limited to androgen products, anabolic steroids.
    g. 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.
    h. Vaccinations, immunizations, inoculations, vitamin injections or preventive injections, except those provided by the Plan under the coverage provisions for Preventive Care Services/Screenings in the Schedule of Medical/Prescription Drug Benefits section; 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).
    i. Medical marijuana, regardless of medical necessity.
39. **Durable Medical Equipment Exclusions:** Refer to the Corrective Appliances exclusions.
40. **Fertility, Genetic, Reproductive and Sexual Dysfunction Services Exclusions**
    a. Expenses for any services (including but not limited to, professional, lab, radiology, surgical, drug and ancillary) 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, costs of non-covered person's surrogate parenting, donor semen, cryostorage of egg or sperm and reversal of sterilization procedures.
    b. Expenses for **surgical treatment of sexual dysfunction** or inadequacy, and any complications thereof, unless a medically necessary standard of care.
    c. Expenses related to **non-prescription prevention of pregnancy.**
    d. Expenses for **genetic services, tests and/or procedures** except when performed for 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 and except for genetic testing that is medically necessary to determine the efficacy of various medical (e.g., oncology related) treatments.
    e. 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.
41. **Foot and Hand 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/Designee or Appropriate Claims Administrator 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.

42. **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/Prescription Drug Benefits for a description of the genetic services that are covered by the Plan. **Plan Participants may 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 and pre-and-post medically necessary Genetic testing services).

43. **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 (except for medically necessary treatments for hair loss due to a medical condition for children under the age of 18); 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/Radiotherapy (oncology conditions) or other medical conditions. See Chemotherapy in the Schedule of Medical/Prescription Drug Benefits.

44. **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/Prescription Drug 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.

45. **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 office visit or surgical implantation services will be covered as described in the Schedule of Medical/Prescription Drug Benefits, with coverage determined based on the type of provider (i.e., MD, ND) providing the services. Note, coverage for services provided by a Naturopath will only include the office visit and Naturopath office visits may not be covered under all Medical Plans.

46. **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.**

47. **Rehabilitation/Habilitative Therapies Exclusions (In-patient or Out-patient)**
    a. Expenses for education, job training and/or vocational rehabilitation.
    b. Expenses for massage therapy, Rolfing, and related services (except massage therapy when performed by a physical therapist or Chiropractor as part of a medically necessary rehabilitation/habilitative program).
    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/Designee or Appropriate Claims Administrator, 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) are not 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 speech therapy for functional purposes including, but not limited to, stuttering, stammering and conditions of psychoneurotic origin, except as provided under the Rehabilitation/Habilitative section of the Schedule of Medical/Prescription Drug Benefits (i.e., except as secondary to a specific medical condition).
    f. Expenses for treatment of delays in childhood speech development unless as a direct result of an illness, injury, surgery or result of a covered treatment.
    g. Expenses for treatment of developmental delays/learning disorders are not covered; initial diagnostic testing for these conditions is covered.
48. **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/Prescription Drug Benefits.
    b. Expenses related to non-human (Xenografted) organ and/or tissue transplants/implants if these are otherwise considered experimental, investigational, or unproven.
    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/Prescription Drug Benefits.
49. **Vision Care Exclusions**
    a. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures, unless determined medically necessary due to an underlying medical condition.
    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 for coverage of routine vision care and refractive errors.
    c. Vision therapy (orthoptics) and supplies.
50. **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/Prescription Drug Benefits. Note however that the Plan **does not** pay for post-weight loss skin reduction surgery/treatment unless for medically necessary reasons to alleviate significant complications of weight loss. See the Weight Management row in the Schedule of Medical/Prescription Drug 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 (including virtual/online/telephonic) to health clubs, exercise programs, weight loss programs, gymnasiums, and/or any other facility or exercise equipment for physical fitness or weight loss/management.

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 choose an out-of-network (Non-Network) provider of your choice. Benefits paid are determined by the provider chosen. The national Provider Network Organization that is available under the Medical Plan is listed in the Quick Reference Chart in the front of this document.

IN-NETWORK SERVICES

In-Network Health Care Providers have agreements with the Plan's Provider Network Organizations 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 covered services or supplies. The In-Network Health Care Provider generally deals directly with the Plan for any additional amount due.

Network Providers are providers (hospitals, physicians, behavioral health providers and other ancillary medical vendors) that have agreed to a special reduction in fees to the network subscribers who use covered services under the Plan. Use of a network provider will result in the greatest discount on billed charges for both you and the Plan. Network providers will accept payment from the plan as payment in full less any applicable deductible, coinsurance or copay that is your responsibility. **Network providers cannot 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).**

NON-NETWORK (OUT-OF-NETWORK) SERVICES

Non-Network Health Care Providers (also called out-of-network or non-par providers) have no agreements with the Network 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 (or the non-network provider if you have so directed) for the Allowed or Contracted Charge (as defined by this Plan – see Definitions section for details) for any Medically Necessary covered services or supplies, subject to the Plan's out-of-network Deductibles and Coinsurance and Limitations and Exclusions. Generally, Plan Participants must pay for (or be invoiced by) their out-of-network provider for covered services and will be responsible for filing out-of-network claims to the Appropriate Claims Administrator before any out-of-network reimbursement will be made to the Plan Participant. **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 (this is called "balance billing")**.

EXCEPTIONS TO NORMAL PLAN REIMBURSEMENT FOR NON-NETWORK PROVIDERS

There are some exceptions to the way the Plan makes payment for non-network provider services:

Reason for Non-Network Provider Use	What the Plan Pays
The patient had a **true medical emergency** and no control over the choice of providers, Urgent Care or Emergency Room facilities.	In-Network benefit for covered services per the Schedule of Medical/Prescription Drug Benefits adjudicated at the lessor of billed charges or up to 200% of Medicare schedule of charges.
The patient used a non-network provider because there were no network providers who could perform the required service in the geographic area, as determined and **pre-certified** by Utilization Management (**Gap/Adequacy Exception**).	In-Network benefit for covered services per the Schedule of Medical/Prescription Drug Benefits adjudicated at the lessor of billed charges or up to 200% of Medicare schedule of charges.
The patient used a non-network provider because **Transition of Care or Continuity of Care was approved by the Appropriate Claims Administrator** for specific and limited services that need to continue and were already underway for the patient prior to the provider network change that otherwise classified the provider as non-network.	In-Network benefit for covered services per the Schedule of Medical/Prescription Drug Benefits adjudicated at the lessor of billed charges or up to 200% of Medicare schedule of charges.
The patient had no choice of **Ancillary Services** provided **by non-network provider(s) in conjunction with elective or preventive primary services performed by network provider(s) and facilities**. *	In-Network benefit for covered services per the Schedule of Medical/Prescription Drug Benefits adjudicated at the lessor of billed charges or up to 200% of Medicare schedule of charges.

***Ancillary Services example**: In-network elective or preventive medical or surgical procedures where provider office or facility and surgeon are in-network providers, **but ancillary medically necessary services are provided by non-network providers through no fault or choice of the patient (including provider designations such as: assistant surgeon, certified surgical assistant, anesthesiologist, nurse anesthetist, radiologist, pathologist and lab processing technicians, and neurological monitoring providers etc.)**. In these cases, Ancillary Services can be adjudicated at in-network benefit levels applicable to each plan option. However, due to claims filing/timing discrepancies, these non-network provider ancillary claims may not be identified with/ "connected" to the primary in-network service providers/facilities' claims adjudication processes and as a result, initially may be paid at out-of-network benefit levels. Under these circumstances, it is the member's responsibility to review related Explanations of Benefits (EOB's) from the Appropriate Claims Administrator and appeal any adverse ancillary benefits outcome in a timely manner. For all Ancillary Services claims adjudications, Allowable charges will be determined by the Appropriate Claims Administrator and even though adjudicated at in-network benefit levels, there may still be a difference between billed charges of the ancillary providers and Allowable Charges of the Plan, that could result in balance billing to you.*

UTILIZATION MANAGEMENT (UM) – MEDICAL/PRESCRIPTION DRUG 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, new costly drugs coming to market 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.** Thus, the Plan has adopted a Utilization Management Program designed to help control increasing health care costs by avoiding unnecessary services or services that are costlier 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. **Retrospective Review:** Review of health care services **after** they have been provided; and
4. **Case Management:** A process whereby the patient, the patient's family, Physician and/or other Health Care Providers, and the Plan work together under the guidance of the Plan's independent Utilization Management services 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.
5. **High-Cost Non-Specialty Drug Advocacy Services (MedAssist)**: See Quick Reference Chart at the beginning of this document for contact details of Prescription Drug Appropriate Claims Administrator for participation in MedAssist, a program to direct and guide towards manufacturer copay/coinsurance assistance (commonly known as "copay cards") for high-cost non-specialty prescription drugs maintained on a list (subject to change) by the Appropriate Claims Administrator, for non-Medicare eligible members. By participating in a manufacturer copay assistance program, members can reduce their out-of-pocket liability for these eligible drugs and also help reduce some of the related Plan cost.
6. **Specialty Drug Advocacy Services (SDAV):** These services provide a Select Drugs and Products^{SM} Program that requires covered persons to engage with the SDAV service provider (see Quick Reference Chart at the beginning of this document for contact details), when prescribed outpatient Specialty Prescription Drugs or Products listed on the Specialty Select Drugs and Products List. "Engage" includes enrollment in the Program and adjudication of Specialty Drug cost by an alternate funding program prior to meeting Plan coverage criteria. Some alternate funding programs require verification of income as a condition of meeting alternate funding program criteria, and such information will not be provided to the Plan and is not considered in determining coverage by the Plan. Failure to prior authorize and complete the requirements of the Select Drugs and Products Program will result in a cost containment penalty equal to a 100% reduction in benefits payable. Such cases will be treated as an adverse benefit determination under the Plan.

MANAGEMENT OF THE UM PROGRAM

The Plan's Utilization Management Program (UM) is administered by independent, professional Utilization Management entities, aka UM Company(s) operating under administration contracts with the Plan. The UM Company may be the Appropriate Claims Administrators or an affiliate or division of the respective Appropriate Claims Administrators or may be under a separate administration contract with the Plan, or any of all of these, to deliver UM services for medical, behavioral health and

prescription drug benefits. Certain classes of prescription drugs (and all Specialty Drugs) must be pre-certified (prior authorization "PA") under the pharmacy benefit UM program. The names and phone numbers of the UM Company(s) that apply to your Plan are listed on the Quick Reference Chart in the Introduction chapter 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, surgical or prescription drug 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 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 and sleep studies, to name a few) are Medically Necessary for the patient and his/her diagnostic history or condition.

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 (especially if they are a Network provider) will generally initiate the pre-certification request and 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**. If a required pre-certification is **not** completed for an in-network provider, there is no penalty to you and medically necessary and otherwise eligible services will be covered according to the schedule of in-network benefits. See Schedule of Medical/Prescription Drug Benefits in an earlier chapter for the penalty that **does** apply for failure to pre-certify out-of-network services that otherwise require pre-certification and are eligible for coverage under the out-of-network provisions of the Schedule of Medical/Prescription Drug Benefits.

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 (for both in- network and out-of-network service providers). 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. **Maternity length of stay** expected to last longer than forty-eight (48) hours for a vaginal delivery, or last longer than ninety-six (96) hours for a cesarean delivery (C-section) - although **notification** to the Utilization Management Company within 48 hours of the admission is preferred.
2. **Chemotherapy/Radiation treatment** to facilitate care and ensure access to Concierge Customer Service, Case Management or Disease Management services, as may apply.
3. **Inpatient, elective, non-emergency Hospital** admissions and **Behavioral Health inpatient admissions** (including a 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 outpatient diagnostic procedures like endoscopy/colonoscopy services, high tech and radiology services, lab procedures etc. regardless of where performed - although some or all of these outpatient services may require provider orders to validate medical necessity and appropriate clinical need), 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 and Outpatient Infusion Services)
6. **Facility, Provider Office or Home-Based Infusion Services for medically provided Specialty Pharmaceuticals**
7. **Newborn inpatient stays beyond the mother**
8. **OB related inpatient admissions (i.e., complications or extensions of overnight stays)**
9. **Genetic Testing for high-risk pregnancies e.g., women >35 or other Medically Necessary Genetic Testing**
10. **Gene and Cellular Therapy services and products**
11. **Transplantation services**
12. **Bariatric (Weight Management) Surgery** (lap band adjustments do not require pre-certification)
13. Partial/Intensive Outpatient **Behavioral Health/Substance Abuse Services**
14. Outpatient or Home **Physical/Occupational/Pulmonary/Cardiac/Speech Therapies** after first five (5) visits per patient per year (except PT provided by Chiropractor during 25-visit annual or rolling twelve-month limitations does not require pre-certification)
15. **Chiropractic Spinal Manipulation** services beyond **25 visits** per person per calendar year for in-network or per rolling 12-month period for out-of-network.
16. **Non-Emergency Ambulance Transport**
17. **Cochlear Implants**
18. **Sleep Studies**
19. **Synagis** shots (vaccine to help prevent/reduce RSV or BPD disease in high-risk pediatric patients under 2 years of age).

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/Prescription Drug Benefits. In addition, for Specialty Drugs included on the Specialty Select Drugs and Products List, mandatory participation in Specialty Drug Advocacy Services with the Appropriate Claims Administrator, is required for alternate funding sources to be identified and potentially qualified.

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. Pre-certification requests 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 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, address and phone number 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 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 notification. 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 coverage of 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.

RETROSPECTIVE REVIEW BY THE UM COMPANY
All claims for medical services or supplies, that have not been reviewed under the Plan's Pre-certification or Concurrent (Continued Stay) Review Programs but should have been, 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, caregivers, Health Care Providers, and Appropriate Claims Administrator 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 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 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, or if you undergo a medical procedure that has not been pre-certified and is later determined by the Appropriate Claims Administrator to be not medically necessary, **claims for these services may be denied.** Further, if the claim is for out-of-network services that are otherwise medically necessary and covered under the Plan but not pre-certified, there is a penalty applied to the member that reduces the amount of covered benefits available (see Schedule of Medical Benefits section under Pre-Certification Penalty).

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, telephone 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, thus, 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 to 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
- Osteoarthritis
- Oncology
- Tobacco Cessation
- Weight Management

Regardless of whether 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 that are available to all active employees, COBRA continuation medical plan members and retiree medical plan participants (during the first 18 months after retirement) and their respective 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**. Public safety employees who are sworn officers participating in the Public Safety Personnel Retirement System, and civilian personnel (including Public Safety 911 Operator, civilian EMT, civilian Paramedic and Crime Scene Specialist) are eligible for a maximum of thirty-six (36) visits per person, per issue, per year, for traumatic event counseling and therapy services following exposure to these events in the line of duty and in the course and scope of their job duties and in accordance with the provisions of Arizona House Bill 2502 or City of Mesa policy, as may apply.

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 (face-to-face, telephonic, or video conferencing) 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.

Eligible employees may use the services offered by the EAP immediately upon becoming employed by the City of Mesa. Household members are also eligible and both employees and household members **are not required to be enrolled** in one of the City's medical plans to use EAP services.

Behavioral Health benefits for extended behavioral health or substance abuse care (or limited extensions of free EAP type counseling services through another medical plan network) are available to eligible 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/Prescription Drug 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 your family members who are enrolled for dental coverage must all be enrolled in the same dental plan option.

- **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.
- **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.

All Dental Plan Options have a Dental Network benefit available. You may use any dental provider of your choice, but if your provider is part of the contracted 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 Appropriate Claims Administrator and Dental Network.

All Dental Plan Options have Special Health Care Needs dental benefits available (effective April 1, 2024). Members diagnosed with "Special Health Care Needs" (see Definitions section), that significantly impair the member's ability to obtain covered dental services, may be eligible for additional services, including

- Additional visits, consultations and/or exams
- Up to four total dental cleanings per benefit year
- Treatment delivery modifications by a dental provider which may include limited anesthesia when necessary for dental providers to provide oral health care

Covered Dental Expenses: You are covered for expenses you incur (up to annual Plan Maximums per person per calendar year) 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/Designee or Appropriate Claims Administrator to be **"Medically/Dentally Necessary,"** but only to the extent that the Plan Administrator/Designee or Appropriate Claims Administrator 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/Dentally 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 must 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 must pay before Plan benefits that require a deductible be paid, begin. **The Plan's Individual Dental Deductible is $50.**
- The Family Deductible is the maximum amount that a family of three or more must pay before Plan benefits that require a deductible be paid, begin. **The Plan's Family Dental Deductible is $150.** If you have a family and there are three or less eligible members in your family, then each individual must meet his/her individual deductible before benefits that require a deductible be paid, will be paid for that individual. 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 Services (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 above the Annual Maximum Dental Plan Benefits.
4. All expenses for dental services or supplies **not** covered by the Plan.
5. All charges more than 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 but may be subject to "quantity/frequency" limitations (see the Schedule of Dental Benefits for details).
- **Overall Lifetime Maximum Orthodontia Plan Benefits**: The Overall "Lifetime" Maximum Plan Benefits per person, payable for Orthodontia services under this Plan is $3,000, while the Annual Maximum Plan Benefit per person, 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

This table explains what the Plan pays. All benefits are determined according to Allowed or Contracted Charge allowances and Dental 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 Plan	Dental Choice Plus Plan	Preventive Choice Plan
Annual Maximum Payable for Dental Services		$2,000 per person per calendar year	$2,300 per person per calendar year	$1,000 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/included in the Annual Maximum Plan Benefits except when marked with an asterisk*.** • Preventive Oral examination is limited to three times per calendar year. • Prophylaxis, scaling, cleaning, and polishing is limited to three cleanings per calendar year (up to four cleanings for Special Healthcare Needs patients). • Bitewing x-rays are limited to twice per calendar year. • Full mouth or Panoramic x-rays are 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
Basic Restorative Services • Tooth extractions. • Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restoration for decayed or broken teeth. • Periodontal prophylaxis and treatment of periodontal and other diseases of the gums and supporting structures of the mouth (gingiva and/or alveolar bone). • Antimicrobial agents. • Curadont remineralization services up to twice per tooth per calendar year. • Administration of local anesthesia in connection with covered dental services; administration of nitrous oxide in connection with any dental procedure or exam.	Basic Restorative services are **subject to Annual Maximum Plan Benefits.**	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 Dental 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 Plan	Dental Choice Plus Plan	Preventive Choice Plan

Major Restorative Services
• Dental x-rays for diagnosis of dental condition.
• Injection of necessary antibiotic drugs by attending Dentist.
• Space maintainers.
• Occlusal adjustment.
• Oral surgery, including extractions and surgical procedures.
• Administration of general anesthesia and/or intravenous sedation. 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/Designee or Appropriate Claims Administrator, 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.
	• Major 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 with 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

SCHEDULE OF DENTAL BENEFITS

This table explains what the Plan pays. All benefits are determined according to Allowed or Contracted Charge allowances and Dental 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 Plan	Dental Choice Plus Plan	Preventive Choice Plan
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.	• Must be enrolled in the Choice Plus Dental Plan in each calendar year in which yearly or lifetime Orthodontia benefits are covered (i.e., up to 2 years minimum) • 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 started/banded before the patient's effective date with the City of Mesa Dental Choice Plus Plan is not reimbursable/covered**.	Not covered	80% of Allowed Charges, no deductible; maximum payable is $1,500 per year per person and $3,000 per person per lifetime	Not Covered

DENTAL PLAN EXCLUSIONS

The following is a list of dental services/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 and/or related services provided for apprehension or anxiety, except when provided for pain management services in the provision of dental and oral surgical procedures and, except for nitrous oxide services which are covered for reduction/elimination of apprehension or anxiety for any dental or oral surgical procedures.
2. **Bacteriologic studies and susceptibility testing** for dental caries (cavities) are not covered.
3. **Cosmetic Services:** Expenses for dental Surgery or dental treatment for cosmetic purposes, as determined by the Plan Administrator/Designee or Appropriate Claims Administrator, 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/Designee or Appropriate Claims Administrator 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/Designee or Appropriate Claims Administrator 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 because 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 because 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/Designee or Appropriate Claims Administrator 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 because 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/Designee or Appropriate Claims Administrator 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.
23. **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.
24. **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.
25. **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.
26. **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).
27. **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.
28. **Orthognathic services, surgery**: Expenses for orthognathic treatment including surgical procedures.
29. **Periodontal Splinting:** Expenses for periodontal splinting.
30. **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.
31. **Pictures/Photographs:** Expenses related to pictures (photographs) of teeth and/gums.
32. **Sealants for Individuals aged 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 because 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) listed in 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 three options available for vision coverage: **Basic Vision Plan, Vision Plus Plan and Vision Premium Plus Plan**. The primary difference between these options is in the frequency of coverage for materials purchases such as eyeglasses/lenses and contact lenses and in the case of the Vision Premium Plus Plan, availability of enhanced in-network benefits for certain vision materials purchases. 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 one of these Vision Plan options. The City of Mesa pays a portion of the premium for the elected coverage and employees/retirees pay the rest (subject to change on an annual basis).

To Obtain Vision Services: please contact the Vision Care Plan listed in the Quick Reference Chart in the Introduction chapter of this document.

Services Provided: the following is a list of services covered 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 because 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 or frequencies.
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 **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 this document). 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 and Vision Premium 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 health and wellness • Retinal Screening (Digital/Photographic) • **Every calendar year**	$10 copay $20 copay	**Well Vision Exam**	• Focuses on eyes and overall health and wellness • Retinal Screening (Digital/Photographic) • **Every calendar year**	$10 copay $20 Copay
Prescription Glasses		$10 copay	**Prescription Glasses**		$10 copay
Frames (selection/brands vary by provider)	• $170 allowance for wide selection of frames • $190 allowance for featured frame brands • $95 allowance at Costco/Walmart/Sam's Club • 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/brands vary by provider)**	• $170 allowance for wide selection of frames • $190 allowance for featured frame brands • $95 allowance at Costco/Walmart/Sam's Club • 20% savings on the amount over applicable allowances • **Every calendar year**	Included in Prescription Glasses copay + Discounted amounts above allowances (if applicable)
Lenses for Eyeglasses	• Single vision, lined bifocal, trifocal and lenticular lenses • **Every other calendar year**	Included in Prescription Glasses copay	**Lenses for Eyeglasses**	• Single vision, lined bifocal, trifocal and lenticular lenses • **Every calendar year**	Included in Prescription Glasses copay
Lenses Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Impact-resistant lenses (no copay for children under age 26) • Average savings of 30% on all other non-covered options/enhancements (e.g., scratch resistant and anti-glare coatings, tints, light-reactive lenses, UVA/UVB protection) • **Every other calendar year**	$0 copay From $95 - 105 From $150 - $175 $10 copay	**Lenses Enhancements**	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Impact-resistant lenses (no copay for children under age 26) • UVA/UVB Protection • Average savings of 30% on all other non-covered options/enhancements (e.g., scratch resistant and anti-glare coatings, tints, light-reactive lenses) • **Every calendar year**	$0 copay From $95 - $105 From $150 - $175 $10 copay $0 copay
Contacts (available in lieu of eyeglass lenses and frames)	• $220 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 copay	**Contact Lenses allowance and Frames allowance can be used in the same calendar year, but the contact lenses allowance is instead of prescription lenses for frames (out-of-pocket expense if purchased)**	• $220 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 copay
VSP EasyOptions (choice of one of these upgrades per person, per calendar year)	• Not covered or included		**VSP EasyOptions (choice of one of these upgrades per person, per calendar year)**	• **Vision Premium Plus Plan only** • $250 frame allowance (instead of $170 frame allowance), or • $300 contact lens allowance (instead of $220 contact lens allowance), or • Fully covered premium or custom progressive lenses, or • Fully covered light-reactive lenses, or • Fully covered anti-reflective coating	

SCHEDULE OF VISION BENEFITS cont.

In-Network Essential Medical Eye Care (EMEC) Program	Retinal screening for members with diabetes $0. Additional exams and services (frequency as medically necessary) for members with diabetes, glaucoma, or age-related macular degeneration and for all members, exams and services for diagnosis and treatment of eye conditions, including pink eye, vision loss and cataracts: $20 copay per exam with in-network providers. Limitations and coordination with medical plan coverage may apply.
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 Locations	1. Costco/Walmart/Sam's Club Optical: Vision care materials purchased at these locations will have different allowances and no additional discounts compared to other approved retail and VSP Network providers (many but not all exam services at these retail locations are in-network, but some are out-of-network coverage only) 2. EasyOptions upgrades in Premium Plus Vision Plan **not available** at Costco/Walmart/Sam's Club 3. Online in-network (copay, allowances, and discounts) Retail Purchasing for Contacts, Frames and Sunglasses – through Eyeconic – accepts prescriptions from both in-network and out-of-network providers
Out-of-Network Vision Care Coverage	**Frequency of coverage is the same as in-network services (varies by Basic Vision, Vision Plus or Vision Premium Plus Plan)** Exam – up to $70 coverage for out-of-network Exam services Contacts – up to $200 allowance ($250 for medically necessary contacts) – both including fitting/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 **Laser Vision Correction** • Average 15% discount off regular prices or 5% off promotional prices from contracted facilities **Hearing Aid Discount Program** • Through TruHearing DHMO – large selection of digital hearing aids; free enrollment/membership in TruHearing

FLEXIBLE SPENDING ACCOUNT PLAN

HEALTH AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS (FSA)

The Flexible Spending Account Plan (FSA) is an IRS qualified benefit plan that allows:

- **Automatic payroll deducted benefit plan premiums on a pre-tax basis** for medical/behavioral health/prescription drug, dental and vision care plans if you enroll when first eligible or after a Qualifying Event or following annual Open Enrollment plan changes (except Committed Partner and Committed Partner children coverage is not pre-tax) and,
- **Annually elected pre-tax dollars from each paycheck** to pay for either health or dependent care expenses that are your out-of-pocket responsibility and are eligible to be reimbursed through your enrolled **Health or Dependent Care FSA accounts** as may apply.

When you enroll in pre-tax qualified benefit plans or establish FSA accounts each year, the portion of your salary deducted from your paycheck and applied to your payroll deducted premiums and 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 out-of-pocket expenses (and certain health insurance-related premiums) that you would otherwise pay for with after-tax dollars. Participants in a Health or Dependent Care FSA Plan or participants whose payroll deductions for medical, dental and vision plan insurance benefits are deducted on a pre-tax basis, may experience a slight reduction in future Social Security benefits because, when you receive these tax-free benefits under the Plan, the amount of both your earned income that is subject to Social Security taxes and resultant Social Security contributions made by both you and the City, are reduced.

The City's FSA Plan is administered by an Appropriate Claims Administrator (see Quick Reference Chart section at the front of this document for contact information). To participate in the FSA Plan, you must make your elections via the City's online enrollment system (see Quick Reference Chart section). Your effective date in the FSA Plan is either your hire date or the first of the month following your hire date (your enrollment election), if you enroll when first eligible/hired, 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 annual election balance may be used to reimburse/pay for certain health care expenses incurred during the calendar year. Your Dependent Care FSA posted 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 your Flexible Spending Accounts, (or use your FSA debit card to pay for an expense), you cannot receive reimbursement for those expenses from any other source (e.g., secondary insurance etc.), claim that expense as a tax 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 100% covered by your medical, prescription drug, behavioral health, dental or vision care programs or are out-of-pocket expenses that you are responsible for after insurance has made eligible payments. ***NOTE: Eligible FSA expenses may be incurred by any of your family members who are your 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. Even though a non-qualified tax dependent may be eligible for and covered in a City sponsored health plan(s) e.g., Committed Partner and Committed Partner children, the non-qualified tax dependent's out-of-pocket health care expenses are not eligible Health FSA expenses under your Health FSA account with the City (or in the case of Committed Partner children, not eligible for Dependent Care FSA account reimbursement).***

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 some or all of your 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 request/keep itemized invoices/statements, receipts, and related documentation until and if you are required by the Appropriate Claims Administrator to substantiate allowable debit card usage under the FSA Plan. Note, prescription drug purchases (from drug store merchants registered with IIAC) and fixed copay amounts for medical services that you use your Health FSA debit card to pay for, do not generally require substantiation with the Appropriate Claims Administrator – these are auto substantiated when the related debit card transaction occurs.

ELIGIBLE AND INELIGIBLE HEALTH FSA EXPENSES

There are many eligible expenses approved by IRS regulations (and subject to change from time to time), for your Health FSA funds for you and your qualified tax dependents, including medical, behavioral health, dental and vision care deductibles, copays and co-insurance amounts, prescription drug copays and co-insurance amounts and expenses for many over-the-counter medicines and products. For detailed information on eligible FSA expenses, refer to the Appropriate Claims Administrator employee portal, register/sign-in and click on "Resources", then "Eligible Expenses" and "Health FSA" to review a list of eligible expenses. Alternatively, you can contact the Appropriate Claims Administrator customer service center by phone to make inquiries about eligible expenses.

OVER THE COUNTER (OTC) MEDICINES & PRODUCTS

Over the Counter (OTC) items include medicines/drugs/supplements and products that alleviate or treat injury or illness or are feminine menstrual products and supplies, for you or your qualified tax dependents. These medicines and products must be used for a **medical, dental or vision purpose** only and cannot be cosmetic in nature or merely beneficial to your general health (although some items may also be dual purpose). Additionally, purchases must be in reasonable quantities that can be used in the calendar year in question (no year-end stockpiling or inventory build-up for re-sale or distribution).

OTC medicines/drugs/products (or dual-purpose items that could be either OTC medicines/drugs or general health items), require an adequate receipt to be considered for Health FSA reimbursement, and generally do not require a prescription or letter of medical necessity substantiation. An adequate receipt for any OTC expenses includes: the description/name of the medicine/drug/product, the date purchased, name of the service provider/distributor 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 and product labeling 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 product labeling.

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 $3,300 for calendar year 2026. 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. If you are enrolling as a new employee, only expenses that are incurred **after** your benefits effective date, and during your active employment, will be eligible for reimbursement.

****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. However, if you are enrolled in a City sponsored FSA Health Account in the next calendar year, money left in your account at the end of the preceding calendar year, **up to and including $660**, will not be forfeited but will be rolled over into your next calendar year account (approximately February of the next calendar year). **Remember, to receive any eligible rollover funds in the next calendar year, you must be enrolled in and have an active Health FSA Account when the rollover is processed, otherwise you forfeit the rollover.**

HOW TO SUBMIT HEALTH FSA CLAIMS FOR REIMBURSEMENT

After you are enrolled in the Health FSA, you may use your Appropriate Claims Administrator FSA debit card or 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, or an FSA debit card is used (unless these are all coincidently the same date).

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 initiated when you use the debit card to pay the expense. You should keep itemized receipts and related documentation like an EOB, until and if you are required by the Appropriate Claims Administrator to substantiate debit card usage under the Health FSA Plan. Note, unsubstantiated debit card usage/claims are a debt to the Plan and require repayment of the unsubstantiated amount upon notification from the Appropriate Claims Administrator. If these claims remain

unsubstantiated and have not been repaid by March 31 of the following calendar year, the unsubstantiated amounts may be forgiven and reallocated to taxable income to you (in the next available City paycheck processed for you after the reconciliation/reallocation is finalized), for the calendar year in which the forgiveness of this debt is processed. Under these circumstances, your paycheck may incur a reduction in net pay to reflect the payment of additional tax liability, and your W-2 for that calendar year from the City's payroll department will include the additional taxable income for the preceding calendar year that remains unsubstantiated and uncollected/forgiven. You will be responsible to consult with your tax advisor for further action required by you (if any).

2. **Reimbursement requests** that you initiate and submit to your online account, mobile app, by email, by fax or postal mail to the Health FSA Appropriate Claims Administrator. If you submit your claim online or by mobile app, complete the requested information and provide adequate documentation by upload, fax, email, or postal mail. If you submit both your claim and adequate documentation by email, fax, or postal mail (i.e., not online or via mobile app) you will need to print/complete a Health FSA Claim Form which you can access from the 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 Appropriate Claims Administrator's 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.

3. **FlexConnect** reimbursement management allows you to opt-in through the Appropriate Claims Administrator's member portal or mobile app, to establish a FlexConnect account within the member portal and authorize automatic downloads of your insurance claims (EOB information) directly from your medical, dental or vision plan vendors. FlexConnect prepares and alerts you when your Health FSA claims from this source are ready to be processed. Go into the member portal and click the "reimburse me" button next to each FlexConnect prepared claim when you want the claim to be finalized. Once finalized, payment will be forwarded by check or direct deposit (as you designate), without you needing to gather/submit/upload adequate documentation. **Note, you may not click the "reimburse me" button for a FlexConnect prepared claim if you have already used (or intend to use) your FSA debit card to make payment to the provider for that claim.**

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, but substantiation if applicable, can be accepted until the following March 31.

ANY MONEY LEFT IN YOUR HEALTH FSA ACCOUNT OVER $660 AFTER THE 90-DAY (RUN-OUT PERIOD), WILL BE FORFEITED; LEFTOVER AMOUNTS IN YOUR HEALTH FSA UP TO AND INCLUDING $660 WILL BE ROLLED OVER TO THE NEW CALENDAR YEAR, (USUALLY IN FEBRUARY) AND ADDED TO THE HEALTH FSA DEBIT CARD FOR USE IN THE BALANCE OF THAT CALENDAR YEAR, PROVIDING YOU ARE ACTIVELY ENROLLED IN A CITY SPONSORED HEALTH FSA ACCOUNT AT THAT TIME.

DEPENDENT CARE FSA

The Dependent Care FSA lets you set aside money to pay for eligible child(ren) or dependent elder care services that are needed so you and your spouse (if applicable) can work. 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 unable to provide 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 reimbursed to you in a calendar year from your Dependent Care FSA account. Also, to have the reimbursements from this account be excluded from your income, you must provide a statement/invoice from the service provider each time you submit a claim, 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 camp
- 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), and for whom you can submit a taxpayer ID or social security number

INELIGIBLE DEPENDENT CARE FSA EXPENSES

- Expenses for non-disabled children ages 13 and 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
- Overnight camp fees
- Registration fees
- Transportation expenses
- Late payment fees
- Payment for services not yet provided (more than 30 days in advance) or for services in the preceding or future calendar year
- Medical care
- Payments made to care providers or individuals who do not provide a taxpayer ID or Social Security number

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 $7,500 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 $3,750 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. 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. If you are enrolling as a new employee, only expenses that are incurred **after** your benefits effective date will be eligible for reimbursement.

****IMPORTANT NOTICE: **** 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**.

HOW TO SUBMIT DEPENDENT CARE FSA CLAIMS FOR REIMBURSEMENT

If you are enrolled in the Dependent Care FSA, once payroll deductions for your contributions to your Dependent Care FSA account have been posted to your account and you incur expenses for certain qualifying child or elder care expenses, you can use your Dependent Care FSA debit card to pay for those services. Your dependent care provider must be established as a dependent care service "merchant" who accepts debit/credit card payment transactions. If you also have a Health FSA account for the calendar year in which you have a Dependent Care FSA account, your Dependent Care FSA debit card is a combined card with two separate account balances, one for Dependent Care and one for Health Care FSA balances. You can use your Dependent Care FSA debit card balances to pay for eligible dependent care expenses already received, being received concurrently or up to 30 days in advance of the services being received, providing the services are received in the current calendar year.

Alternatively, you can pay for your qualified dependent care expenses using personal funds on an ongoing basis and submit claims to the Appropriate Claims Administrator after the services have been provided and paid for (online, mobile app, fax, or by postal mail), with itemized receipts. The submitted 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. 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/address and Tax Identification Number or Social Security Number of the service provider. If the claim qualifies as an eligible expense, you will receive a check or direct deposit (if you have opted-in online or by mobile app for direct deposit) from the Appropriate Claims Administrator. Claims may be submitted for reimbursement up to March 31 after the end of the calendar year in which you are enrolled and incur the expense.

ANY MONEY LEFT IN THE DEPENDENT CARE FSA ACCOUNT AFTER THE 90-DAY PERIOD FOLLOWING THE END OF THE CALENDAR YEAR, 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 calendar year to the next, you must **actively enroll** and elect your Annual Election Amount each year during Open Enrollment. This is critically important if you expect to receive any Health FSA rollover funds in the new calendar year. Employees may enroll in the Plan upon becoming employed by the City, during the Open Enrollment period, or if there is an eligible 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 (including no transfers in your combined Health and Dependent Care FSA debit card, as may apply).

CHANGE IN STATUS

The only time you may open a new FSA account or change your Annual Election Amount during the calendar year, outside of the annual Open Enrollment period, 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 that may apply), **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, foster or legal guardianship 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 City benefit programs, 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 or furlough 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.
5. Change that is consistent with your right to Special Enrollment as described in the paragraph on Loss of Other Coverage in the section of this Plan Document dealing with Special Enrollment.
6. **For Dependent Care FSA accounts only:** change Annual Election Amount within 31 days of an event change that is consistent with a change in cost of dependent care coverage, including but not limited to: increase/decrease in the cost of care as a result of moving from one child-care center/provider to another with different rates; increase or reduction in the hours (and cost) of care provided; decreases in cost (up to and including $0), due to care being provided at no charge by relatives, older siblings, telecommuting employee/spouse or other stay-at-home individual).

GENERAL INFORMATION ON HEALTH OR DEPENDENT CARE FSA

Termination of Employment and Effect on FSA:

If you terminate your employment, retire, or become ineligible for FSA Plan coverage while still employed 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 that you incur 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, and Dependent Care FSA debit card transactions will cease on your termination date.
- **Health Care** – participation in the Health FSA will cease (and Health FSA Debit Card transactions 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, during the remainder of the calendar year in which the termination of employment occurred, and during the period until March 31 of the following calendar year.

FSA Plan Accounting:

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

- Account balances, account alerts and transaction history
- View debit card charges for Health FSA and Dependent Care FSA accounts
- Sign up for direct deposit of FSA reimbursements
- Enter requests for reimbursement
- Upload (or mobile app camera) claim documentation
- View reimbursement requests' status
- Opt-in to FlexConnect automatic reimbursement management
- FlexConnect alerts
- Read important messages
- View reimbursement schedules
- If Mobile app – tap to call Customer Service; text messaging account information and alerts
- Use health education tools
- Use Kinside dependent care provider tools and research
- Make FSA Store purchases
- Review FAQ's

LIFE INSURANCE PROGRAMS

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

BASIC GROUP TERM LIFE INSURANCE & ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE
Eligibility:

- **City Manager:** The Basic Group Term Life Insurance Plan covers the City Manager at 200% of annual base salary rounded up to the nearest $1,000, to a maximum of $1,000,000. Basic 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 base salary rounded up to the nearest $1,000, to a maximum of $500,000. Basic AD&D benefits are provided at the same level of coverage as Life Insurance benefits.
- **Full-time Employees**: The Basic Group Term Life Insurance Plan covers full-time employees only, at 100% of annual base salary rounded up to the nearest $1,000, to a maximum of $500,000. Basic AD&D benefits are provided at the same level of coverage as Life Insurance benefits.
- **Elected Officials:** These officials receive $50,000 in Basic Group Term Life Insurance and Basic AD&D coverage.
- **All Groups**: If the amount of basic group term life insurance coverage the City provides to you is **more than $50,000,** there is an imputed income attribution and potential payroll tax withholding on your pay checks for the calculated value of this received benefit – required by IRS regulations.
- **Dependents and part-time employees are not eligible for Basic Group Term Life and Basic AD&D coverage.**

Effective Date: Coverage will be effective on the first day of the month following your date of hire. If you are not actively at work on the day you become eligible (except for regular days off), you will become eligible on the day you return to active work (although any required premiums for the coverage will commence as of the first of the month following your hire date). Enrollment for Basic Group Term Life and AD&D Insurance occurs automatically at the time of eligible new hire system processing with the City of Mesa.

Coverage End Date: Coverage ends on the last day of employment and/or the date you enter an ineligible job classification (portability or conversion privileges with the applicable insurance carrier, may be available to you thereafter). If termination of employment is due to total disability, you can apply for a subsequent extension of Group Term Life insurance coverage, with a waiver of premium provision. Contact the Employee Benefits Administration Office for information and processing.

Beneficiary Designation/Changing the Beneficiary: If you die while insured, the amount of Group Term Life Insurance Benefits as indicated above under Eligibility, will be payable to your beneficiary. You may elect or change your beneficiary designation 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, Group Term Life/AD&D benefits (if applicable), will be paid in a lump sum to the survivors per the guidelines of the life insurance/ AD&D insurance company. If none of the above survives, benefits will be paid in a lump sum to your estate.

BASIC ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE
This benefit is provided to full-time employees and Elected Officials at no cost and is automatically enrolled when first eligible. If, as an employee covered under this Plan, you die because of an accident, the AD&D benefits provided will be equal to your Basic Group Term Life Insurance coverage amounts (described above) and will be payable to the Basic Group Term Life Insurance beneficiary of record. If, however, you receive a bodily injury covered by the AD&D Plan (including but not limited to dismemberment, loss of sight/hearing/speech, paralysis or brain damage), benefits will be payable proportionately up to 100% of the coverage amount depending upon the type of loss. 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 AD&D benefits other than for loss of life will be paid to you.

VOLUNTARY GROUP TERM LIFE INSURANCE AND VOLUNTARY AD&D INSURANCE

In addition to the Basic Group Term Life and AD&D Insurance previously described, the City offers a Voluntary Group Term Life and AD&D Insurance Plan to full-time and part-time benefit-eligible employees and Elected Officials. You may elect to have yourself, your spouse/committed partner and/or child(ren) covered under the Voluntary Group Term Life and AD&D Insurance Plan. Eligible dependents under this Plan include your legal spouse/committed partner and children from birth to age 26 (or disabled adult children who are age 26 or more who remain unmarried and dependent upon you for support after age 26) or as defined by the insurance carrier insuring and administering this Plan.

You and/or any of your eligible and covered family members will automatically be enrolled in the same amount of coverage for Voluntary AD&D Insurance as you have for Voluntary Group Term Life. The City does not contribute to the cost of Voluntary Group Term Life Insurance or Voluntary AD&D Insurance – premiums for this coverage are your responsibility and are deducted on an after-tax basis via payroll deductions (or direct billed to you should you be on an unpaid authorized leave of absence).

Voluntary Group Term Life Insurance coverage for employees can be elected in $50,000 increments up to a maximum of $1,000,000, with guaranteed issue (GI) available up to $300,000. Spouse/committed partner coverage can be elected in $50,000 increments up to $500,000 with guaranteed issue (GI) up to $50,000. GI is the amount of coverage that you can elect without providing evidence of insurability to the insurance carrier. Dependent children up to age 26 can be covered for $5,000, $10,000, 15,000 or $20,000 (i.e., in $5,000 increments) for all children in your family that you are eligible to cover and with no evidence of insurability required. You pay one "all child(ren)" premium for the coverage amount you elect, not a separate premium for each child. The premiums for all Voluntary group term life and AD&D insurance coverage are deducted through after-tax payroll deduction from the first two paychecks of each month.Effective January 1, 2026, with the introduction of a new insurance carrier for Voluntary Group Term Life and AD&D coverage, employees (and spouse/committed partner as applicable) can automatically continue coverage amounts in force through December 31, 2025, even if those coverage amounts are not at a $50,000 increment level. During future Open Enrollment periods (or applicable qualifying event occurrences), you (or spouse/committed partner as applicable) can 1) opt-out of coverage or, 2) reduce coverage to a lower $50,000 increment level (with a minimum of $50,000) or, 3) increase coverage by one $50,000 increment up to the maximums described above (and with evidence of insurability for coverage increase amounts above respective guaranteed issue amounts).

"All children" voluntary life insurance coverage in force during the 2025 Open Enrollment period will be automatically activated in the enrollment system at the closest amount of coverage to the amount in force as of October 1, 2025. For example, child(ren) coverage at $2,500 and $5,000 on October 1 will be activated at $5,000 coverage in the enrollment system and similarly $7,500 and $10,000 coverage will be activated at $10,000 coverage in the enrollment system for a January 1, 2026, effective date. Additionally, you have the option in Open Enrollment to actively opt-in or change child(ren) life insurance coverage to any of the available coverage increments and automatically override any opt-out or coverage that was activated and intended for January 1, 2026, child(ren) voluntary life insurance coverage.

For new employees (or spouses/committed partners or dependent children) who elect to participate in this coverage, the effective date of Voluntary Group Term Life and AD&D insurance coverage will be the first day of the month following your date of hire (for both you and your enrolled family members). If you are not actively at work (except for regular days off, holidays or vacation) on the day you would normally become first eligible and enrolled, you will be eligible on the day you return to active work (although premiums are due from the first of the month following your date of hire).

Late enrollees are employees (or spouses/committed partners) who do not have **any** Voluntary Group Term Life and AD&D insurance coverage in force with the City of Mesa at the time of the late enrollment. Late Enrollees may elect Voluntary Group Term Life and AD&D Insurance coverage during an annual Open Enrollment period or upon certain qualifying events. The amount of coverage available to Late Enrollees (and Late Enrollee spouse/committed partners) is the same as for new hire employees except that evidence of insurability (EOI) approval is required for all amounts of elected coverage. There is no Guaranteed Issue for Late Enrollees except if the Late Enrollee is electing coverage for the first time as of January 1, 2026, with the City's transition to a new insurance carrier (as described above).

Beneficiary Selection: When you apply for coverage under this Plan, you must choose a beneficiary, using the procedure described above for Basic Group Term Life Insurance. You may designate the same or different beneficiaries for your Voluntary Group Term Life Insurance as compared to the beneficiary designations you make for Basic Group Term Life Insurance coverage. Your Voluntary AD&D Insurance benefits will be payable to the Voluntary Group Term Life insurance beneficiary of record. You will be the beneficiary for your spouse and children covered under this Voluntary Group Term Life and AD&D Insurance.

(STD) INSURANCE

Voluntary Short-Term Disability Insurance (STD) is a benefit offered by the City to full-time and part-time benefit eligible employees. This benefit is designed to protect a portion of your salary when you cannot work because of an accident, illness, or pregnancy (and not resulting from self-inflicted injuries, active participation in a riot, commission of a crime, during incarceration or due to war (declared or undeclared). 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.

Eligibility: Full-time and part-time benefit eligible employees are eligible for this benefit as of the first of the month following the date you enter an eligible group, or subsequently as of any January 1 following a timely annual Open Enrollment period enrollment.

Premiums: You pay the full premium owed for this coverage (no City contributions). Premiums are payable through after-tax payroll deductions in the first two pay checks of each month (unless on unpaid leave of absence and/or receiving short term disability benefits, in which case direct billings from Payroll following the first two pay periods of each month). The premium rate/amount depends upon the Plan elimination period you choose (higher premiums for shorter elimination periods) and the amount of weekly benefit you would receive if an approved STD claim were paid to you.

Benefits: There are three STD Plan options:

- 14-day elimination waiting period, or
- 29-day elimination waiting period, or
- 44-day elimination waiting period

Weekly Benefit Amount: 66.67% of base weekly earnings to a maximum benefit of $2,000 per week and minus any applicable deductible sources of other income (e.g. sick pay, retirement system payments, third party judgements or settlements, social security disability payments or worker's compensation income payments).

Definition of Disability: the insurance carrier makes the determination of your status/eligibility if you file a claim for short-term disability benefits (with all required documentation), are continuously disabled through your elimination period, and:

- You are limited from performing the material and substantial duties of your regular occupation with the City due to pregnancy, sickness, or injury, and
- You have a 20% or more loss in weekly earnings due to this same disability, and
- You are under the regular care of a physician during the disability period

Late Entrant Waiting Period Expansion/Benefit Period Limitation: there is a limitation on the number of days (paid weekly) of disability payment for which you are eligible, if you are a Late Entrant (i.e. go from opted out to enrolled more than 31 days after initially eligible). For example, if you do not enroll in any plan option when first eligible as a new hire but elect enrollment in a subsequent Open Enrollment period you would be considered a Late Entrant. Late Entrants are subject to a 60-day waiting period (regardless of the Plan option elected) for each illness (including pregnancy) but not injury related disability claim that is filed within the first 12 months after coverage is in force. Thereafter, waiting periods revert to 14, 29, or 44 day periods depending upon the plan in which you are enrolled.

Maximum Benefit Period:

- 26 weeks (including "unpaid" benefit waiting periods of 14, 29 or 44 days respectively or 60-day waiting periods for Late Entrants)

This chapter briefly outlines information about the Short-Term Disability coverage. For a more detailed explanation, including limitations, exclusions and other terms and conditions of this insurance, refer to the insurance company handbook (Certificate of Insurance) available in the Employee Benefits Administration Office and online at www.mesaaz.gov/benefits.

LONG TERM DISABILITY (LTD) INSURANCE

The City of Mesa participates in four 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 Elected Officials Retirement Plan (EORP), one for members of the Arizona State Retirement System (ASRS) and another fully insured secondary program with a contracted insurance provider for sworn members of both PSPRS and EORP retirement system/plans. This chapter section highlights some of the key aspects of these long-term disability benefits (partial income replacement when you are unable to work due to a covered illness, injury, or pregnancy on or off the job). However, the disability carrier or third-party administrator's certificate/policy dictates the exact benefits of each of the LTD Plans.

LTD benefits are partially or fully taxable income to you (depending upon whether you are receiving benefits from a retirement system or a supplemental secondary program, or both) and are subject to applicable tax laws, including Arizona State income 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) AND ELECTED OFFICIALS' RETIREMENT PLAN (EORP) MEMBERS – MEDICAL RETIREMENT DISABILITY BENEFITS

Employees who are members of the Public Safety Personnel Retirement System and the Elected Officials Retirement Plan 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. Membership in PSPRS/EORP requires a pension contribution which is deducted on a before tax basis from your biweekly salary as a mandatory deduction and subject to change each fiscal year based upon PSPRS/EORP rules and requirements. The City also contributes an equivalent or better amount to the respective pension systems/plans depending upon the rules and requirements of those systems/plans.

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 Arizona 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 received from other sources if any, and a minimum monthly benefit of $50. The cost of this coverage is included in your Arizona State Retirement System pension contribution (which is deducted on a before tax basis from your biweekly salary as a mandatory deduction and subject to change each fiscal year based upon ASRS rules and requirements). The City of Mesa also contributes an equal amount to the cost of this pension and disability coverage.

SECONDARY LONG TERM DISABILITY INSURANCE BENEFITS FOR PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM (PSPRS) MEMBERS AND ELECTED OFFICIALS' RETIREMENT PLAN (EORP) MEMBERS:

Employees enrolled in the Public Safety Personnel Retirement System and Elected Officials Retirement Plan have fully insured secondary Long-Term Disability (LTD) coverage through an insurance carrier listed on the Quick Reference Chart in the Introduction chapter of this document. Members must satisfy a 180-day (6-month) elimination (waiting) period while disabled, before any LTD benefits under this insurance policy can be paid (and assuming that a claim has been filed within twelve (12) months of the commencement of a total disability).

Under the secondary insurance policy, during the first two years of disability, the definition of disability is "unable to perform the essential duties of the own occupation". After two years, the employee must be "unable to perform all material duties of ANY occupation for which he/she is or may reasonably become qualified, based upon education, training or experience". Benefits payable equal 60% of your base monthly earnings (to maximum monthly earnings of $8,333) when the disability commenced, **reduced** by income receipts from other sources if any (e.g., PSPRS/EORP Medical Retirement disability benefits, Workers' Compensation benefits, SS disability benefits). The maximum monthly benefit is $5,000 and the minimum monthly benefit is $100. The maximum benefit period under this policy is normal retirement age (65), unless the date of disability commenced at age 60 or greater, in which case the maximum benefit period will be to a maximum of 60 months at age 60, 48 months at age 61, 42 months at age 62, 36 months at age 63, 30 months at age 64, 24 months at age 65, 21 months at age 66, 18 months at age 67, 15 months at age 68 and 12 months at age 69 or over. This coverage is provided at no premium cost to you (100% City paid) and any benefits received are taxable income amounts.

BUSINESS TRAVEL ACCIDENT/COMMUTER TRAVEL ACCIDENT INSURANCE

The City provides Business Travel Accident/Commuter Travel Accident Insurance (BTA) to full-time employees and Elected Officials. This policy provides a $200,000 death benefit to your beneficiaries if you die due to an accident that occurs while you are travelling on City business or commuting to or from work with the City, using your normal route. The policy also provides proportional benefits to you (up to the $200,000 death benefit amount) if you incur an accidental business travel related bodily injury covered by the BTA Plan (including but not limited to dismemberment, loss of sight/hearing/speech, paralysis, or brain damage). The beneficiary designation(s) that you make for your Basic Group Term Life Insurance coverage are automatically the beneficiary designations for your BTA coverage.

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 about those claims. **Claims covered by these procedures include those claims filed under the Medical Plan (including the Behavioral Health benefits and the Prescription Drug benefits) and the Dental Plan.** For claims administration and appeals processes 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 ensure 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 **give 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 electronic or **written** proof of claim (itemized bill with diagnostic and procedure codes 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 Medical Network Providers and Dental Network Providers: If eligible services are provided through one of the Plan's provider network organizations, the 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 network provider directly, and in accordance with the benefit provisions of the Plan. Network 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 network providers may not require coinsurance or deductible at the time the service is rendered but will bill you AFTER the provider has received payment from the Plan. Also, your portion of the coinsurance should be based on the allowed amount to the network provider and not the total billed charges (unless such amounts are the same);
2. Send the initial bill for services to you; instead, the network provider must bill the Plan directly by sending the initial claim to the Appropriate Claims Administrator.

If a network provider does not adhere to the above claim/fee submission guidelines, contact the Appropriate Claims Administrator for assistance. If however, you pay a network Provider an amount more than 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 network provider directly.

Claims When Using Non-Network Providers: Non-network 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-network providers may also require you to pay (at the time service is rendered) for all or part of the charge for the services they provide. Once the non-network 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-network provider claim to be considered for processing, the claim must list the following information (sometimes called a "super bill":

- Patient's name, Plan ID number, address and date of birth
- Member or Subscriber's name, Plan ID number and date of birth
- An itemized description of the services or supplies provided using proper coding techniques
- Details of the charges for those services or supplies

- Diagnosis and procedure code(s) including modifiers
- Date(s) and location where the services or supplies were provided
- 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.

Note: If **you** pay a non-network 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. A receipt indicating payment must be submitted along with the claim for you to receive the reimbursement payment. Payments more than $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 for your portion of eligible charges.

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-Network 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 for 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). 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 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 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 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 facts.

REQUIRED INFORMATION IF YOU ARE ENROLLED IN 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 later.

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 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, 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 there is an adverse effect on any specific 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 cost allowed 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/Prescription Drug 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/Prescription Drug 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/Prescription Drug 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 reserve 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 decide 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 is extended due to failure to submit information, the 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 decide 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) about 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 per 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 levels of appeal review. 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 considers 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 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 about 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 about 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 level appeal 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 request
   - 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

   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 or mediation 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 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 considers 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 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 about 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 about 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
5. This concludes the urgent care claim appeal process under this Plan. **This Plan does not offer a voluntary appeal or mediation 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 per 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 per 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 the 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 considers 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 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 about 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 about 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
5. This concludes the concurrent claim appeal process under this Plan. **This Plan does not offer a voluntary appeal or mediation 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/Prescription Drug 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 is extended due to failure to submit information, the 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 are 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 electronically, 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 electronically, 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 levels of appeal review. 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 considers 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 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 about 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 about 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. 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.
6. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit, the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, or the subordinate of any such individual.
7. 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

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

Overview of Claims and Appeals Timeframes				
	Urgent	**Concurrent**	**Pre-service**	**Post-service**
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 a 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 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 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 the information and documents received in a 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, 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 (because the new information) the Plan reverses its denial and provides coverage, a Notice is provided to claimant and IRO	Within 1 business day of the Plan's decision	Expeditiously
External Review decision by IRO to claimant and Plan	Within 45 calendar days of the IRO's receipt of the request for external review	As expeditiously as the claimant's medical condition or circumstances require but in no event more than 72 hours after the IRO's receipt of the request for expedited external review. (If notice is not in writing, within 48 hours of the date of providing such non-written notice, IRO must provide written notice to claimant and Plan.)
Upon Notice from the IRO that it has reversed the Plan's adverse benefit determination	Plan must immediately provide coverage or payment for the claim	Plan must immediately provide coverage or payment for the claim

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 based on 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 procedure 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/Designee or Appropriate Claims Administrator 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 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

https://insurance.az.gov

GRIEVANCE PROCEDURE FOR NONDISCRIMINATION PROVISIONS OF AFFORDABLE CARE ACT EFFECTIVE JANUARY 1, 2017

See the Required Notices Section of this Plan Document for Affordable Care Act Nondiscrimination Notice and related Grievance Procedures.

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/prescription drug benefits (including Behavioral Health) and/or dental benefits under this Plan and may also be entitled or required 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 or alternatively, circumstances that may result in you and/or your covered Dependents being reimbursed for your healthcare expenses from some other source in primary position (first) and this Plan in a secondary position or not at all. Either of these outcomes 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
3. Workers' Compensation.

This Plan operates under rules that prevent it from paying Benefits which, together with the benefits from other sources described in the above paragraphs, would allow you to recover more than 100% of eligible expenses you incur, or operates to prevent the Plan from paying any benefit at all (or a partial benefit as may apply) if another plan is responsible for all the benefit to which you or your covered dependents are entitled . In many instances, you may recover less than 100% of those eligible expenses from the duplicate sources of coverage or recovery, depending upon the rules of those sources, as applicable deductibles, copays and/or coinsurance may still prevail. **This Plan will not provide any coverage if you are eligible to recover from Workers' Compensation sources.**

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 for 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 may have more than one family member working outside the home who are covered by more than one group health plan. If this is the case with your family, **you must let the Medical and Prescription Drug Appropriate Claims Administrator(s) know about all your family coverage in advance of or in conjunction with when you or your providers 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 Allowed expenses.** Sometimes, the combined benefits that are paid will be **less than** the total Allowed expenses.

NOTE:

- **The City of Mesa Health Plan does not coordinate benefits as a secondary payor with primary plans in which the claimant's responsibility for any specific claim is a copayment and,**
- **The City of Mesa Health Plan does not coordinate benefits as a secondary payor on outpatient prescription drugs regardless of plan type. If the City's Health Plan is secondary on outpatient prescription drugs that are covered under another primary coverage plan, you must present your primary coverage credentials when purchasing these prescription drugs. You may not choose to use the City's Prescription Drug benefit in primary position if it should be in secondary position, regardless of which Plan has the best out-of-pocket outcome for you or your covered dependents.**

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: because 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 or 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 pays first; and the plan that has covered the other parent for the shorter period 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 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 determine the order of benefits, the plan that covered the person for the longer period pays first; and the plan that covered the person for the shorter period 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.

MEDICARE AND OTHER COVERAGE PROVIDED/REQUIRED BY FEDERAL OR STATE LAW - COORDINATION OF BENEFITS

Medicare Eligibility: 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 becoming age 65, you may either retain or cancel your and their coverage under this Plan, as may apply.

Medicare and Participation in Active Employee Medical Plans: If you retain your or your spouse and/or Dependent Child(ren) coverage under this Plan and you or they are also Medicare eligible or become Medicare eligible and you remain actively employed, this Plan's benefits and your contributions for coverage will remain the same, and this Plan continues to pay first, and Medicare pays second.

Medicare and Participation in Retiree Medical Plans: If you, your spouse or Dependent Child(ren) are enrolled in a Retiree Medical Plan under this Plan and you or they are also Medicare eligible or become Medicare eligible, Medicare pays first, and this Plan pays second.

Medicare and Total Disability: If you become totally disabled and 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 you and 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 actively employed (medically retired) and will be enrolled (if otherwise eligible) in Retiree Medical Plans under this Plan. Under these circumstances, 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 an end-stage renal disease (ESRD) diagnosis, this Plan continues to pay 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 (if applicable). 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 (also called Medicare + Choice or Part C): This Plan does not coordinate with Medicare Advantage plans.

Medicare and Medicare Private Contracts or When Using Non-Medicare Providers: 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. Claims filed on this Plan by a Private Contract Provider, or a non-Medicare contracted provider (or by the Medicare eligible participant) with the Appropriate Claims Administrator, must include documentation of the Medicare private contract arrangement or non-Medicare provider status, for the Plan to pay normal plan benefits for eligible services.

When Covered by this Plan and by a non-City sponsored Medicare Part D Plan Prescription Drug Plan: If you are an active employee and have dual coverage under both this Plan and a Medicare Part D Plan, this Plan will not coordinate that dual prescription drug coverage with a Medicare Part D plan. **You must choose which prescription drug coverage you want to use when purchasing outpatient retail or mail order prescription drugs.** Effective January 1, 2017, if you are a Medicare eligible retiree enrolled in a Retiree Medical plan under this Plan, you must opt-in to City sponsored Medicare Part D Prescription Drug benefits for eligible retirees and individuals and dis-enroll from any other Medicare Part D coverage you have.

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 because 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 (VA) Hospital or facility because 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, 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, this Plan pays first and does not coordinate benefits with the Motor Vehicle coverage.

Workers' Compensation Coverage: 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 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.

HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY TO OTHER COVERAGE

When this Plan pays **second to Medicare or other group health care coverage**, this Plan may reduce its benefits so that the total benefits paid by all plans including this Plan, are not more than 100% of "Allowable Expenses". This Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under this Plan that is unpaid by the plan or plans that calculated first (primary plans). This Plan will credit Plan deductibles and coinsurance (but not copays) that it would have credited in the absence of other health care coverage. In addition, when this Plan pays second, it will never pay more than it would have paid for each claim as it is submitted (Plan's normal liability), had it been the Plan that paid first. If Medicare or other group health care coverage that calculated first, deny an expense that is covered by the Plan, the Plan may pay primary for that expense if it is otherwise an eligible covered expense under the Plan.

For purposes of Coordination of Benefits, "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 based on Allowable Charges, any amount more than the highest Allowable Charge is not an Allowable Expense.
- If the coordinating plans provide Benefits or services based on negotiated fees, any amount more than the highest of the negotiated fees is not an allowable expense.
- If one coordinating plan determines Benefits based on Allowable Charges and the other coordinating plan provides Benefits or services based on 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.
- 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 COORDINATION OF BENEFITS (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 the Appropriate Claims Administrator determines to be proper under this provision. Any amounts so paid will be benefits paid 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 (or applies any applicable coordinating primary plan deductible), for otherwise Plan covered expenses, 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: 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.

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. This chapter explains when and how this continuation of coverage occurs. Continuation of coverage does **not** apply to life insurance, accidental death and dismemberment, short-term disability, long-term disability or other income replacement coverage. See the Life/AD&D 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 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 in full at their own expense. **Note, Committed Partners and Committed Partner child(ren) are not Qualified Beneficiaries and therefore not entitled to COBRA Continuation coverage (except that Committed Partners and Committed Partner child(ren) are eligible for the same COBRA Continuation coverage as other Qualified Beneficiaries when the Qualifying Event is death of the employee or retiree).**

This notice is provided to all covered Employees and 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 COBRA law itself. Note: It is important that you and your spouse and adult covered family members 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** because 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 legal 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, stepchild, foster child or legal guardianship child 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 (as specified in the law) occur, **and**, because 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 with active employment health plan coverage, even though entitled to Medicare) then COBRA is not yet offered.

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 enroll and 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 a further 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 Medicare benefits within the 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 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 voluntary or involuntary termination of employment (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 e.g., ages out	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)
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 e.g., aging out, loss of child relationship status, 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. **<u>you</u> notify the COBRA Administrator** that a Dependent Child lost Dependent status (and must be removed from active coverage), you divorced or have become legally separated (and must remove your former/separated spouse from active coverage), or you have become entitled and enrolled in Medicare (and wish to terminate your active enrollment status)

then the COBRA Administrator will give you and/or your covered Dependents as may apply, notice of the date on which your and/or their active 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 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 the notice date, you and/or they will have no group health coverage from this Plan after the date coverage ended.

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 the full cost for it (plus a statutorily allowed monthly administration fee), and unless you are eligible for a subsidy towards that full cost, as may otherwise be provided by federal or state law under limited circumstances. 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 and about grace periods for payment of those amounts. If there is a change in the health coverage and cost provided by the Plan to similarly situated active employees and their families, that same change and/or cost impact 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 you 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 must 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% to the full cost 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 with a 30-day grace period (including the 1st of the month) to make those payments**. If payments are not made on or before the end of the grace period, COBRA Continuation Coverage will be canceled as of the last day of the month for which full premium payment was received. Payment is considered made when it is postmarked. You will be responsible to reimburse the Plan for any claims incurred and paid after the termination date of COBRA continuation coverage.

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 Eligibility will be confirmed by the City's Employee Benefits Administration office (upon

request), 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 COBRA Continuation Coverage period, 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 your 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 because of loss of eligibility for the coverage, or termination because 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 thus, 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 your 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 due to disability as described in the following section). Thus, 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 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 (if any) 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 Circumstances

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 of a covered child **ceasing 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 a loss in coverage requiring COBRA to be offered. If a qualified beneficiary rejects the COBRA coverage, the alternative plan is 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 period can be credited toward covering the 18, 29, or 36-month COBRA period. For example, if an employee can maintain the same coverage and premium for six months while on a 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 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 decide 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.

REQUIRED NOTICES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act), signed into law on September 26, 1996, requires health plans that offer maternity coverage to pay/provide benefit coverage for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).

This law was effective for group health plans for plan years beginning on or after January 1, 1998.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48-hours following a vaginal delivery, or less than 96-hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48-hours (or 96-hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48-hours (or 96-hours, as applicable).

AFFORDABLE CARE ACT NONDISCRIMINATION STATEMENT AND GRIEVANCE PROCEDURES (EFFECTIVE JANUARY 1, 2017):

City of Mesa Health Plan complies with applicable Federal civil rights laws and does not discriminate in health programs and activities based on race, color, national origin, sex, age, or disability. The Health Plan has adopted an internal grievance procedure providing for prompt resolution of complaints alleging discrimination based on these factors. The Plan Administrator (or designee) has been designated as the Grievance Coordinator for these purposes (address and contact information described in the General Information section of the City of Mesa Health Plan Document). Applicable grievances must be submitted in writing within sixty (60) days of awareness of the alleged discriminatory action and include the following information: name and address of person filing the grievance, problem or actions alleged to be discriminatory (including relevant evidence) and remedy or relief sought.

The Grievance Coordinator will review the complaint/submitted evidence and issue a confidential written decision no later than thirty (30) days after the grievance is received and including a notice of the right to pursue further administrative appeal with the Plan's Employee Benefits Advisory Committee (EBAC), within fifteen (15) days of receiving the Grievance Coordinator's decision. EBAC will meet to discuss the appeal at the next scheduled time (monthly) and issue a written decision no later than thirty (30) days after Committee review of the appeal.

The availability and use of this internal grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination, in court or with the U.S. Department of Health and Human Services, Office of Civil Rights, within one hundred and eighty (180) days of the date of the alleged discrimination, electronically at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail (complaint forms available online at http://www.hhs.gov/ocr/office/file/index.html) to: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509H, HHH Building, Washington, D.C 20201.

City of Mesa Health Plan will make appropriate arrangements to ensure that individuals with disabilities and/or limited English proficiency are provided services and assistance to participate in this grievance process and/or generally participate in Health Plan enrollment, claims and other benefit services.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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, distributed to you upon enrollment in the Plan, and also available in the Employee Benefits Administration Office or via our website at www.mesaaz.gov/benefits. For your convenience, the Plan's Notice of Privacy Practices is also contained in this Required Notices section of the Plan Document.

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. 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.
     f. To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.
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 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:
   a. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law.

b. 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.
c. Not use or disclose the information for employment-related actions and decisions.
d. 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).
e. 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.
f. Make PHI available to the individual in accordance with the access requirements of HIPAA.
g. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA.
h. Make available the information required to provide an accounting of PHI disclosures.
i. 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
j. 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.

4. 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:
    - Plan Administrator,
    - Employees of the City of Mesa Employee Benefits Administration Unit,
    - Staff designated by the Plan Administrator, such as Payroll staff, certain other City staff that provide financial, technological, and administrative support and assistance and the Employee Benefits Advisory Committee for appeals and grievances, and
    - Business Associates under contract to the Plan including but not limited to employee benefits consultant staff, medical, dental and vision plan preferred provider organization network, Appropriate Claims Administrators, Utilization review/case management/disease management entities, prescription benefit manager and subsidiary entities, and employee assistance program administrator.
5. The persons/entities described 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.
6. **Effective April 21, 2005, in compliance with HIPAA Security** regulations, the Plan Sponsor will:
    - 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.
    - Ensure that the adequate separation discussed above, specific to electronic PHI, is supported by reasonable and appropriate security measures.
    - 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
    - Report to the Plan any security incident of which it becomes aware concerning electronic PHI.
7. We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

NOTICE OF PRIVACY PRACTICES **(Updated Effective February 16, 2026)**

This notice describes how health plan medical information about you may be used and disclosed and how you can get access to this information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, imposes conditions on how a group health plan may use and disclose your individual health information, referred to here as "protected health information", or "PHI." It also gives you certain rights with respect to that information. The City of Mesa Health Plan (self-insured group health plan, which includes

Medical, Pharmacy, Dental, fully insured Vision Care and Flexible Spending Accounts as sponsored by the City of Mesa.), (hereafter referred to as the "Plan"), is required by law to take reasonable steps to maintain the privacy of your personally identifiable health information. The plans covered by this notice may share health information with each other to carry out Treatment, Payment, or Health Care Operations, a described below. *These plans are collectively referred to as "the Plan" in this notice, unless specified otherwise.* It is important to note that HIPAA's privacy rules only apply to health plans. Different privacy or confidentiality policies may apply to other City of Mesa sponsored programs, such as life insurance or disability.

Your Privacy Practices Rights:

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices:

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures:

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions. To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records:

- You can ask to see or get a copy of your health and claims records and other health information we have about you.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records:

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications:

- You can ask us to contact you in a specific way (for example, home, office, or mobile phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share:

- You can ask us not to use or share certain health information for treatment, payment, or our operations.

- We are not required to agree to your request, and we may say "no," for example, if it could affect your care. If we agree to your request, we may still share this information if you need emergency treatment.

Get a list of those with whom we've shared information:

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:

You can ask for a paper copy of this notice at any time and we will provide you with a paper copy promptly.

Choose someone to act for you:

- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:

- You can complain if you feel we have violated your rights, by contacting us.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **https://www.hhs.gov/hipaa/filing-a-complaint/index.html.**
- We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share: if you have a clear preference for how we share your information in the situations described below tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the below cases, we *never* share your information unless you give us written permission:

- Marketing purposes or Sale of your information

Our Uses and Disclosures:

How do we typically use or share your health information?

- **Help manage the health care treatment you receive:** We can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
- **Run our organization:** We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. *Example: We use health information about you to develop better services for you.*
- **Pay for your health services:** We can use and disclose your health information as we pay for your health services. *Example: We share information about you with your dental plan to coordinate payment for your dental work.*
- **Administer your plan:** We may disclose your health information to your health plan administrator for plan administration purposes.
- **How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Help with public health and safety issues: We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Comply with the law: We will share information about you when state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director: We can share health information about you with organ procurement organizations and we can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: we can use or share health information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions: we can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

How to Exercise Your Rights in This Notice or for Additional Information: you should contact:

Privacy Officer
Employee Benefits Administration
20 E. Main Street, Suite 600
Mesa, AZ 85201
Phone: (480) 644-2299 Fax: (480) 644-3013

Complaints: if you believe that your privacy rights have been violated, you may file a written complaint with the Plan in care of the Plan's Privacy Officer, at the address listed above. Additional information on how to file a complaint is available on the Department of Health and Human Services website at *www.hhs.gov/ocr/hipaa/*. You will not be retaliated against for filing a complaint.

Changes to the Terms of this Notice:

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, and on our web site.

GENERAL INFORMATION

NAME OF THE PLAN: 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 or service agreements with insurance vendors such as the vision plan, EAP, life insurance, accidental death and dismemberment insurance, business travel accident/commuter travel accidental death insurance, short term disability, long term disability for sworn personnel and elected officials, legal/identity theft services and pet care membership discount services. Refer to the Quick Reference Chart in the Introduction chapter of this document for the names of any insurance companies or service providers administering or insuring these benefits.

Other services are self-insured by the City or member employees, including the Medical/Behavioral Health/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 specific stop-loss reinsurance for Plan Expenses in the self-insured portions of the medical and prescription drug benefit plans. Specific stop-loss insurance reimburses the Plan for certain losses more than 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.

PLAN ADMINISTRATOR:
The City of Mesa Employee Benefits Administrator is the Plan Administrator. The Plan Administrator is 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 to 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 notification 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.

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 **31 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:

8. Change of name.
9. Change of address.
10. Marriage, divorce, or death of you or any covered Spouse/Committed Partner or Dependent Child.
11. Any information regarding the status of you, your Spouse/Committed Partner, or a Dependent Child, including, but not limited to:
    a. The Dependent Child reaching the Plan's limiting age for their relationship status; or
    b. The existence of any physical or mental Disability or the fact that a disability no longer exists.
    c. Medicare enrollment or disenrollment (notify applicable Appropriate Claims Administrators).
    d. 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.

DEFINITIONS

The following are definitions of specific terms and words used in this document or clarify 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, because 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 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 or during authorized teleworking periods. 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 workday immediately preceding that day. Note that this actively at work provision is not applicable to employees who are 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 are 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 or dentally 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 or dentally 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 the Appropriate Claims Administrator (and/or it's contracted cost containment affiliates) to assist in determining the amount the Plan will allow for the submitted non-network 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 or preventable facility-acquired conditions. (See Definition of "Never Events" below.)

Any amount more than 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 Care services including Emergency Ambulance services**, the Plan allowed charges are the **greater** of:

- Billed charges reduced for cost sharing, or

- the negotiated amount for in-network providers (the median amount if more than 1 amount to in-network providers) reduced for cost sharing, or
- 100% of the Plan's usual payment (Allowed Charge) formula reduced for cost-sharing, or
- (if such data 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 services as those terms are defined in this Plan. Refer to the Schedule of Medical/Prescription Drug 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 transportation includes transportation of individuals who cannot use public or private transportation because of their medically necessary requirement to be positioned in a wheelchair or stretcher or otherwise provided with medical services during transportation. Non-emergency medical services transportation and medical services during transportation 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 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 each 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, Ambulatory Surgical Facility, or other Specialized Health Care Facility other than room and board and secondary or assisting Health Care Practitioners, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., anesthesia 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 Appropriate Claims Administrator to be medically necessary; and
3. the assistant surgeon actively participated in the surgical procedure (was not stand-by or merely observational).

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 and the member paid deductibles, copays, or coinsurance, and what the provider billed/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 may 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 patient's child.

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 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 may be covered under the Drugs and Medicines section of the Schedule of Medical/Prescription Drug Benefits of this Plan.

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated, and staffed primarily for 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 each 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 newborn 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 each of the following requirements:
   - It is operated and equipped in accordance with any applicable state law for 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 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:

$$\text{BMI} = \frac{\text{(weight in kilograms)}}{\text{(height in meters) times (height in meters)}}$$

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 Claims 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 the related 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 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 carrier or 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.

Continuity of Care: See the definition of Transition of Care/Continuity of Care.

Contract Year: The period 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 or dentally necessary services or supplies to contracted network providers. With respect to a network provider, 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 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 if less.

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 more than 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 in-network allowed charge amount on an eligible claim exceeds the actual billed charges, the participant will pay their coinsurance on the lesser amount (on the billed charges), and the Plan will pay their coinsurance on the allowed charge amount, plus, the Plan will pay the participant's additional coinsurance responsibility on the difference in the 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 or Medicare 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, Dental 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 specific 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/Designee or Appropriate Claims Administrator.

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 and payment for (if applicable) coverage under the Plan and is covered by one or more parts of 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 individual and family deductible applied to non-network services. See the Schedule of Medical/Prescription Drug 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.

Subspecialty	Diagnosis, Treatment or Prevention of Diseases Related To:
Oral Surgery	extractions and surgical procedures of the mouth.
Orthodontics	abnormally positioned or aligned teeth.
Pedodontics	treatment of dental problems of children.
Periodontics	structures that support 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 (or age 18 if a legal guardianship child) whether married or unmarried**:

- natural children (son or daughter),
- legal foster children,
- stepchildren (who are the natural, adopted, legal foster or legal guardianship children of the employee's or retiree's legal spouse or authorized Committed Partner),
- legally adopted child(ren) or children placed for legal 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 (see definition of Disabled and Totally Disabled) 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 Disabled Adult 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 mental or physical condition, illness, or injury 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 (18th birthday if a legal guardian child), 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 or Disabled Adult 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 under age 18); children of a former spouse or former Committed Partner unless employee or retiree has adopted or attained legal guardianship of children.

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 (providing any required premiums are paid timely) 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: 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 Limited Overall, and/or Annual Maximum Plan Benefits for those services or supplies has not been reached.

Emergency Care: The Plan Administrator/Designee or Appropriate Claims Administrator 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 or within a free-standing but duly licensed and accredited emergency services facility,** 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 department or facility 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/Designee or Appropriate Claims Administrator 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 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 or digital enrollment election to the Plan Administrator (generally using online technology applications provided or contracted 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 (except Voluntary Life/AD&D Insurance may be requested for Eligible Dependents even if the Employee does not enroll for Voluntary Life/AD&D Insurance and subject to insurance carrier limitations as to the amount of coverage that can be requested for Eligible Dependents). 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/Designee or Appropriate Claims Administrator 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/Designee or Appropriate Claims Administrator, **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/Designee or Appropriate Claims Administrator, 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 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/Designee or Appropriate Claims Administrator 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, 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, United Healthcare, 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.

Gender/Gender Identity Care: Services will be considered under the applicable benefit level and limited as any other preventive or medically necessary service outlined in the Health Plan Document. Services will not be limited based on an individual's documented gender/gender identity.

Gene and Cellular Therapy/Products: As defined by the Office of Tissues and Advanced Therapies (OTAT) of the U.S. Food and Drug Administration, provided under either the Plan's medical benefits or prescription drug benefits. Such products are listed at https://www.fda.gov/vaccines-blood-biologics/cellular-gene-therapy-products/approved-cellular-and-gene-therapy .

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 (MD or DO), 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 Home Health Care Agency/Provider 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 each 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 each 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 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.

Infertility: clinical diagnosis of infertility includes post-puberty and premenopausal females who are age 35 or above unable to become pregnant after six-months of unprotected intercourse (or medically supervised artificial insemination); 12 months unable to become pregnant for post-puberty females under age 35.

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 Provider Network Organizations, as distinguished from Non-Network Services that are provided by a Health Care Provider that is **not** a member of (under contract with) these provider organizations. See the Quick Reference Chart in the Introduction section of this document for details/names of the Plan's Provider Network Organizations.

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.

Late Entrant: an eligible employee, spouse or eligible child(ren) who enrolls in a City sponsored health, life or disability plan, more than 31 days after their initial eligibility date of hire or qualifying event date. Late entrants generally enter plan enrollments during Open Enrollment periods, after an initial or recent opt-out status. The effect on coverage and benefits (if any) as a result of Late Entrant status will differ plan type by plan type. See respective sections for details.

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 costlier 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 for 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 a full year for the Plan Participant.

- **Annual Maximum Plan Benefits** are the maximum Benefits payable each Calendar Year because 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/Designee or Appropriate Claims Administrator (e.g., the City's contracted Appropriate Claims Administrator or 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/Designee or Appropriate Claims Administrator 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/Designee or Appropriate Claims Administrator to meet all 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 is "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 "**Cost-Efficient"** if it is no costlier 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 is Medically Necessary for the coverage provided by the Plan.

5. A Hospitalization or confinement to a Specialized Health Care Facility will **not** 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 Medically Necessary if it is furnished in a Hospital or Specialized Health Care Facility or other costlier 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 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 contracted member of the Plan's Provider Network Organizations, as distinguished from In-Network Services that are provided by a Health Care Provider that is a contracted member of the Plan's Provider Network Organizations.

Non-Participating Provider: A Health Care Provider who does not participate in the Plan's contracted Provider Network Organizations.

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 (or by virtual telecommunications technologies) 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, receiving a routine injection, or receiving diagnostic testing results by phone is an Office Visit for the purposes of this Plan (although each may be covered benefits under other procedural codes).

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 annual 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/Designee.

Orthodontics, Orthodontia: The science of the movement of teeth 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 or align a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, walkers, and cranial remolding devices. 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 in-network Deductibles, Coinsurance and/or Copays, each covered person or family member 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. (Note: there is no Out-of-Pocket Maximum for out-of-network services/charges.)

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 contracted Provider Network Organizations.

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 re-training of muscle strength, joint motion, or sensory and neurological function along with balance, coordination, and flexibility 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 and payment (if applicable) for coverage under the Plan and is 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 and/or covered benefits under the Plan 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 Pharmacy Benefit Manager/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: see Provider Network Organization.

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.

Preventive Supplemental Services: Refers to the following preventive services codes that are not required to be covered as preventive services or that would only be covered when specifically billed as preventive, but that this plan will cover at the in-network preventive care services level (100%) when billed as preventive or diagnostic:

1) Z12.83 Diagnosis Code for Skin cancer screening
2) 82306 (Vitamin D; 25 hydroxy, includes fraction(s), if performed)
3) 82607 (Cyanocobalamin (Vitamin B-12))
4) 82670 (Estradiol)

5) 82746 (Folic acid; serum)
6) 83721 (Lipoprotein, direct measurement; LDL cholesterol)
7) 85652 (Sedimentation rate, erythrocyte; automated)
8) 87480 (Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe)
9) 87510 (Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, direct probe technique)
10) 87660 (Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique)
11) 80076 (Hepatic function panel)
12) 82248 (Bilirubin; direct)
13) 82270 (Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or a single triple card for consecutive collection)
14) 82274 (Blood, occult, or fecal, hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations)
15) 82570 (Creatinine; other source)
16) 84075 (Phosphatase, alkaline)
17) 85027 (Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count)
18) 80048 Basic metabolic panel this panel must include the following: calcium (82310), carbon dioxide (82374)
19) 80050 General health panel this panel must include the following: comprehensive metabolic panel (80053), blood count, complete (cbc), automated
20) 80051 Electrolyte panel this panel must include the following: carbon dioxide (82374), chloride (82435)
21) 80053 Comprehensive metabolic panel this panel must include the following: albumin (82040), bilirubin, total (82247)
22) 80074 Acute hepatitis panel this panel must include the following: hepatitis a antibody (haab), igm antibody (86709), hepatitis b core antibody (hbcab), igm
23) 82728 Ferritin
24) 83540 Iron
25) 83550 Iron binding capacity
26) 84439 Thyroxine; free
27) 84479 Thyroid hormone (t3 or t4) uptake or thyroid hormone binding ratio (thbr)
28) 84480 Triiodothyronine t3; total (tt-3)
29) 84481 Triiodothyronine t3; free
30) 84550 Uric acid; blood
31) 84703 Gonadotropin, chorionic (hcg); qualitative
32) 85004 Blood count; automated differential wbc count
33) 85007 Blood count; blood smear, microscopic examination with manual differential wbc count
34) 85045 Blood count; reticulocyte, automated
35) 85048 Blood count; leukocyte (wbc), automated
36) 85049 Blood count; platelet, automated
37) 86708 Hepatitis A antibody (haab); total
38) 86709 Hepatitis A antibody (haab); igm antibody
39) 86735 Antibody; mumps
40) 86762 Antibody; rubella
41) 86765 Antibody; rubeola
42) 86787 Antibody; varicella-zoster
43) 87081 Culture, presumptive, pathogenic organisms, screening only
44) 87147 Culture, typing; immunologic method, other than immunofluoresence (e.g., Agglutination grouping), per anti-serum
45) 87205 Smear, primary source with interpretation; gram or giemsa stain for bacteria, fungi, or cell types
46) 87210 Smear, primary source with interpretation; wet mount for infectious agents (e.g., saline, india ink, koh preps)
47) 83695 Lipoprotein (a)
48) COVID-19 testing services (including OTC kits), anti-viral medication (when medically indicated), vaccinations

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.

Provider Network Organization (also known as Preferred Provider Network): A group or network of Health Care Providers under contract with the Plan or under contract with the Third-Party Administrators contracted 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 deductible, copayment, or coinsurance for which the covered employee, retiree or dependent is responsible.

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 because 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 or designee'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 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 compliant 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" using 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.
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 manufacturer's 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, or by a non-network provider for professional or ancillary services, except where any of these services are described in the In-Network and Non-Network Services – Medical Plan Section as being Exceptions to Normal Plan Reimbursement for Non-Network Providers, shall be the **lesser of**: (a) charges billed by the facility or professional services or ancillary provider or, (b) rates negotiated by the primary provider-payer network contracted by the Plan or, (c) rates negotiated by any secondary provider-payer network utilized by the Appropriate Claims Administrator or, (d) rates negotiated by any cost-containment bill review and complex claims review program utilized by the Appropriate Claims Administrator and if each of these determinations is exhausted or not applicable to the particular claim, then (e) a maximum allowable amount not to exceed 200% of the Medicare Allowable (or Medicare

Similar) 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 due to a malignancy.

Rehabilitation/Habilitative 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/Prescription Drug Benefits and the Exclusions chapter of this document to determine the extent to which Rehabilitation/Habilitative Therapies are covered.

1. **Active Rehabilitation** refers to therapy in which a patient, who is able 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/Habilitative 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.
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 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 outcome of repairing and restoring or reforming the shape and function of part or all the tooth or teeth.

Retail Medical Clinics/Convenience Care Clinics: Walk-in clinics in retail stores like pharmacies and supermarkets, staffed by nurse practitioners or physician assistants and provide high-quality care for routine illnesses and some chronic care management, usually open on days, evenings, and weekends.

Retiree: There are four groups of retirees defined by most recent hire date and cumulative length of service upon retirement:

• **Employees hired prior to November 1, 1991,** who retire from the City of Mesa do not have to fulfill a minimum service requirement or,

• Employees hired **beginning November 1, 1991,** and on or before **December 31, 2000,** who retire from the City of Mesa are required to have 10 **or more years of service** in benefits-eligible position(s) with the City of Mesa or,

• Employees hired on or after **January 1, 2001, through December 31, 2005,** who retire from the City of Mesa are required to have **15 or more years of service** in benefits-eligible position(s) with the City of Mesa or,

• Employees hired on or after **January 1, 2006,** who retire from the City of Mesa are required to have **20 or more years of service** in benefits-eligible position(s) with the City of Mesa, **including at least 10 years of consecutive service immediately prior to retirement**.

• **Effective January 1, 2023,** years of service definitions described above, include all **cumulative** periods of service in benefits-eligible position(s) from first hire date, with a minimum of 10 years of **consecutive** service in benefits-eligible position(s) immediately prior to retirement.

The retiree categories identified above may be eligible for various City contributions, discounts or retirement system healthcare subsidies applied towards the monthly cost of retiree coverage – see Retired Employees of the City of Mesa and Retired Employees With a Medical Retirement Due to Disability in the Eligibility and Enrollment Section of this document for details.

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.

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** 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 always; 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.

Special Health Care Needs: For dental plan benefit accommodations, Special Health Care Needs are any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition requiring medical management, health care intervention and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

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: refers to medications or biologic products that have ANY of the following features associated with their use or acquisition: 1) difficult or unusual process of administration to the patient when self-administered or healthcare practitioner administered, 2) require enrollment in a FDA mandated Risk Evaluation and Mitigation Strategy ("REMS"), 3) require enhanced data collection efforts, 4) require patient management services that are enhanced to the normal practice of pharmacy, 5) are products used in the treatment of rare diseases, and, 6) require patient training or side effects management. These medications may also have one or more of the following qualities: are oral, injectable, self-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 pharmacy service. Specialty drugs are managed by: the Prescription Drug Program/Appropriate Claims Administrator/Pharmacy Benefit Manager (PBM); for drugs and products on the Select Drugs and Products Program (see definition below), the Specialty Drug Advocacy Service Appropriate Claims Administrators under contract to the Plan (see Quick Reference Chart section); healthcare provider and/or facility administered Specialty drugs may be managed by the medical plan Appropriate Claims Administrator. Examples of Specialty Drugs can

include certain medications to treat hemophilia, immunity disorders, multiple sclerosis, rheumatoid arthritis, psoriasis, hepatitis, and many types of cancer.

Specialty Drug Advocacy Service/Program: see Quick Reference Chart section for details and contact information for Appropriate Claims Administrator who provides Specialty Drug Advocacy services to the Plan (advocacy and alternate funding enrollment and qualification program).

(Specialty) Select Drugs and Products Program (List): A "list" of Specialty drugs and products, typically dispensed by specialty pharmacy provider(s) within the Appropriate Claims Administrator's network/affiliations and potentially eligible for alternate partial or full funding through Specialty Drug Advocacy Program service provider arrangements. Select Drugs and Products Program drug list is updated periodically and without prior notification, to address changes in prescription labelling, new market entrants, safety and efficacy considerations and availability of alternate partial or full funding entities. All Specialty drugs may require any or all of step-therapy, quantity limitations, administrative review or prior authorization prior to coverage and dispensing under the Plan and require engagement and participation in advocacy and financial support services through the Specialty Drug Advocacy Program Administrator if the Specialty drug is also under the Select Drugs and Products Program.

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/Designee or Appropriate Claims Administrator will determine which surgical procedures will be separate procedures and which will be included as a single procedure for determining Plan Benefits. When the procedures will 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

Telehealth/Telemedicine: services for the delivery of medical, behavioral health and other health-related consultations via secure telecommunications technologies, including telephones, video conferencing, text and email messages and online internet portal access, delivered by a contracted telehealth/telemedicine provider or under a virtual office visit setting delivered by professional/physician and health care practitioners.

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. For Behavioral Health Therapist, see the definition of Behavioral Health Practitioners.

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 Total Disability exists will be made by a Physician and approved by the appropriate Long Term Disability carrier or administrator. 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.

Transition of Care/Continuity of Care: Transition of Care/Continuity of Care allows patients to continue to receive services for acute medical and behavioral health conditions with health care professionals who are not in the Medical Network administered by the Appropriate Claims Administrator, at in-network coverage levels for a defined time-period until the safe transfer of care to an in-network health care professional or facility can be arranged. Patients must specifically apply in writing to the Appropriate Claims Administrator within 30 days after the effective date of the patient's new Medical Network coverage or transfer of a provider from in-network to non-network provider status. Examples of specified medical and behavioral health conditions that may qualify for Transition of Care/Continuity of Care authorization: Pregnancy; newly diagnosed or relapsed cancer in the midst of treatment or reconstruction; trauma; transplant candidates, unstable recipients or ongoing care recipients; recent major surgeries in clinical follow-up period; acute conditions in active treatment (heart attacks, stroke or unstable chronic conditions); hospital confinement on the Plan effective date; behavioral health conditions during active treatment.

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/Prescription Drug 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 or Dental 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 (also known as Prior Authorization) 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 because 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/Prescription Drug 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.