PLAN DOCUMENT AMENDMENT #1

FOR

ARIZONA LOCAL GOVERNMENT EMPLOYEE BENEFIT TRUST

EMPLOYEE BENEFIT TRUST

EFFECTIVE JULY 1, 2017

NOTICE IS HEREBY GIVEN that the Arizona Local Government Employee Benefit Trust Employee Benefit Trust document is amended effective July 1, 2017.

CHANGE 1. The following subsection “HIGH DEDUCTIBLE HEALTH PLAN (HDHP),” which appears in the subsection “Schedule of Medical Benefits” in the section entitled “HIGHLIGHTS OF THE EMPLOYEE BENEFIT TRUST,” is hereby deleted in its entirety and replaced with the following:

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION – HDHP</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVERALL PLAN YEAR MAXIMUM</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>DEDUCTIBLE, PER PLAN YEAR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductibles are separate, that is, expenses applied toward the satisfaction of the In-Network deductible amount will not be applied toward satisfaction of the Out-of-Network deductible, and vice versa.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Participant</td>
<td>$3,750</td>
<td>$7,000</td>
</tr>
<tr>
<td>Per Family</td>
<td>$7,500</td>
<td>$14,000</td>
</tr>
<tr>
<td>MAXIMUM OUT-OF-POCKET EXPENSES PER PLAN YEAR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-pocket expenses are separate, that is, expenses applied toward the satisfaction of the In-Network out-of-pocket amount will not be applied toward satisfaction of the Out-of-Network out-of-pocket amount, and vice versa.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Participant</td>
<td>$3,750</td>
<td>$14,000</td>
</tr>
<tr>
<td>Per Family</td>
<td>$7,500</td>
<td>$28,000</td>
</tr>
<tr>
<td>UTILIZATION MANAGEMENT PENALTY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There will be a reduction of payment by 20% for failure to precertify inpatient confinements, organ transplants, certain outpatient procedures, chemotherapy/radiation therapy, psychological and neuropsychological testing, and durable medical equipment over $2,500. See the Utilization Management section for details and for a list of services or supplies that must be Precertified.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## BENEFIT DESCRIPTION – HDHP

<table>
<thead>
<tr>
<th>COPAYMENTS AND BENEFIT PERCENTAGES</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>100% after deductible</td>
<td>100% after deductible</td>
</tr>
<tr>
<td>Behavioral/Mental Health and Substance Use Disorders – Inpatient (Precertification required) (Includes residential treatment)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Behavioral/Mental Health and Substance Use Disorders – Outpatient (Includes Partial Hospitalization) (Telemedicine is covered for behavioral/mental health if available through the Outpatient facility; telemedicine for substance abuse is not covered)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Additionally, an Employee Assistance Program (EAP) provides employees with 3 counseling sessions per benefit issue, per household, per Plan year. Call (800) 321-2843 or visit <a href="http://www.HolmanGroup.com">www.HolmanGroup.com</a> for more information.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy &amp; Radiation Therapy (Precertification required)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Chiropractic Treatment (26 visits Plan Year maximum) (eligible charge is $40/visit) (Office visit and X-ray charges apply to the maximum)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Diabetes Self-management Training</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Diagnostic Testing (Advanced Imaging – MRI, CAT, PET, MRA, ultrasounds, DEXA scans, nuclear stress tests, etc.)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Diagnostic Testing (X-ray, lab) – Inpatient (Services performed or analyzed outside a Physician’s office)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Diagnostic Testing (X-ray, lab) – Outpatient (Services other than in a Physician’s office)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>BENEFIT DESCRIPTION – HDHP</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>----------------------------------------------------------------</td>
<td>-----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Diagnostic Testing (X-ray, lab) – In-Office</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Covered up to $2,500 per item; expenses over $2,500 may be</td>
<td></td>
<td></td>
</tr>
<tr>
<td>covered if the item is reviewed and approved by the Utilization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management company)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Services in an Emergency Room</strong></td>
<td>100% after deductible</td>
<td>100% after deductible</td>
</tr>
<tr>
<td>(Out-of-network services are subject to the In-network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>deductible and out-of-pocket amount)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Extended Care/Skilled Nursing Facility</strong></td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(60 days Plan Year maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Aid</strong></td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Includes 1 hearing aid up to $1,000 per 3 year period)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Exam/Testing</strong></td>
<td>100% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(1 visit Plan Year maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(60 visits Plan Year maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(100 visits Lifetime maximum, including bereavement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>counseling)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital / Facility Inpatient Expenses</strong></td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(See also Rehabilitation Facility)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and Board is limited to the semi-private room rate, or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>if the Hospital has private rooms only, the lowest private</td>
<td></td>
<td></td>
</tr>
<tr>
<td>room rate. Eligible charge for ICU is the ICU charge.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital / Facility Outpatient Expenses</strong></td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required for outpatient surgery)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Infertility/Sterility</strong></td>
<td>Refer to appropriate service for benefit percentages</td>
<td></td>
</tr>
<tr>
<td>(Covered up to diagnosis of infertility/sterility only)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## BENEFIT DESCRIPTION – HDHP

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternity</strong></td>
<td><strong>Refer to Preventive Care</strong></td>
<td></td>
</tr>
<tr>
<td>Preconception and Prenatal care as required by federal law</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>Lactation Consultations</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>All other eligible charges</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Maternity related expenses for dependent Children are covered. Only 1 routine ultrasound is covered during the course of the pregnancy.

### Mexico Coverage for Santa Cruz County

- **($10,000 Plan Year maximum)**
- **Primary Care Physician**
  - 100% after deductible
  - Not Covered
- **Specialist**
  - 100% after deductible
  - Not Covered

This benefit is only available to Santa Cruz County Eligible Employees and their Eligible Dependents. Only International Medical Solutions (IMS) providers are considered In-Network. See Preferred Provider Section for important information regarding this benefit.

### Newborn Care – Routine Inpatient

- 100% after deductible
- 50% after deductible

### Organ Transplants

- (Transportation/accommodation expenses are limited to a combined maximum of $5,000 per transplant)
- 100% after deductible
- Not Covered

See the Medical Benefits section for more details about this benefit.

### Orthotics/Prosthetics

- (2 prosthetic bras Plan Year maximum)
- 100% after deductible
- 50% after deductible
# BENEFIT DESCRIPTION – HDHP

<table>
<thead>
<tr>
<th>Physician Services</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Visits</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Inpatient Surgery</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient Visits</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required for services over $1,000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Teladoc Services ($45 billed charge per visit, until the deductible is met)</td>
<td>100% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Drugs (Inpatient)</th>
<th>Refer to Hospital / Facility Inpatient Expenses</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Prescription Drugs (Outpatient)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Formulary Generics and some lower cost Brand Name products</td>
<td>100% after deductible</td>
</tr>
<tr>
<td>Formulary Brand Name products and some higher cost Generics</td>
<td>100% after deductible</td>
</tr>
<tr>
<td>Non-Preferred products (both Brand Name and Generics)</td>
<td>100% after deductible</td>
</tr>
<tr>
<td>Prescribed Preventive Medications and Contraceptives as required by federal law</td>
<td>100%, no deductible</td>
</tr>
</tbody>
</table>

Includes prescribed preventive medications that are recommended by the USPSTF, as well as FDA-approved, preferred generic and brand name contraceptives at no member cost.
### BENEFIT DESCRIPTION – HDHP

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care includes the following once: routine office visit, physical exam, X-ray &amp; lab, annual PSA screening, mammogram (once for members ages 35-40, then annually thereafter), skin cancer screening performed by a M.D. or D.O., and all AZLGEBT Wellness Program on-site screenings. Preventive services are also covered as recommended by the United States Preventive Services Task Force (USPSTF) and immunizations will be covered as recommended by the Centers for Disease Control (CDC). All services are limited to no more than once annually or as recommended by the USPSTF.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100%, no deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rehabilitation Services (Physical, Occupational, Speech, &amp; Cardiac Rehab Therapies)</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>(60 visits Plan Year maximum for all types of therapy combined) (Additional visits may be covered if they are precertified)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rehabilitation Facility – Inpatient (60 days Plan Year maximum)</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Second/Third Surgical Opinion (If the Plan requires a second opinion and only Out-of-Network providers are available, then services will be paid at the In-Network benefit level)</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sleep Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep Study</td>
</tr>
<tr>
<td>Other eligible expenses</td>
</tr>
<tr>
<td>100% after deductible</td>
</tr>
<tr>
<td>50% after deductible</td>
</tr>
</tbody>
</table>
### BENEFIT DESCRIPTION – HDHP

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vasectomy (covered only in the Physician’s office)</td>
<td></td>
<td>Refer to <strong>Physician Services – Office Visits</strong></td>
</tr>
<tr>
<td>Female sterilization as required by federal law</td>
<td></td>
<td>Refer to <strong>Preventive Care</strong></td>
</tr>
<tr>
<td><strong>Temporomandibular Joint Syndrome</strong> ($300 Plan Year maximum)</td>
<td></td>
<td>Refer to the applicable service for benefit percentages</td>
</tr>
<tr>
<td>Maximum includes surgical and nonsurgical treatment combined, including orthognathic surgery.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong> (includes all covered charges billed by facility)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Other Covered Expenses</strong></td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

**CHANGE 2.** The following subsection “PPO PLAN,” which appears in the subsection “Schedule of Medical Benefits” in the section entitled “HIGHLIGHTS OF THE EMPLOYEE BENEFIT TRUST,” is hereby deleted in its entirety and replaced with the following:

### PPO PLAN

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OVERALL PLAN YEAR MAXIMUM</strong></td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td><strong>DEDUCTIBLE, PER PLAN YEAR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductibles are separate, that is, expenses applied toward the satisfaction of the In-Network deductible amount will <strong>not</strong> be applied toward satisfaction of the Out-of-Network deductible, and vice versa.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Participant</td>
<td>$500</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>MAXIMUM OUT-OF-POCKET EXPENSES PER PLAN YEAR</strong></td>
<td>$5,500</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Out-of-pocket expenses are separate, that is, expenses applied toward the satisfaction of the In-Network out-of-pocket amount will <strong>not</strong> be applied toward satisfaction of the Out-of-Network out-of-pocket amount, and vice versa.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Participant</td>
<td>$14,300</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>
### BENEFIT DESCRIPTION – PPO PLAN

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UTILIZATION MANAGEMENT PENALTY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There will be a reduction of payment by 20% for failure to precertify inpatient confinements, organ transplants, certain outpatient procedures, chemotherapy/radiation therapy, psychological and neuropsychological testing, and durable medical equipment over $2,500. See the Utilization Management section for details and for a list of services or supplies that must be Precertified.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COPAYMENTS AND BENEFIT PERCENTAGES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>
| Behavioral/Mental Health and Substance Use Disorders – Inpatient  
(Precertification required)  
(Includes residential treatment) | 80% after deductible | 50% after deductible |
| Behavioral/Mental Health and Substance Use Disorders – Outpatient  
(Includes Partial Hospitalization)  
(Telemedicine is covered for behavioral/mental health if available through the Outpatient facility; telemedicine for substance abuse is not covered) | 80% after deductible | 50% after deductible |
| Chemotherapy & Radiation Therapy  
(Precertification required) | 80% after deductible | 50% after deductible |
| Chiropractic Treatment  
(26 visits Plan Year maximum)  
(Eligible charge is $40/visit)  
(Office visit and X-ray charges apply to the maximum) | $30 copay, then 100%, no deductible | 50% after deductible |
| Diabetes Self-management Training | 80% after deductible | 50% after deductible |
| Diabetes Supplies  
(Only for Participants enrolled in the Sweet Savings Program) | 100%, no deductible | 50% after deductible |
| **Refer to the Durable Medical Equipment benefit for durable medical equipment (including, but not limited to, insulin pumps).** |  |  |
### BENEFIT DESCRIPTION – PPO PLAN

<table>
<thead>
<tr>
<th>Diagnostic Testing (Advanced Imaging – MRI, CAT, PET, MRA, ultrasounds, DEXA scans, nuclear stress tests, etc.)</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic Testing (X-ray, lab) – Inpatient</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic Testing (X-ray, lab) – Outpatient (Services performed or analyzed outside a Physician’s office)</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray</td>
<td>$30 copay, then 100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Non-complex Lab (if the total allowed amount per visit is less than $500)</td>
<td>$30 copay, then 100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Complex Lab (if the total allowed amount per visit is $500 or more)</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic Testing (X-ray, lab) – Standalone Facility (Services other than in a Physician’s office)</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray</td>
<td>$30 copay, then 100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Non-complex Lab (if the total allowed amount per visit is less than $500)</td>
<td>$30 copay, then 100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Complex Lab (if the total allowed amount per visit is $500 or more)</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Benefit Description – PPO Plan</td>
<td>In-Network</td>
<td>Out-Of-Network</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Diagnostic Testing (X-ray, lab) – In-Office</strong></td>
<td>$30 copay, then 100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td>$45 copay, then 100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Covered up to $2,500 per item; expenses over $2,500 may be covered if the item is reviewed and approved by the Utilization Management company)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Services in an Emergency Room</strong></td>
<td>$100 copay, then 80% after deductible</td>
<td>$100 copay, then 80% after deductible</td>
</tr>
<tr>
<td>(Out-of-network services are subject to the In-network deductible and out-of-pocket amount)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copay waived if admitted directly to Hospital from Emergency room.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Extended Care/Skilled Nursing Facility</strong></td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(60 days Plan Year maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Aid</strong></td>
<td>50% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Includes 1 hearing aid up to $1,000 per 3 year period)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Exam/Testing</strong></td>
<td>$30 copay, then 100%, no deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(1 visit Plan Year maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(60 visits Plan Year maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(100 visits Lifetime maximum, including Bereavement counseling)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital / Facility Inpatient Expenses</strong></td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(See also Rehabilitation Facility)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and Board is limited to the semi-private room rate, or if the Hospital has private rooms only, the lowest private room rate. Eligible charge for ICU is the ICU charge.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## BENEFIT DESCRIPTION – PPO PLAN

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital / Facility Outpatient Expenses</strong></td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required for outpatient surgery)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Infertility/Sterility</strong></td>
<td>Refer to appropriate service for benefit percentages</td>
<td></td>
</tr>
<tr>
<td>(Covered up to diagnosis of infertility/sterility only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td>Refer to Preventive Care</td>
<td></td>
</tr>
<tr>
<td>Preconception and Prenatal care as required by federal law</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lactation Consultations</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>All other eligible charges</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

- Maternity related expenses for dependent Children are covered.
- Only 1 routine ultrasound is covered during the course of the pregnancy.

### Mexico Coverage for Santa Cruz County
($10,000 Plan Year maximum)

<table>
<thead>
<tr>
<th>Primary Care Physician</th>
<th>$20 copay, then 100%, no deductible</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist</td>
<td>$30 copay, then 100%, no deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

- This benefit is only available to Santa Cruz County Eligible Employees and their Eligible Dependents.
- Only International Medical Solutions (IMS) providers are considered In-Network. See Preferred Provider Section for important information regarding this benefit.

### Newborn Care – Routine Inpatient

<table>
<thead>
<tr>
<th></th>
<th>80% after deductible</th>
<th>50% after deductible</th>
</tr>
</thead>
</table>

### Organ Transplants
(Transportation/accommodation expenses are limited to a combined maximum of $5,000 per transplant)

<table>
<thead>
<tr>
<th></th>
<th>80% after deductible</th>
<th>Not Covered</th>
</tr>
</thead>
</table>

See the Medical Benefits section for more details about this benefit.

### Orthotics/Prosthetics
(2 prosthetic bras Plan Year maximum)

<table>
<thead>
<tr>
<th></th>
<th>80% after deductible</th>
<th>50% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>BENEFIT DESCRIPTION – PPO PLAN</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Visits</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Inpatient Surgery</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient Visits</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Physician’s fee for services not performed in a Physician’s office)</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required for services over $1,000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Copay is per provider and applies to all covered services performed during the visit, unless otherwise specified elsewhere in the Plan)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>$30 copay, then 100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>$45 copay, then 100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>All other eligible expenses rendered during an office visit that are not covered under the copay, including airborne allergy treatment</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

Precertification is required for surgical services over $1,000.
For the purposes of the Plan, the following types of providers are considered Primary Care Physicians: Family Practitioner, General Practitioner, Internist, Pediatrician, and OB/GYN.

|                         |            |                |
|                         |            |                |
| **Teladoc Services**    | $25 copay, then 100%, no deductible |                |
| **Prescription Drugs**  | (Inpatient) |                |
|                         | Refer to **Hospital / Facility Inpatient Expenses** |                |
### BENEFIT DESCRIPTION – PPO PLAN

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription Drugs</strong> (Outpatient)</td>
<td>Refer to the <strong>Schedule of Prescription Drug Benefits</strong> subsection</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>100%, no deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Preventive care includes the following once: routine office visit, physical exam, X-ray &amp; lab, annual PSA screening, mammogram (once for members ages 35-40, then annually thereafter), skin cancer screening performed by a M.D. or D.O., and all AZLGEBT Wellness Program on-site screenings. Preventive services are also covered as recommended by the United States Preventive Services Task Force (USPSTF) and immunizations will be covered as recommended by the Centers for Disease Control (CDC). All services are limited to no more than once annually or as recommended by the USPSTF.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Rehabilitation Services (Physical, Occupational, Speech, & Cardiac Rehab Therapies)**
(60 outpatient visits Plan Year maximum for all types of therapy combined)
(Additional visits may be covered if they are precertified)

<table>
<thead>
<tr>
<th></th>
<th>80% after deductible</th>
<th>50% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rehabilitation Facility – Inpatient</strong> (60 days Plan Year maximum)</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

**Second/Third Surgical Opinion**

Refer to **Physician Services – Office Visits**

Copays will be waived if the Second/Third Opinion is mandated by the Utilization Management company. Additionally, if the Plan requires a second opinion and only Out-of-Network providers are available, then services will be paid at the In-Network benefit level.
# BENEFIT DESCRIPTION – PPO PLAN

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sleep Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep Study</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Other eligible expenses</td>
<td>Refer to applicable service for benefits</td>
<td>Refer to applicable service for benefits</td>
</tr>
<tr>
<td><strong>Sterilization</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vasectomy (covered only in the Physician’s office)</td>
<td>Refer to <strong>Physician Services – Office Visits</strong></td>
<td></td>
</tr>
<tr>
<td>Female sterilization as required by federal law</td>
<td>Refer to <strong>Preventive Care</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Temporomandibular Joint Syndrome</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>($300 Plan Year maximum)</td>
<td>Refer to the applicable service for benefit percentages</td>
<td></td>
</tr>
<tr>
<td>Maximum includes surgical and nonsurgical treatment combined, including orthognathic surgery.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(includes all covered charges billed by facility)</td>
<td>$45 copay, then 100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Other Covered Expenses</strong></td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

CHANGE 3. The paragraph, shown below, is hereby ADDED to the section entitled “PREFERRED PROVIDER ORGANIZATION”:

For Santa Cruz County Eligible Employees and their Eligible Dependents, In-Network providers in Mexico are available through the International Medical Solutions Mexico PPO network at [http://www.internationalmedsolutions.com](http://www.internationalmedsolutions.com). Covered expenses will be payable as shown under the “Mexico Coverage” benefit in the Schedule of Medical Benefits.
CHANGE 4. Exclusion #47, which appears in the subsection “Other General Exclusions” in the section entitled “GENERAL EXCLUSIONS AND LIMITATIONS,” is hereby deleted in its entirety and replaced with the following:

47. **Telephone** conversations with a Physician, except as covered by the Plan under the Teladoc benefit.

Copies of the Plan document and this Plan document amendment are maintained on file by the Plan Administrator and by the Benefit Services Manager.

This Employee Benefit Trust document amendment is hereby adopted in its entirety.
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

FOR

ARIZONA LOCAL GOVERNMENT

EMPLOYEE BENEFIT TRUST

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ARIZONA LOCAL GOVERNMENT

EMPLOYEE BENEFIT TRUST SUMMARY PLAN DESCRIPTION

This Summary Plan Description is intended to describe the provisions of the Arizona Local Government Employee Benefit Trust (“AZLGEBT” or the “Trust”), which is a form of a group health plan sponsored and maintained by the Trust. The terms of this Summary Plan Description are effective as of July 1, 2016, and govern the administration and payment of claims Incurred on or after that date. Please review the following information carefully; it supersedes any prior written information about the Plan.
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HIGHLIGHTS OF THE EMPLOYEE BENEFIT TRUST

This Plan is maintained for the purpose of providing benefits for Eligible Employees and their Eligible Dependents. Although it has no present intention to do so, the Plan Sponsor has reserved the right to amend or even terminate the Plan. Examples of amendments include, but are not limited to, the inclusion of additional cost containment features, increases in deductibles and out-of-pocket expense amounts, and changes in the benefits provided under this Plan. In addition, your Employer may require you to pay a portion of the cost of coverage (employee only or family coverage). Your share of the cost is determined annually, or more frequently if deemed appropriate, by your Employer.

Eligible Employee

The term “Eligible Employee” shall mean an employee in a benefit eligible position who worked or is regularly scheduled to work at least 20 hours per week for the Employer and who has completed a waiting period of 30 consecutive days while employed. An employee is not a leased employee or an independent contractor.

“Eligible Employee” shall also include elected officials of those AZLGETB member entities who have chosen to offer benefits under this Plan to their elected officials. The minimum hours requirement and the waiting period are waived for such elected officials. Elected officials are not eligible to receive short term disability benefits under the Plan.

In accordance with the Patient Protection and Affordable Care Act as well as IRS rules and guidelines in the Internal Revenue Code, Section 4980H (as amended), the Plan may use a Monthly Measurement Method or a Look-Back Measurement Method, or a combination of the two methods for determining the full-time status of employees. All New Employees who are not expected to work full-time at the time of hire, including variable hour and seasonal workers, may be subject to an Initial Measurement Period not to exceed twelve months.

If the Look-Back Measurement Method is used, then the term “Eligible Employee” shall also include a Variable Hour Employee who has averaged at least thirty (30) hours per week for a complete Measurement Period and is currently in a Stability Period, or Administrative Period (if applicable), as determined by the Plan Sponsor. An employee who continues employment during the Stability Period will remain eligible throughout the Stability Period and Administrative Period (if applicable), regardless of a change in employment status (including, but not limited to, a reduction in hours).

For details and information about the Measurement Periods and, if applicable, Stability Periods and Administrative Periods, see your Personnel or Human Resources department.

The Plan Administrator determines status as an Eligible Employee hereunder.
Eligible Retiree
The term “Eligible Retiree” shall mean a former Graham County employee who qualified for retirement coverage on or before June 30, 1994 or a Gila County employee who qualified for retirement coverage on or before June 30, 1999.

“Eligible Retiree” shall also include independent contractors of Gila County who have been continuously covered under the Plan and where coverage commenced prior to July 1, 1999.

Eligible Dependent
The Employer determines status as an Eligible Dependent hereunder and reserves the right to require such documentation as it deems satisfactory that a dependent is an Eligible Dependent under the Plan. The term “Eligible Dependent” shall mean any one or more of the following except that no Participant covered as an employee shall also be covered as a dependent, regardless of eligibility.

1. The Spouse, as defined by the Plan in the Definitions section, of an Eligible Employee or Eligible Retiree until the date of legal separation or divorce, whichever occurs first.

   A common law spouse is not eligible for coverage under the Plan, even if the employee resides in a state where common law marriage is recognized.

   A Domestic Partner is not eligible for coverage under the Plan, even in a state where domestic partnership is recognized.

2. Any Child of an Eligible Employee or Eligible Retiree who is:

   a. under the age of 26; or

   b. incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of age 26. Such Child must have had continuous coverage as a dependent prior to attainment of such age and have remained covered continuously thereafter. The Plan Administrator may require proof of prior coverage. Additionally, at reasonable intervals during the two years following the dependent’s reaching limiting age, the Plan Administrator may require subsequent proof of the Child's disability and continued incapability of self-sustaining employment. After such two-year period, the Plan Administrator may not require proof more than once each year.

   “Child” includes:

   a. a natural child following birth; or
b. a legally adopted child; or

c. a child legally placed in the employee’s home for the purpose of adoption by the employee; or

d. a stepchild; or

e. an eligible foster child or a child under the court-awarded legal guardianship of the employee; or

f. a child of the employee for whom the employee is required to provide health benefits pursuant to a Qualified Medical Child Support Order (QMCSO) in accordance with procedures adopted by the Plan Administrator. (Special rules apply to QMCSOs. Contact the Plan Administrator in situations of divorce and child custody for information regarding QMCSOs.)

The term “Child” specifically excludes the child of a Covered Dependent Child.

The term “eligible foster child” means an individual who is placed with the Covered Employee or Covered Retiree by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. In addition, eligibility will remain in effect for any child under the legal guardianship of a Covered Employee or Covered Retiree until their twenty-sixth birthday, regardless of whether or not such child has attained age eighteen (or any other applicable age of emancipation of minors which would otherwise no longer render the Covered Employee or Covered Retiree such child’s legal guardian).

**Special Eligibility for Surviving Spouses and Surviving Unmarried Dependents of Certain Law Enforcement Officers**

Pursuant to Arizona Revised Statutes §38-1114 and §38-1141, as amended from time to time, certain Surviving Spouses and Unmarried Dependents of Law Enforcement Officers, as defined in Arizona Revised Statute §38-1114(G)(2) and §38-1141(G)(2), who were killed in the line of duty, or who died from injuries suffered in the line of duty, and who were enrolled in a Health Insurance Program defined in Arizona Revised Statute §38-1114(B) and §38-1141(B) at the time the Law Enforcement Officer was killed in the line of duty or died from injuries suffered in the line of duty, are eligible to continue obtaining, or may be enrolled to obtain, coverage under this Plan. Such eligibility ends for a Surviving Spouse under this section when they remarry, become Medicare eligible or die. Such eligibility ends for a Surviving Unmarried Dependent when they turn eighteen (18) years of age, or until they turn twenty-three (23) years of age if they are a full time student.

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

**Eligibility Date**
(See “Persons Covered and Effective Dates” section for enrollment details and effective dates.)

Employee: The first day of the month coinciding with or after you meet the Plan’s definition of an Eligible Employee.

Dependent: The same as the employee’s or retiree’s Eligibility Date, if you have Eligible Dependents when you first become eligible to participate in the Plan.

**Open Enrollment**
(See “Persons Covered and Effective Dates” section for enrollment details)

The Open Enrollment period is during the month of May. Coverage for a Participant enrolling during Open Enrollment is effective on the first day of July following enrollment.
Schedule of Medical Benefits
This is only a summary of the Plan’s benefits and is not intended to be all-inclusive. Important information is contained in other sections, including benefit exclusions and limitations. You may find the Definitions section helpful in understanding some of the capitalized terms used throughout this Summary Plan Description, and within certain sections where a term is defined and used there. In addition, the Plan has other requirements and provisions that may affect benefits, such as those described in the sections for Utilization Management and Preferred Provider Organization, and it is strongly recommended that you read the entire Summary Plan Description to ensure a complete understanding of the Plan provisions. You also may contact Gilsbar, L.L.C., the Benefits Services Manager, or the Plan Administrator for assistance. All maximums are per Participant, unless specifically noted as per family.

For any benefit subject to a Plan Year and/or Lifetime maximum, Allowable Charges that accumulate towards the benefit limit include any ancillary Allowable Charges associated with that benefit, including but not limited to, office visits, lab tests, X-rays, physician services, etc.

**HIGH DEDUCTIBLE HEALTH PLAN (HDHP)**

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION – HDHP</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OVERALL PLAN YEAR MAXIMUM</strong></td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td><strong>DEDUCTIBLE, PER PLAN YEAR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductibles are separate, that is, expenses applied toward the satisfaction of the In-Network deductible amount will not be applied toward satisfaction of the Out-of-Network deductible, and vice versa.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Participant</td>
<td>$3,500</td>
<td>$7,000</td>
</tr>
<tr>
<td>Per Family</td>
<td>$7,000</td>
<td>$14,000</td>
</tr>
<tr>
<td><strong>MAXIMUM OUT-OF-POCKET EXPENSES PER PLAN YEAR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-pocket expenses are separate, that is, expenses applied toward the satisfaction of the In-Network out-of-pocket amount will not be applied toward satisfaction of the Out-of-Network out-of-pocket amount, and vice versa.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Participant</td>
<td>$3,500</td>
<td>$14,000</td>
</tr>
<tr>
<td>Per Family</td>
<td>$7,000</td>
<td>$28,000</td>
</tr>
<tr>
<td><strong>UTILIZATION MANAGEMENT PENALTY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There will be a reduction of payment by 20% for failure to precertify inpatient confinements, organ transplants, certain outpatient procedures, chemotherapy/radiation therapy, psychological and neuropsychological testing, and durable medical equipment over $2,500. See the Utilization Management section for details and for a list of services or supplies that must be Precertified.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BENEFIT DESCRIPTION – HDHP</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>----------------------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>COPAYMENTS AND BENEFIT PERCENTAGES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>100% after deductible</td>
<td>100% after deductible</td>
</tr>
<tr>
<td>Behavioral/Mental Health and Substance Use Disorders – Inpatient</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Includes residential treatment)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral/Mental Health and Substance Use Disorders – Outpatient</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Includes Partial Hospitalization)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Telemedicine is available only for Behavioral/Mental Health)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy &amp; Radiation Therapy</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Treatment</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(26 visits Plan Year maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(eligible charge is $40/visit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Office visit and X-ray charges apply to the maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Self-management Training</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Diagnostic Testing (Advanced Imaging – MRI, CAT, PET, MRA, ultrasounds, DEXA scans, nuclear stress tests, etc.)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Diagnostic Testing (X-ray, lab) – Inpatient</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Diagnostic Testing (X-ray, lab) – Outpatient</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Services performed or analyzed outside a Physician's office)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing (X-ray, lab) – In-Office</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Covered up to $2,500 per item; expenses over $2,500 may be covered if the item is reviewed and approved by the Utilization Management company)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BENEFIT DESCRIPTION – HDHP</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Emergency Services in an Emergency Room</td>
<td>100% after deductible</td>
<td>100% after deductible</td>
</tr>
<tr>
<td>(Out-of-network services are subject to the In-network deductible and out-of-pocket amount)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended Care/Skilled Nursing Facility</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(60 days Plan Year maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aid</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Includes 1 hearing aid up to $1,000 per 3 year period)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Exam/Testing</td>
<td>100% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(1 visit Plan Year maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(60 visits Plan Year maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(100 visits Lifetime maximum, including bereavement counseling)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital / Facility Inpatient Expenses</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(See also Rehabilitation Facility)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and Board is limited to the semi-private room rate, or if the Hospital has private rooms only, the lowest private room rate. Eligible charge for ICU is the ICU charge.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital / Facility Outpatient Expenses</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required for outpatient surgery)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility/Sterility</td>
<td>Refer to appropriate service for benefit percentages</td>
<td></td>
</tr>
<tr>
<td>(Covered up to diagnosis of infertility/sterility only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>Refer to Preventive Care</td>
<td></td>
</tr>
<tr>
<td>Preconception and Prenatal care as required by federal law</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lactation Consultations</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>All other eligible charges</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Maternity related expenses for dependent Children are covered. Only 1 routine ultrasound is covered during the course of the pregnancy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newborn Care – Routine Inpatient</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>100% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(Transportation/accommodation expenses are limited to a combined maximum of $5,000 per transplant)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

See the Medical Benefits section for more details about this benefit.
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION – HDHP</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthotics/Prosthetics</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(2 prosthetic bras Plan Year maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Visits</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Inpatient Surgery</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient Visits</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required for services over $1,000)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Office visits</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Prescription Drugs (Inpatient)</td>
<td>Refer to Hospital / Facility Inpatient Expenses</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs (Outpatient)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formulary Generics and some lower cost Brand Name products</td>
<td>100% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Formulary Brand Name products and some higher cost Generics</td>
<td>100% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Non-Preferred products (both Brand Name and Generics)</td>
<td>100% after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prescribed Preventive Medications and Contraceptives as required by federal law</td>
<td>100%, no deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Includes prescribed preventive medications that are recommended by the USPSTF, as well as FDA-approved, preferred generic and brand name contraceptives at no member cost.

**Preventive Care**

Preventive care includes the following once: routine office visit, physical exam, X-ray & lab, annual PSA screening, mammogram (once annually for members age 35-40, then as required by law thereafter), skin cancer screening performed by a M.D. or D.O., and all AZLGEHT Wellness Program on-site screenings.

Preventive services are also covered as recommended by the United States Preventive Services Task Force (USPSTF) and immunizations will be covered as recommended by the Centers for Disease Control (CDC). All services are limited to no more than once annually or as recommended by the USPSTF.
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION – HDHP</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rehabilitation Services</strong> (Physical, Occupational, Speech, &amp; Cardiac Rehab Therapies) (60 visits Plan Year maximum for all types of therapy combined) (Additional visits may be covered if they are precertified)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Rehabilitation Facility – Inpatient</strong> (60 days Plan Year maximum)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Second/Third Surgical Opinion</strong> (If the Plan requires a second opinion and only Out-of-Network providers are available, then services will be paid at the In-Network benefit level)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Sterilization</strong> Vasectomy (covered only in the Physician’s office)</td>
<td>Refer to <strong>Physician Services – Office Visits</strong></td>
<td>Refer to <strong>Preventive Care</strong></td>
</tr>
<tr>
<td>Female sterilization as required by federal law</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Temporomandibular Joint Syndrome</strong> ($300 Plan Year maximum)</td>
<td>Refer to the applicable service for benefit percentages</td>
<td></td>
</tr>
<tr>
<td>Maximum includes surgical and nonsurgical treatment combined, including orthognathic surgery.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong> (includes all covered charges billed by facility)</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Other Covered Expenses</strong></td>
<td>100% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>
## PPO Plan

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION – PPO PLAN</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OVERALL PLAN YEAR MAXIMUM</strong></td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td><strong>DEDUCTIBLE, PER PLAN YEAR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductibles are separate, that is, expenses applied toward the satisfaction of the In-Network deductible amount will <strong>not</strong> be applied toward satisfaction of the Out-of-Network deductible, and vice versa.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Participant</td>
<td>$400</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>MAXIMUM OUT-OF-POCKET EXPENSES PER PLAN YEAR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-pocket expenses are separate, that is, expenses applied toward the satisfaction of the In-Network out-of-pocket amount will <strong>not</strong> be applied toward satisfaction of the Out-of-Network out-of-pocket amount, and vice versa.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Participant</td>
<td>$5,000</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Per Family</td>
<td>$13,700</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>UTILIZATION MANAGEMENT PENALTY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There will be a reduction of payment by 20% for failure to precertify inpatient confinements, organ transplants, certain outpatient procedures, chemotherapy/radiation therapy, psychological and neuropsychological testing, and durable medical equipment over $2,500. See the Utilization Management section for details and for a list of services or supplies that must be Precertified.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COPAYMENTS AND BENEFIT PERCENTAGES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>80% after deductible</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Behavioral/Mental Health and Substance Use Disorders – Inpatient (Precertification required) (Includes residential treatment)</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Behavioral/Mental Health and Substance Use Disorders – Outpatient (Includes Partial Hospitalization) (Telemedicine is available only for Behavioral/Mental Health)</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Chemotherapy &amp; Radiation Therapy (Precertification required)</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Chiropractic Treatment (26 visits Plan Year maximum) (Eligible charge is $40/visit) (Office visit and X-ray charges apply to the maximum)</td>
<td>100% after $25 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Diabetes Self-management Training</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>BENEFIT DESCRIPTION – PPO PLAN</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Diabetes Supplies (Only for Participants enrolled in the Sweet Savings Program)</td>
<td>100%, no deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Refer to the <strong>Durable Medical Equipment</strong> benefit for durable medical equipment (including, but not limited to, insulin pumps).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Testing (Advanced Imaging – MRI, CAT, PET, MRA, ultrasounds, DEXA scans, nuclear stress tests, etc.)</strong></td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Diagnostic Testing (Lab) – Inpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Testing (Lab) – Outpatient (Services performed or analyzed outside a Physician’s office)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the total allowed amount per visit is less than $500</td>
<td>100% after $25 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>If the total allowed amount per visit is $500 or more</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Diagnostic Testing (Lab) – In-Office</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>100% after $25 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>100% after $35 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Diagnostic Testing (X-ray) – Inpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Testing (X-ray) – Outpatient (Services performed or analyzed outside a Physician’s office)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>100% after $25 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>100% after $35 copay</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong> (Covered up to $2,500 per item; expenses over $2,500 may be covered if the item is reviewed and approved by the Utilization Management company)</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>BENEFIT DESCRIPTION – PPO PLAN</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Emergency Services in an Emergency Room</td>
<td>80% after $100 copay and deductible</td>
<td>80% after $100 copay and deductible</td>
</tr>
<tr>
<td>(Out-of-network services are subject to the In-network deductible and out-of-pocket amount)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copay waived if admitted directly to Hospital from Emergency room.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended Care/Skilled Nursing Facility</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(60 days Plan Year maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aid</td>
<td>50% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Includes 1 hearing aid up to $1,000 per 3 year period)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Exam/Testing</td>
<td>100% after $25 copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(1 visit Plan Year maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(60 visits Plan Year maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(100 visits Lifetime maximum, including Bereavement counseling)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital / Facility Inpatient Expenses</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(See also Rehabilitation Facility)</td>
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<td></td>
</tr>
<tr>
<td>Room and Board is limited to the semi-private room rate, or if the Hospital has private rooms only, the lowest private room rate. Eligible charge for ICU is the ICU charge.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital / Facility Outpatient Expenses</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>(Precertification required for outpatient surgery)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility/Sterility</td>
<td>Refer to appropriate service for benefit percentages</td>
<td>Refer to Preventive Care</td>
</tr>
<tr>
<td>(Covered up to diagnosis of infertility/sterility only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>Refer to Preventive Care</td>
<td></td>
</tr>
<tr>
<td>Preconception and Prenatal care as required by federal law</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>Lactation Consultations</td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>All other eligible charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity related expenses for dependent Children are covered.</td>
<td>Only 1 routine ultrasound is covered during the course of the pregnancy.</td>
<td></td>
</tr>
<tr>
<td>BENEFIT DESCRIPTION – PPO PLAN</td>
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<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------------------</td>
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<td>----------------</td>
</tr>
<tr>
<td><strong>Newborn Care – Routine Inpatient</strong></td>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>
| **Organ Transplants**  
(Transportation/accommodation expenses are limited to a combined maximum of $5,000 per transplant) | 80% after deductible | Not Covered |
| See the Medical Benefits section for more details about this benefit. | | |
| **Orthotics/Prosthetics**  
(2 prosthetic bras Plan Year maximum) | 80% after deductible | 50% after deductible |
| **Physician Services** | | |
| Inpatient Visits | 80% after deductible | 50% after deductible |
| Inpatient Surgery | 80% after deductible | 50% after deductible |
| Outpatient Visits | 80% after deductible | 50% after deductible |
| Outpatient Surgery  
(Physician’s fee for services not performed in a Physician’s office)  
(Precertification required for services over $1,000) | 80% after deductible | 50% after deductible |
| Office visits  
Primary Care Physician | 100% after deductible  
$25 copay | 50% after deductible |
| Specialist | 100% after deductible  
$35 copay | 50% after deductible |

Copay is per provider and applies to all covered services performed during the visit, unless otherwise specified elsewhere in the Plan. The serum for airborne allergy treatment is not covered under the copay benefit and is subject to deductible and coinsurance. Precertification is required for surgical services over $1,000.

For the purposes of the Plan, the following types of providers are considered Primary Care Physicians: Family Practitioner, General Practitioner, Internist, Pediatrician, and OB/GYN.

| Prescription Drugs (Inpatient) | Refer to Hospital / Facility Inpatient Expenses |
| Prescription Drugs (Outpatient) | Refer to the Schedule of Prescription Drug Benefits subsection |
**Preventive Care**

- Preventive care includes the following once: routine office visit, physical exam, X-ray & lab, annual PSA screening, mammogram (once annually for members age 35-40, then required by law thereafter), skin cancer screening performed by a M.D. or D.O., and all AZLGBT Wellness Program on-site screenings.

- Preventive services are also covered as recommended by the United States Preventive Services Task Force (USPSTF) and immunizations will be covered as recommended by the Centers for Disease Control (CDC). All services are limited to no more than once annually or as recommended by the USPSTF.

**Rehabilitation Services**

*(Physical, Occupational, Speech, & Cardiac Rehab Therapies)*

- (60 outpatient visits Plan Year maximum for all types of therapy combined)
- (Additional visits may be covered if they are precertified)

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

**Rehabilitation Facility – Inpatient**

- (60 days Plan Year maximum)

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

**Second/Third Surgical Opinion**

- Copays will be waived if the Second/Third Opinion is mandated by the Utilization Management company. Additionally, if the Plan requires a second opinion and only Out-of-Network providers are available, then services will be paid at the In-Network benefit level.

**Sterilization**

- Vasectomy (covered only in the Physician’s office)

- Female sterilization as required by federal law

**Temporomandibular Joint Syndrome**

- ($300 Plan Year maximum)

- Maximum includes surgical and nonsurgical treatment combined, including orthognathic surgery.

**Urgent Care Facility**

- (includes all covered charges billed by facility)

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% after deductible $35 copay</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

**Other Covered Expenses**

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>
Schedule of Prescription Drug Benefits for the PPO Plan
The following schedule summarizes amounts paid by the Plan. Please refer to the Prescription Drug Benefit section for a description of covered expenses and benefit exclusions and limitations.

<table>
<thead>
<tr>
<th>Prescription Card Options – PPO PLAN</th>
<th>30-day Supply</th>
<th>90-day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred Retail Pharmacy Option</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribed Preventive Medications and Contraceptives as required by federal law*</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Formulary Generics and some lower cost Brand Name products</td>
<td>$15</td>
<td>$30</td>
</tr>
<tr>
<td>Formulary Brand Name products and some higher cost Generics*</td>
<td>$40</td>
<td>$100</td>
</tr>
<tr>
<td>Non-Preferred products (both Brand Name and Generics)*</td>
<td>$80</td>
<td>$200</td>
</tr>
<tr>
<td>Specialty drugs (available only through the Navitus Specialty Rx Program)</td>
<td>$100</td>
<td>Not Available</td>
</tr>
<tr>
<td><strong>Non-Preferred Retail Pharmacy Option</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribed Preventive Medications and Contraceptives as required by federal law*</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Formulary Generics and some lower cost Brand Name products</td>
<td>$20</td>
<td>$40</td>
</tr>
<tr>
<td>Formulary Brand Name products and some higher cost Generics*</td>
<td>$45</td>
<td>$112.50</td>
</tr>
<tr>
<td>Non-Preferred products (both Brand Name and Generics)*</td>
<td>$85</td>
<td>$212.50</td>
</tr>
<tr>
<td><strong>Mail Order Option</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribed Preventive Medications and Contraceptives as required by federal law*</td>
<td>Not Available</td>
<td>$0</td>
</tr>
<tr>
<td>Formulary Generics and some lower cost Brand Name products</td>
<td>Not Available</td>
<td>$20</td>
</tr>
<tr>
<td>Formulary Brand Name products and some higher cost Generics*</td>
<td>Not Available</td>
<td>$80</td>
</tr>
<tr>
<td>Non-Preferred products (both Brand Name and Generics)*</td>
<td>Not Available</td>
<td>$160</td>
</tr>
<tr>
<td><strong>Non-Participating Pharmacy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Classes</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
Brand Name Penalty: If your Physician authorizes the use of a Generic drug, but you choose to use the Brand Name drug, you must pay the difference between the actual cost of the Generic and Brand Name in addition to the Brand Name copayment.

Diabetic supplies are covered at 100%, no deductible at participating pharmacies if you are enrolled in the Sweet Savings Program.

Prescribed Preventive Medications and Contraceptives as required by federal law includes prescribed preventive medications that are recommended by the USPSTF, as well as all FDA-approved preferred Generic and Brand Name prescribed female contraceptives (including but not limited to injectable, implants, IUDs, oral, and transdermal) at the following member cost:

- $0 cost for Generic
- $0 cost if there is no Generic equivalent or when Physician does not authorize Generic
- $0 cost for over-the-counter with a prescription
- Otherwise, refer to other existing drug costs.

- If the Plan imposes a penalty for choosing Brand Name when Generic is available and authorized by the Physician, such penalty continues to apply.

Brand Name means a trade name medication.

Generic drug means a prescription drug that has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Formulary Brand Name drug means a trade name prescription medication that is on the Formulary Brand Name drug list, compiled by the third party payor, of safe, effective therapeutic drugs specifically covered by this Plan.

Non-Formulary Brand Name drug means a trade name prescription medication that is not on the Formulary Brand Name drug list.

Specialty drugs means prescription medications that require special handling, administration or monitoring. These drugs are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the patient’s drug therapy. Specialty drugs are used to treat complex, chronic and often costly conditions, such as cancer, chronic kidney failure, post-transplant anti-rejection, multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia. These drugs may have a limited distribution or may need prior authorization to have them ordered through a specialty pharmacy.
Schedule of Short Term Disability Benefits
The Short Term Disability Benefit is subject to the benefit maximums shown below. See the Short Term Disability Benefits section for details.

**Note:** Elected officials who are covered under the Plan are not eligible to receive short term disability benefits.

**Maximum Weekly Benefit:** 60% of the Covered Employee’s Weekly Earnings at the time the Total Disability began

**Minimum Payable:** $100 per week

**Maximum Benefit Period:** 135 calendar days

**Waiting Period:** The longer of exhaustion of all paid leave or 45 calendar days of Total Disability

**Survivor Benefit:** 30 calendar days
DEFINITIONS

For this Summary Plan Description, the following terms have the meanings given them in this section, unless otherwise defined elsewhere in the Summary Plan Description for the purpose of specific provisions. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this Summary Plan Description for that information.

Accident: An unintentional, unforeseeable and undesirable happening that results in bodily injury for which medical treatment is required.

Actively at Work and Active Work: Actually performing the regular duties of the employee’s occupation at an Employer-designated work site. For a vacation, holiday or scheduled non-working day (e.g., weekend, etc.), Actively at Work and Active Work mean the capacity to perform the regular duties of the employee’s occupation at an Employer-designated work site. An employee will be deemed Actively at Work if the employee is absent from work due to a health factor.

Administrative Period: A period of time selected by the Employer beginning immediately following the end of the Measurement Period and ending immediately before the start of the associated Stability Period. This period of time may be used by the Employer to determine if a Variable Hour Employee averaged at least 30 hours per week during the Measurement Period and, if so, to make an offer of coverage. Any applicable Administrative Period will not exceed 90 days.

Allowable Charge: See the ‘Reasonable and Customary and Allowable Charge’ definition.

Benefit Services Manager: Gilsbar, L.L.C., the entity that performs certain contracted nondiscretionary administrative services for the Plan pursuant to the terms of the Benefit Services Management Agreement.

Calendar Year: A period of twelve months commencing January 1 and ending December 31 of the same year.

Certificate of Coverage: A written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual’s previous coverage.

Chiropractic Treatment: Skeletal adjustments, modalities, spinal/cerebral manipulation or other treatment in connection with the detection and correction, by manual means, of structural imbalance or subluxation of the human body. Such treatment is done to remove interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.
Clinical Trial: An Approved Clinical Trial as defined by PPACA, and includes phase I, II, III or IV trials that are federally funded by specified Agencies (National Institutes of Health (NIH), the CDC, CMS, a cooperative group or center of any of the previous entities or the Dept. of Defense or Veterans Affairs, or a qualified non-governmental research entity identified by NIH guidelines) or are conducted under an investigational new drug application reviewed by the FDA (if such application is required).


Continuous Period of Confinement: All periods of confinement due to the same or a related cause or condition, unless periods are separated by one month during which the Covered Employee or Covered Dependent was not confined in either a Hospital or an Extended Care Facility or Skilled Nursing Facility.

Cosmetic or Cosmetic Surgery: Services or supplies designed to improve appearance, or surgery performed to reshape normal structures of the body in order to improve the patient’s appearance and self-esteem.

Covered Dependent: A dependent covered pursuant to the eligibility requirements of the Plan; however, a dependent eligible as a dependent of more than one Covered Employee may not be a Covered Dependent of more than one employee.

Covered Employee: An employee covered pursuant to the eligibility requirements of the Plan, except that no employee may be covered simultaneously as an employee and a dependent.

Custodial or Custodial Care: Care or confinement provided primarily for the maintenance of the Participant, essentially designed to assist the Participant, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, and supervision over medication which can normally be self-administered and all domestic activities.

Elective Surgical Procedure: Any non-Emergency surgical procedure which may be scheduled at the convenience of the patient or the surgeon without jeopardizing the patient’s life or causing serious impairment to the patient’s bodily functions.

Eligibility Date: The day on which employees and dependents of employees become eligible to participate in the Plan.

Eligible Dependent: (See Highlights section.)
Eligible Employee: (See Highlights section.)

Eligible Retiree: (See Highlights section.)

Emergency Medical Condition: A severe medical condition of recent onset that would lead a reasonably prudent and knowledgeable layperson to believe that failure to obtain immediate medical attention could result in serious jeopardy to health or serious impairment to bodily function or to any bodily organ or part.

Examples of Emergency medical conditions include, but are not limited to:
- Chest pain
- Heart attack
- Head injuries
- Strokes (cerebrovascular accidents)
- Poisoning
- Convulsions
- Severe bleeding
- Fractures
- Vomiting blood
- Extreme difficulty breathing
- Sudden severe pain anywhere in the body
- Threat of bodily harm to self or others

If you believe you are having a medical emergency, call 911 (or the appropriate emergency number in your area) or go immediately to the nearest appropriate medical facility.

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

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

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

Employer: The following county governments or associations in Arizona, including any affiliate or subsidiary thereof:
- Apache County
- Gila County
- Graham County
Essential health benefits: Under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental or Investigational: Any treatment, equipment, new technology, drug, procedure or supply which:

1. is not recognized by the state or national medical communities;

2. does not have final approval from the appropriate government regulatory bodies of the United States;

3. is not supported by conclusive, scientific evidence regarding the effect on health outcome; or

4. is not considered standard medical treatment for the patient’s specific condition when compared with established, more conventional or widely recognized treatment alternatives.

Any treatment, equipment, new technology, drug, procedure or supply may be considered Experimental or Investigational within this definition, even if a Physician has previously prescribed, ordered, recommended or approved such treatment. The Plan Administrator determines what is considered Experimental or Investigational. Routine patient costs associated with participation in approved Clinical Trials shall not be considered Experimental or Investigational for qualified individuals.

Extended Care or Skilled Nursing Facility: A licensed facility operating pursuant to law which is primarily engaged in providing (for compensation from its patients) skilled nursing care on an Inpatient basis during the convalescent stage of Illness or Injury under 24-hour-a-day supervision of a Physician or registered graduate Nurse, and which maintains permanent facilities for the care of ten or more bed patients. Such a facility must maintain complete medical records on each patient.
and have established methods and procedures for the dispensing and administering of drugs. In no event shall the term include a facility that is primarily:

1. A rest home, retirement home or home for the aged;

2. A school or similar institution;

3. Engaged in the care and treatment of Substance Abuse, or of mentally ill or senile persons; or

4. Engaged in Custodial Care.

Full-time Employee or Full-Time Employment: With respect to a calendar month, an Employee who is employed an average of at least 30 hours of service per week with the Employer.


Home Health Care Agency: An agency that:

1. Is primarily engaged in providing skilled nursing and other therapeutic services to the patient in his home;

2. Is duly licensed or approved by the appropriate governmental body if such licensing or approval is legally required;

3. Has policies established by a professional group associated with the organization, including at least one Physician and at least one registered Nurse to govern the services provided;

4. Provides for full-time supervision of such services by a Physician or by a registered Nurse; and

5. Maintains a complete medical record of each patient.

Home Health Care Expenses: The Allowable Charge made by a health care agency for the following necessary services or supplies furnished to the Covered Employee, Covered Retiree, or Covered Dependent in such individual’s home in accordance with the home health care plan for care for which the patient would otherwise have been hospitalized:

1. Part-time or intermittent nursing care by or under the supervision of a registered Nurse;

2. Part-time or intermittent home health care aide services that consist primarily of caring for the patient;
3. Physical therapy, Occupational Therapy and speech therapy provided by the Home Health Care Agency; and/or

4. Medical supplies, drugs and medications prescribed by a Physician and laboratory services by or on behalf of a certified Home Health Care Agency, to the extent such items would have been covered under any other provisions of the Plan had the Covered Employee, Covered Retiree, or Covered Dependent been confined in a Hospital.

Hospice: A licensed service that offers a coordinated program of home care and Inpatient care for a Terminally Ill patient and the patient’s family. The program provides supportive care to meet the special needs from the physical, psychological, spiritual, social and economic stresses often experienced during the final stages of life.

Hospital: An institution operated pursuant to law that is accredited by the appropriate national regulatory body for Hospital accreditation. It must be primarily engaged in providing (for compensation from its patients) medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an Inpatient basis. It must also provide such facilities under the supervision of a staff of Physicians and with 24-hour-a-day nursing service by registered graduate Nurses. In addition, the definition of a Hospital shall include the following:

1. A surgery center;

2. A rehabilitation hospital, if it provides medical supervision by a Physician, 24-hour-a-day nursing services by registered graduate Nurses and treatment programs developed by a staff of professionals who specialize in rehabilitative care, and has transfer arrangements with at least one other Hospital providing acute care and surgical facilities;

3. A Substance Abuse treatment center that is licensed by the state or federal government, subject to any exclusions and limitations on such treatment contained in this Plan.

The definition of a Hospital shall not include any institution or part thereof which is used principally as a rest facility, Extended Care Facility, nursing facility, facility for the aged or for Custodial Care, or a halfway house.

Illness: A bodily or Mental/Emotional Disorder of any kind of any Participant. Illness includes pregnancy for the purpose of benefit determination. Illness also includes Injury where appropriate to the context.

Incurred or Incurred Date: The actual date a specific service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered.
**Injury:** A bodily injury resulting from an Accident sustained by any Participant. All injuries sustained by a Participant in one Accident will be considered one Injury.

**Inpatient:** A person who is confined in a Hospital as a registered bed patient and who is charged at least one day’s room and board by the Hospital.

**Late Enrollee:** A Participant who enrolls in the Plan other than:

1. during the first period in which the individual is eligible to enroll under the Plan; or
2. during a Special Enrollment Period.

**Lifetime Maximum Benefit:** The Lifetime Maximum Benefit is the absolute limit on what this Plan will pay for each Participant’s covered expenses, even if other provisions of the Plan appear to entitle the Participant to more. “Lifetime” shall mean while covered under this Plan or any other plan maintained by the Employer.

**Marriage or Married:** A union that is legally recognized as a marriage under the state law where such marriage was performed.

**Measurement Period:** A period of time selected by the Employer during which a Variable Hour Employee’s hours of service are tracked to determine if they average at least 30 hours during this period. The beginning dates and the lengths of each Measurement Period are set by the Plan Sponsor and will be applied uniformly to each category of employees.

- Initial Measurement Period: For a newly-hired Variable Hour Employee, this Measurement Period may start at any time from the date of hire to the first day of the month after the employee begins working and end no later than after the first 12 months of service.

- Standard Measurement Period: For Ongoing Employees, this Measurement Period will start on the same day each year and will last no longer than 12 months.

**Medically Necessary or Medical Necessity:** Describes medical treatment, as determined by the Plan Administrator, that:

1. Is appropriate and consistent with the diagnosis;

2. In accordance with accepted medical standards, would not have been omitted without adversely affecting the patient’s condition or the quality of medical care rendered;

3. Is not primarily Custodial Care; and
4. As to institutional care, could not have been provided in a Physician’s office, in the Outpatient department of a Hospital or in a lesser facility without adversely affecting the patient’s condition or the quality of medical care rendered.

The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is “medically necessary.” In addition, the fact that certain services are excluded from coverage under this Plan because they are not “medically necessary” does not mean that any other services are deemed to be “medically necessary.”

**Medicare:** All parts of Health Insurance for the Aged provided by Title XVIII of the Federal Social Security Act of 1965, as now constituted or as hereafter amended.

**Mental/Emotional Disorder:** Any disorder characterized by abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional or behavioral disturbances are the dominant feature. Mental/Emotional Disorders include mental disorders, mental Illnesses, psychiatric Illnesses, mental conditions and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement.

**New Employee:** An Employee who has not been employed for at least one complete Standard Measurement Period, or who is treated as a New Employee following a period during which the Employee was credited with zero hours of service.

**Nurse:** A licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) who does not usually live with the patient and is not a member of his family.

**Occupational Therapy:** The therapeutic use of self-care, work or other therapy activities for the sole purpose of reducing disability and restoring function and motor skills following an Injury or Illness.

**Ongoing Employee:** An Employee who has been employed by the Employer for at least one complete Standard Measurement Period.

**Outpatient:** A person who is not admitted as an Inpatient but who receives medical care.

**Outpatient Surgery:** Surgery performed on an Outpatient basis at a Hospital, ambulatory surgical facility, or Physician’s office. An ambulatory surgical facility is defined as a licensed, specialized facility, within or outside the Hospital facility, that meets all the following criteria:

1. Is established, equipped and operated in accordance with the applicable laws in the jurisdiction in which it is located and primarily for the purpose of performing surgical procedures;
2. Is operated under the supervision of a Medical Doctor (M.D.) who is devoting full time to such supervision;

3. Provides at least two operating rooms and one post anesthesia recovery room;

4. Provides the full-time service of one or more Registered Nurses for patient care in the operating rooms;

5. Maintains a written agreement with at least one or more Hospitals in the area for immediate acceptance of patients who develop complications;

6. Maintains an adequate medical record for each patient. The medical record must contain 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.

Partial Hospitalization: A structured, Hospital-based program. Patients receive intense treatment usually between the hours of 8 a.m. and 5 p.m., Monday through Friday, and are capable of remaining in their home environment in the evenings. Individual, group or family therapy is provided a minimum of four hours a day, three times a week.

Participant: Any Eligible Employee, Eligible Retiree, or Eligible Dependent who has elected coverage under this Plan. Participant, covered individual, covered person, and member have the same meaning.

Physician: A duly licensed Doctor of Medicine (M.D.), Osteopath, Podiatrist, Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), Doctor of Optometry, Chiropractor and auxiliary personnel which can include clinical psychologists, board-certified social workers, licensed professional counselors, Family Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, Nurse midwives, physical and occupational therapists or any other licensed practitioner of the healing arts if he or she performs a covered service:

1. within the scope of the license; and

2. applicable state law requires such practitioner to be licensed.

Plan: The arrangement created by this Plan Document and Summary Plan Description, and which may be amended from time to time.

Plan Administrator: Arizona Local Government Employee Benefit Trust.

Plan Document: This Plan Document and Summary Plan Description.
Plan Year: A period of twelve consecutive months commencing on either the effective date of the Plan or on the day following the end of the first Plan Year if the first Plan Year is a short year.

Preferred Provider Organization or PPO: A network of providers offering discounted fees for services and supplies to Participants. The network will be identified on the Participant’s Plan identification card.

Reasonable and Customary and Allowable Charge:

Reasonable and Customary: For the purposes of the plan generally, a charge is considered Reasonable and Customary:

1. If the charge is made for medical or dental services or supplies essential to the care of the Participant; and

2. If the charge is in the amount normally charged by the provider for similar services and supplies; and

3. If the charge does not exceed the amount ordinarily charged by most providers of comparable services and supplies in the geographic area where the services or supplies are received.

Whether a charge is Reasonable and Customary may be established by the Plan Administrator by use of any customary or accepted method.

Allowable Charge: The following are Allowable Charges under this plan and are agreed to be Reasonable and Customary:

1. A contracted rate of a Preferred Provider Organization servicing the Plan with the agreement of the Plan Administrator is an Allowable Charge.

2. A charge billed by an Out-of-Network provider is determined to be an Allowable Charge under the following rules applied in the order of priority as they are listed:

   a. If the Plan Administrator determines that the Allowable Charge is a lower amount than is otherwise applicable under the following rules, then that lower amount is the Allowable Charge;

   b. If the billed charge is discounted according to an agreement negotiated specifically for the patient by the Plan Administrator directly with the provider, the Allowable Charge is the discounted charge;

   c. If the billed charge is for dialysis, the Allowable Charge is the lesser of the billed charge or one-hundred thirty percent (130%) of the Medicare allowable charge;
d. If the billed charge is for chemotherapy drugs obtained through the pharmacy, home health provider, infusion provider, or directly from the pharmaceutical company, the Allowable Charge is the lesser of the billed charge or the average wholesale price of the drug;

e. If the billed charge is for specialty drugs obtained through the pharmacy, home health provider, infusion provider, or directly from the pharmaceutical company, the Allowable Charge is the lesser of the billed charge or the average wholesale price of the drug minus fifteen percent (15%);

f. If the billed charge is for specialty drugs dispensed by a facility on an Inpatient or Outpatient basis, the Allowable Charge is the lesser of the billed charge or 150% of the average wholesale price;

g. If the billed charge is for an implant (including but not limited to knee and hip replacements, pins, rods, cochlear implants, ocular implants), the Allowable Charge is the lesser of the billed charge or one and one-half (1 ½) times the invoice amount of the supplies;

h. If the billed charge is discounted according to an agreement with a repricing service that covers the Plan, the Allowable Charge is the discounted amount;

i. If the medical or dental service or supply appears on the Reasonable and Customary Table utilized by the Plan Administrator, then the Allowable Charge is the lesser of the billed charge or the amount as listed on the Table;

j. If the billed charge is a facility charge that does not appear on the Reasonable and Customary Table utilized by the Plan Administrator, then the Allowable Charge is the lesser of the billed charge or 200% of the Medicare allowable charge; and

k. If none of the foregoing applies, the Allowable Charge is the billed charge.

Reconstructive Surgery: Surgery performed to restore function by reshaping abnormal structures of the body caused by Illness, Injury, congenital defects or developmental abnormalities.

Residential Treatment Center: A facility that provides treatment 24 hours a day and can usually serve more than twelve people at a time. Treatment may include individual, group and family therapy; behavior therapy; special education; recreation therapy or medical services. Residential treatment is usually more long-term than Inpatient Hospitalization. Residential treatment is for (1) severe and persistent mental illness that results in the person being unable to maintain independent functioning without support and continued treatment for an indefinite period of time or (2) substance abuse in which the patient is at a high risk for relapse.
Routine Physical Exam: Exam by doctor not required because of Illness or Injury.

Second Surgical Opinion: A written report from a qualified Physician, who is not financially or professionally associated with the first Physician, as to the Medical Necessity of a future surgical procedure that was recommended by another Physician. This will include all Outpatient tests and diagnostic procedures Medically Necessary to render such opinion.

Sound, Natural Tooth: Any tooth that is sufficiently supported by its surrounding natural structures and is not decayed or weakened by previous dental work to the extent that it is more susceptible to damage. This susceptibility includes, but is not limited to, a tooth that is restored by a multi-surface restoration or a tooth that has had root canal therapy.

Spouse: An individual who is legally married to a Covered Employee.

Stability Period: A period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period (and, if elected by the Employer, the Administrative Period associated with that Standard Measurement Period or Initial Measurement Period), and is used by the Employer as part of the Look-back Measurement Method. The Stability Period is a period of time equal to the Measurement Period in which the Variable Hour Employee’s eligibility status is fixed.

Substance Abuse: The regular, excessive and compulsive drinking of alcohol and/or physical, habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Summary Plan Description: This Plan Document and Summary Plan Description.

Temporomandibular Joint (TMJ) Syndrome: One or more jaw joint problems including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but is not limited to, orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Terminally Ill: Someone who has a life expectancy of approximately six months or less, as certified in writing by the Physician who is in charge of the patient’s care and treatment.

Variable Hour Employee: An Employee is considered a Variable Hour Employee if, based on the facts and circumstances at the Employee’s start date, the Employer cannot determine whether the Employee is reasonably expected to be employed on average at least 30 hours of service per week during the initial measurement period because the Employee’s hours are variable or otherwise uncertain.
PERSONS COVERED AND EFFECTIVE DATES

Election of Coverage
If you are an Eligible Employee as defined by the Plan in the Highlights, you may elect coverage under the Plan by submitting a completed, valid enrollment form which you may obtain from the Plan Administrator. You may elect coverage for yourself only, you and your Spouse, you and your dependent children, or your whole family. The application process involves electing coverage and paying the required contribution, if any, for the type of coverage you’ve chosen. Your Employer determines annually or more frequently if deemed appropriate, whether (and to what extent) employees will be required to contribute towards the cost of coverage under the Plan. Contributions may be required to obtain employee and/or dependent coverage.

Effective Date of Employee Coverage
Your Eligibility Date is listed in the Highlights section. This is the earliest date that you may become covered under the Plan. If you choose not to enroll within 31 days of your Eligibility Date, you will be considered a Late Enrollee. You will also be considered a Late Enrollee if you do not enroll within 31 days of a Special Enrollment event described later in this section.

Your coverage is effective as follows:

1. If you are an Eligible Employee, at 12:01 A.M. on your Eligibility Date, if you enroll within 31 days of becoming eligible; or

2. If you are a Late Enrollee, at 12:01 A.M. on the first day of July following the date of the request for enrollment (see Open Enrollment Period later in this section).

If you are enrolling during a Special Enrollment period, see the subsection below entitled “Special Enrollment Periods.”

If you are not required to make a contribution to the cost of your coverage (that is, it is non-contributory), it is effective at 12:01 A.M. on your Eligibility Date. However, you must complete an enrollment form in order for your claims to be paid promptly.

If, for reasons not related to a health condition, you are not Actively at Work on the date you would otherwise become covered under the Plan, your coverage will not begin until the day you return to Active Work.

Effective Date of Dependent Coverage
Your dependents may be covered under the Plan only if you are a Covered Employee or Covered Retiree and if the dependents meet the Plan’s requirements for Eligible Dependents. If you have
Eligible Dependents when you first become eligible to participate in the Plan, the Eligibility Date for these dependents is the same as your Eligibility Date. Any dependent not enrolled within 31 days of the Eligibility Date is considered a Late Enrollee. A dependent will also be considered a Late Enrollee if not enrolled within 31 days of a Special Enrollment event described later in this section.

Dependent coverage is effective as follows:

1. If you are an Eligible Employee, at 12:01 A.M. on the Eligibility Date, if you apply for dependent coverage within 31 days of becoming an Eligible Employee; or

2. If you or your dependent is a Late Enrollee, at 12:01 A.M. on the first day of July following the date of the request for enrollment (see Open Enrollment Period later in this section).

If you are enrolling your dependent during a Special Enrollment period, see the subsection below entitled “Special Enrollment Periods.”

If dependent coverage is non-contributory, coverage is effective at 12:01 A.M. on the Eligibility Date. Your dependents must be listed on your enrollment form in order for claims to be paid promptly.

If you did not have an Eligible Dependent when you first became eligible to participate in the Plan, but you later acquire one, coverage for this dependent is effective as described above. However, in this case the Eligibility Date is the date the Eligible Dependent was acquired. For a newborn child, the Eligibility Date is the date of birth. For an adopted child (under age 18), the Eligibility Date is the date of adoption or the date of placement in your home while you are covered under this Plan.

Newborn children will be covered from the time of birth for necessary medical care only if: a) the Covered Employee is carrying dependent coverage on the date of the baby’s birth, or b) enrollment for dependent coverage is made prior to the baby’s birth, or c) enrollment is made and required contributions are authorized within 31 days of the date of birth. When enrolling for the dependent coverage, coverage is effective from the baby’s date of birth and contributions for the dependent coverage are required beginning the first day of the month following the date of birth. Contributory coverage for an adopted child (under age 18) is effective on the date of adoption or the date of placement in your home if application is made within 31 days after this date. These are exceptions to provision (1) above.

Special Enrollment Periods
The employee must make a request for Special Enrollment to the Plan Administrator within 31 days of marriage, birth, adoption or the loss of other coverage (other than Medicaid or a State Children’s Health Insurance Program). The request must be made in writing to the Plan Administrator.
Coverage is effective as follows:

1. For marriage, the date of marriage.

2. For loss of other coverage, the first day of the month following enrollment.

3. For birth or adoption, the date of birth or adoption, or the date the child is placed in the home for adoption.

Special enrollment rights are also available for employees and/or their dependents who lose coverage under Medicaid or a State Children’s Health Insurance Program (SCHIP) or become eligible for a premium assistance subsidy from Medicaid or SCHIP as provided for in the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). In these cases, the employee must make a request for Special Enrollment to the Plan Administrator within 60 days of loss of Medicaid or SCHIP coverage, or notice of eligibility for a premium assistance subsidy, whichever applies. Coverage will become effective no later than the first day of the month after application is made to the Plan Administrator.

If an employee or a dependent does not enroll within 31 days of marriage, birth or adoption or the loss of other coverage, and requests coverage later, he is considered a Late Enrollee and may enroll only during the Open Enrollment Period.

Open Enrollment Period
The Open Enrollment Period and the corresponding coverage effective date are shown in the Highlights section. During the Open Enrollment Period only, the Plan allows an Eligible Employee (and/or his Eligible Dependents) who is not currently enrolled and who has completed any waiting period (i.e., a Late Enrollee) now to elect coverage.

During the Open Enrollment period only, Participants who are currently enrolled may also elect to change their plan selection, add or drop dependents, or drop coverage altogether.

Change in Family Status
Once you are in the Plan, you must notify the Plan Administrator within 31 days of any family status change, such as a newborn baby, or when your first family member becomes eligible, or when you no longer need coverage for a certain family member, or when they are no longer eligible as defined in the Plan.
Change in Coverage Status
If your coverage status changes from dependent to employee or from employee to dependent, all individual deductibles, benefit maximums, and out-of-pocket expense amounts applicable to your individual coverage will carry over as if there had been no change in status.

When Both Spouses Are Covered Employees
When both you and your Spouse are Covered Employees and you have family coverage for dependent children, one Spouse may be treated as a dependent for billing purposes and in calculating the family deductible and out-of-pocket expense amount (when applicable). This provision allows families in which both Spouses are Covered Employees to get the full benefit of their family coverage. In addition, an employee may not enroll their dependents without enrolling themselves in the Plan.

Election of Coverage Regarding Medicare
Medicare regulations applicable to employers with twenty or more employees require that any active Participant who has reached age 65 and is eligible for Medicare must choose one of the following coverage options:

1. Primary coverage under this Plan (Plan benefits will be paid without regard to Medicare), or
2. Sole coverage under Medicare (coverage under this Plan will terminate).

When eligible, Plan Participants must enroll in Medicare coverage in a timely manner in order to assure maximum coverage.

Court-ordered Coverage for a Child
Federal law requires the Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below. Be sure you read them carefully.

The Plan Administrator shall enroll for immediate coverage under this Plan any alternate recipient who is the subject of a “medical child support order” (“MCSO”) or “national medical support notice” (“NMSN”) that is a “qualified medical child support order” (“QMCSCO”) if the child named in the MCSO is not already covered by the Plan as an eligible dependent, once the Plan Administrator has determined that the order or notice meets the standards for qualification set forth below.

“Alternate recipient” shall mean any child of a Covered Employee who is recognized under a MCSO as having a right to enrollment under this Plan as the Covered Employee’s Eligible Dependent.
“MCSO” shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Covered Employee’s child or directs the Covered Employee to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or

2. Enforces a law relating to medical child support described in Social Security Act §1908 with respect to a group health plan.

“NMSN” shall mean a notice that contains the following information:

1. Name of an issuing state agency;

2. Name and mailing address (if any) of an employee who is a Participant under the Plan;

3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Covered Employee or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipient(s)); and

4. Identity of an underlying child support order.

“QMCSO” is an MCSO that creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Employee or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Covered Employee and the name and mailing address of each Alternate Recipient covered by the order;

2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

3. The period of coverage to which the order pertains; and

4. The name of this Plan.

In addition, a NMSN shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of “NMSN”;

   a. Identifies either the specific type of coverage or all available group health coverage. If the employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the employer and the Plan Administrator will assume that all are designated; or
b. Informs the Plan Administrator that, if a group health plan has multiple options and the Eligible Dependent is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan’s default option (if any); and

2. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as “qualified” if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Participants without regard to this section, except to the extent necessary to meet the requirements of a state law relating to MCSOs, as described in Social Security Act §1908.

Upon receiving a MCSO, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Covered Employee and each Alternate Recipient covered by the order (at the address included in the order) in writing of the receipt of such order and the Plan’s procedures for determining whether the order qualifies as a QMCSO; and

2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a NMSN, the Plan Administrator shall:

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

   a. Whether the child is covered under the Plan; and

   b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

3. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the order.
“GINA”
“GINA” shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term “genetic information” means, with respect to any individual, information about:

1. Such individual’s genetic tests;

2. The genetic tests of family members of such individual; and

3. The manifestation of a disease or disorder in family members of such individual.

The term “genetic information” includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detects genotypes, mutations, or chromosomal changes.

Therefore, this Plan will not discriminate in any manner with its Participants on the basis of such genetic information.
The Preferred Provider Organization ("PPO" or "In-Network") is a network of Arizona Physicians, Hospitals and other health care providers established specifically to provide comprehensive medical services to Plan Participants at reduced rates. As a Participant in the Plan, you will receive a list of providers that belong to the PPO network. It is the Participant’s choice as to which provider to use.

Use of PPO providers is referred to as “In-Network.” If you choose the In-Network option, please follow the procedures for its use carefully. When medical care is needed, be sure the provider is still under contract with the PPO shown on your ID card. When your doctor refers you to another provider, make sure that provider is also under contract with the PPO before services are rendered.

Eligible expenses for services rendered in an In-Network Hospital by an Out-of-Network provider, including, but not limited to, an anesthesiologist, radiologist or pathologist, will be payable at the same benefit percentage level that an In-Network provider would be paid for such services if you did not have the option of choosing an In-Network provider. All other charges by Out-of-Network providers will be payable at the Out-of-Network benefit percentage shown in the Highlights, even if you are referred to the Out-of-Network provider by an In-Network provider.

The copayment amount and the applicable benefit percentage for Physician office visits on the PPO Plan option are shown in the Highlights. A Participant is required to pay only the listed copay amount for same-day office visit services by an In-Network Physician and, if applicable, the copay amount for same-day services by an In-Network laboratory. The copay applies to the services outlined in the Schedule of Medical Benefits.

Any In-Network charge (1) for a service rendered on a different day, (2) for a service rendered outside the Physician’s office (except as set forth above), or (3) billed as a separate facility fee is specifically excluded from the copay benefit associated with the original office visit. Such charges will be considered for payment by other applicable benefit provisions of the Plan. After the copay, the Plan will apply the applicable benefit percentage to the remaining covered expenses up to the maximum office visit limit, if any, and then the appropriate deductibles, benefit percentages and other Plan limits apply.

When you receive care from an In-Network provider, the benefit percentage payable for your covered expenses will be the higher percentage shown in the Highlights. When you receive care from an Out-of-Network provider, the benefit percentage payable will be the lower percentage shown in the Highlights. This lower percentage will apply to any expenses covered by the Plan, if you had the option of using an In-Network provider and chose instead to use an Out-of-Network provider. The lower percentage will not apply if you must use an Out-of-Network provider in an Emergency.
The limit on your out-of-pocket expenses will be increased up to the maximum shown in the Highlights for covered expenses incurred at an Out-of-Network provider. This means that you will pay more out of your pocket before the Plan increases its benefit percentage to one hundred percent (100%).

When you receive care from an In-Network provider, the lower Plan Year deductible shown in the Highlights will apply. When you receive care from an Out-of-Network provider, the higher Plan Year deductible shown in the Highlights will apply.

A current list of In-Network providers is available, without charge, from BlueCross® BlueShield® of Arizona or through the website located at www.myGilsbar.com. If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, please contact your Employer.

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

Each Participant has a free choice of any provider, and the Participant, together with his provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO network providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any PPO network provider.
DEDUCTIBLES AND OUT-OF-POCKET EXPENSES

Deductibles and out-of-pocket expenses represent the portion that the Participant pays of covered expenses. This section describes generally these cost-sharing provisions of the Plan. The Plan Sponsor determines these amounts.

Plan Year Deductible
The Plan Year deductible is the amount of covered expenses Incurred by an individual during the Plan Year for which no benefits will be paid. After you or a Covered Dependent has satisfied the Plan Year deductible, the Plan pays a certain percentage of the covered expenses for that individual that are Incurred during the rest of the Plan Year. Deductible accumulation period is July 1 through June 30. Copayments do not accrue toward the deductible, except when the High Deductible Health Plan option is selected.

Family Plan Year Deductible
If the dollar amount of the family Plan Year deductible, shown in the Highlights, is satisfied by the combined covered expenses applied to the individual deductibles of several Participants in a family, no additional Plan Year deductible amount is required to be satisfied by the Participants of that family for covered expenses Incurred during the remainder of the Plan Year. Once a Participant has satisfied the individual deductible, no additional covered expenses for that person will be counted toward the family deductible.

Out-of-Pocket Expense
Out-of-pocket expense is the amount of covered expenses you must pay before certain benefits begin to be paid at one hundred percent (100%).

If during the Plan Year your out-of-pocket covered expenses satisfy the out-of-pocket expense amount, the rate of payment for certain covered charges will be increased to a full one hundred percent (100%). The one hundred percent (100%) will continue for covered expenses Incurred during the remainder of that Plan Year. You must satisfy your out-of-pocket amount before these benefits will be paid at one hundred percent (100%).

Family Out-of-Pocket Expense
If the dollar amount of the family out-of-pocket expense amount, shown in the Highlights, is satisfied by the combined covered expenses applied to the individual out-of-pocket expense amount of several Participants in a family, no additional out-of-pocket expense amount is required to be satisfied by the Participants of that family for covered expenses Incurred during the remainder of the Plan Year. Once a Participant has satisfied the individual out-of-pocket expense amount, no additional covered expenses for that person will be counted toward the family out-of-pocket expense amount.
MEDICAL BENEFITS

Covered Medical Expenses
Covered expenses (sometimes identified as covered charges, eligible charges, eligible expenses or similar terms) include only the Allowable Charges that:

1. Are Medically Necessary for the care and treatment of Illness or Injury of a Participant; and
2. Are recommended by an attending Physician; and
3. Do not exceed the Reasonable and Customary charge; and
4. Are not excluded by other provisions applicable to this coverage.

The following expenses are covered by the Plan provided they meet the requirements for covered medical expenses described above and are not excluded elsewhere in the Plan. Reimbursement is based upon the Lifetime and Plan Year limits, benefit percentages and other limitations previously described in the Highlights section.

1. **Acupuncture**, when administered by an M.D. or D.O.

2. **Allergy testing** and treatment. Injections of food allergy antigens, sublingual immunotherapy, and the like are covered.

3. Transportation by a professional **ambulance** service to a local Hospital or convalescent facility for Inpatient care, if Medically Necessary, or to the nearest Hospital for Emergency care. Transportation by ambulance to a non-medical facility will be covered only if Medically Necessary. Expenses for transportation by air will be covered only if an air ambulance is Medically Necessary due to a life threatening condition.

4. Services and supplies used in the administration of **anesthesia**, when not duplicated in the Hospital charges.

5. **Bariatric Surgery** if the Covered Person meets all of the following criteria and the procedure is performed by In-Network providers (surgeons, assistant surgeons, anesthesiologists etc.) at an In-Network facility known to have an effective program for doing such a surgery and a follow-up program:
   
   a. The person has been covered under this Plan for a minimum of twenty-four (24) months immediately preceding the date of the procedure; and
   
   b. The Covered Person is at least eighteen (18) years of age, physically mature, and is not older than sixty-five (65) years of age; and
c. Two (2) separate Physicians confirm in writing that the Covered Person:
   i. Is, and has been for two (2) or more years prior to the procedure, Morbidly Obese; and
   ii. Is an acceptable surgical interventional risk (i.e., he/she must otherwise be a good surgical candidate); and
   iii. Does not have a specifically correctable cause of obesity, such as a glandular or endocrine problem;

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

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

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

Benefits will not be provided for subsequent procedures to correct further Injury or Illness resulting from the Covered Person’s non-compliance with prescribed medical treatment follow-up post-surgery. Expenses which are Medically Necessary, in connection with services or supplies and surgical procedures performed in connection with Morbid Obesity are covered.

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

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

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

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

The benefits payable for a bariatric surgery, gastric bypass, or any other type of surgical weight loss procedure are limited that such a Covered Person is only eligible for such benefits one (1) time during the life of the Covered Person.

6. **Blood** and blood derivatives that are not donated or replaced.

7. **Cardiac rehabilitation**, Phases I and II only.

8. **Chiropractic** treatment. Charges for chiropractic care/spinal manipulations for the correction of structural imbalance, distortion, misalignment or subluxation of or in the vertebral column, by manual or mechanical means and the necessary adjunctive modalities (hot, cold therapy etc.).

9. Routine patient costs associated with a qualified individual's participation in a **Clinical Trial**, as defined by the Plan, for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in the Patient Protection and Affordable Care Act (PPACA). A life-threatening condition is a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

A “qualified individual” is someone who is eligible to participate in an “Approved Clinical Trial” and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

“Routine patient costs” include all items and services consistent with the coverage provided by the Plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. If one or more in-network providers are participating in a Clinical Trial, the Plan may require that the qualified individual participate in the Clinical Trial with an in-network provider. The Plan will cover non-network providers outside the state in which the qualified individual resides only if there is not an in-network provider conducting the same trial in state.

Routine patient costs do not include (a) the investigational item, device or service itself; (b) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; (c) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis; and (d) the cost of a health care service that is specifically excluded by the Plan.

10. **Diabetes** self-management training.
11. Rental of **durable medical equipment** when such equipment is deemed Medically Necessary, including, but not limited to, a wheelchair, hospital-type bed, respirator, and equipment for the administration of oxygen. Such equipment may be purchased if, in the judgment of the Plan Administrator, purchase of the equipment would be less expensive than rental or the equipment is not available for rental. If purchased, the Plan will cover replacement only after a five-year period.

12. Room, board and supplies (other than drugs and medicines) billed by an **Extended Care Facility** or Skilled Nursing Facility. Benefits are payable only if the confinement is required due to a need for extended medical care and not for Custodial Care.

13. **Home health** care, if prescribed by a Physician as a plan of treatment. The Physician must certify that the proper treatment of the Injury or Illness would require continued confinement as an Inpatient in a Hospital or Skilled Nursing Facility in the absence of the services and supplies provided as part of the home health care plan. Each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and four hours of home health aide service shall be considered as one home health care visit.

14. **Hospice** care. Covered charges are as follows:

   a. Inpatient Hospice care;

   b. Services of a Physician;

   c. At-home care including part-time nursing care, use of medical equipment, rental of wheelchairs and hospital-type beds;

   d. Emotional support services and physical/chemical therapies; and

   e. Bereavement counseling sessions for covered family members following the death of a Terminally Ill Participant.

15. **Hospital** room and board, at the semi-private Hospital room and board rate. If confinement is in a Hospital providing private rooms only, the covered expense shall be no greater than the rate listed in the Schedule of Benefits. If Medical Necessity requires an intensive care unit or intermediate care unit, the Plan will cover the room and board up to the maximum listed in the Schedule of Benefits.

16. Other **Hospital** services and supplies furnished by the Hospital for medical care during confinement, exclusive of Physician’s and other professional services.

17. Charges to diagnose the condition of **infertility** will be covered.
18. Medical laboratory charges in connection with treatment of an Illness or Injury.

19. Marriage and family counseling for Covered Employees and their covered dependents.

20. Treatment of Mental/Emotional Disorders.

21. Routine Hospital and Physician care for a newborn child prior to discharge from the Hospital. Such care may not be less than 48 hours following a normal delivery or 96 hours following a cesarean section. Refer to “Pregnancy” later in this section for details of the Newborns’ and Mothers’ Health Protection Act of 1996. The maximum benefit is also 48 hours and 96 hours, respectively. Charges for routine newborn care will be covered under the mother’s claim if she is covered under the Plan.

22. Nutritional counseling/classes will be considered a Preventive service. Services will only be eligible if performed by an M.D., D.O., P.A., Registered Dietician (RD), or a Certified Diabetes Educator (CDE).

23. Occupational Therapy performed by a licensed occupational therapist and ordered by a Physician. The therapy must be to restore or rehabilitate due to an Illness or Injury or due to surgery for an Illness or Injury. It must be considered progressive therapy, not maintenance therapy, and must not be performed for the purpose of vocational rehabilitation. Covered expenses do not include either recreational programs or supplies used in Occupational Therapy.

24. Covered medical expenses Incurred for care and treatment due to an organ transplant are subject to the following:

   a. The recipient must be a Participant in the Plan;

   b. Covered organ transplants are limited to transplants of the kidney, cornea, bone marrow and/or stem cell, heart, heart/lung, liver, lung, and pancreas or other organ transplant approved by the FDA that is not Experimental or Investigational. Bone marrow and/or stem cell transplants are considered organ transplants for the purposes of this Plan. Note: stem cell transplants for breast cancer are considered Experimental/Investigational by this Plan;

   c. Charges for obtaining donor organs are covered under the Plan when the recipient is a Participant. Donor charges include those for:

      i. removing the organ from the donor; and

      ii. transportation of the organ to the place where the transplant is to be performed.
d. Except as provided under (c) above, organ procurement does not include donor-related expenses while the Participant is awaiting the transplant, unless the donor is covered under this Plan.

Covered organ transplants must be performed at an In-Network facility known to have an effective program for doing such procedure. If there isn't an In-Network facility that is equipped to perform the transplant, Out-of-Network facilities may be eligible if approved in advance by the Benefit Services Manager and is performed at a facility approved by the reinsurer.

Prior to undergoing the procedures, the Participant who is the recipient of the transplant must receive two opinions with regard to the need for transplant surgery. Each opinion must be in writing by a board-certified specialist in the involved field of surgery. The specialist must certify that alternative procedures, services, or course of treatment would not be effective in the treatment of the Participant's condition.

If the recipient resides more than 50 miles from the transplant location, regularly scheduled commercial transportation to and from the transplant location for the recipient and one companion is covered. The cost of reasonable and necessary lodging and meals for one companion accompanying the recipient to the transplant location is also covered. Itemized receipts for these expenses are required.

25. Orthopedic shoes / Orthotics: Charges for orthopedic shoes and other related orthotic supportive appliances, including their replacement once in each twelve month period, or, if under nineteen years of age, once in each six month period if necessitated by the child's growth. Charges will only be covered when ordered by an M.D. or D.P.M. and dispensed by a certified orthotics laboratory.

26. Outpatient Surgery charges for necessary services and supplies for surgical procedures performed on an Outpatient basis at a Hospital, ambulatory surgical facility, or Physician's office, provided that benefits for such charges would be payable if the procedure were performed during a Hospital confinement.

27. Physician's fees for medical care and treatment of an Illness or Injury covered under the terms of this Plan.

28. Physical therapy by a licensed physical therapist. The therapy must be to restore or rehabilitate due to an Illness or Injury or due to surgery for an Illness or Injury.

29. Preadmission testing ordered by a Physician, done on an Outpatient basis and related to the condition for which the patient is to be hospitalized. These tests must be performed at a Hospital, ambulatory surgical facility, or Physician's office prior to confinement as an
Inpatient. No benefits will be payable if the same tests are repeated after Hospital admission, unless Medically Necessary.

30. **Pregnancy** expenses for Covered Employees, Covered Spouses and the covered dependent daughter of a Covered Employee. Under the Newborns’ and Mothers’ Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a 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 her 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).

Coverage for prenatal care is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman.

31. **Prescription drugs** necessary for the treatment of an Illness or Injury, if obtainable only on a Physician’s written prescription and dispensed by a licensed pharmacist (see Prescription Drug Benefits section).

32. **Preventive** care services, as listed in the Schedule of Medical Benefits, and including breast pump supplies and rental of breast pumps for female Participants during breastfeeding. A standard (non-Hospital grade) electric or manual breast pump may be purchased if, in the judgment of the Plan Administrator, purchase would be less expensive than rental or a breast pump is not available for rental; if purchased, the Plan will cover replacement only once per Plan Year.

The sterilization procedures to be considered preventive include sterilization implant (Essure) and surgical sterilization (Sterilization) either abdominally, vaginally or laparoscopically. Eligible charges for a sterilization procedure and all ancillary services will be covered under the preventive benefit when sterilization is the primary purpose of the services provided and/or if it is performed as a standalone procedure and billed as such. However, complications arising following a sterilization procedure are not covered as preventive services. Covered preventive expenses do not include charges for a sterilization procedure to the extent the procedure was not billed separately by the provider or because it was not the primary purpose of the procedure. To the extent sterilization is part of another procedure and/or is not a separate line on the bill, the sterilization procedure is not considered a preventive service.

33. Replacement of a natural eye or limb with an artificial one (prosthesis), and subsequent repair, modification or replacement if it is Medically Necessary. Subsequent replacement is
covered only if the attending Physician certifies in writing that such replacement is Medically Necessary due to:

a. a physical change in the condition of the patient’s site of attachment;

b. the normal, physical growth of a dependent child; or

c. the fact that the existing prosthesis is unusable and cannot be repaired or modified to achieve proper fit and function.

34. **Radiological** tests (X-rays), radium treatments, and treatments with other radioactive substances.

35. **Reconstructive surgery** of the breast on which a **mastectomy** was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications from all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Participant. Reimbursement will be made according to the “Schedule of Medical Benefits” section by type of service.

36. **Rehabilitation Hospital** charges, provided all the following conditions are met:

a. The patient has a physical disability, and his medical condition and functional performance can realistically be improved through the intensive rehabilitation program offered by the Hospital;

b. Other treatment programs offering less intensive care or Outpatient treatment would not achieve the realistic goals sought by the patient through the Hospital’s rehabilitation program; and

c. The patient requires close medical care by a Physician and 24-hour-a-day nursing supervision.

The Utilization Management organization should be notified of the intended stay.

37. **Second Surgical Opinion** charges to confirm that recommended surgery is needed. The Physician who provides the second opinion must be board-certified for the medical condition for which surgery is advised. He must not be scheduled to perform the surgery or be in partnership with or have any financial affiliation with the first Physician in order for the surgical opinion benefit to be paid. If the second Physician disagrees with the first Physician, the Plan will cover a third surgical opinion.
38. **Speech therapy** by a qualified speech therapist. The therapy must be to restore or rehabilitate speech loss due to an illness or injury, to correct dysphagia or swallowing disorders, or due to surgery for an illness or injury. If speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to therapy. Speech therapy is not covered for developmental disorders or for the correction of stuttering, stammering, myofunctional, or conditions of psychoneurotic origin.

39. Elective surgery for **sterilization**, including tubal ligation, female sterilization by any other FDA-approved method, and vasectomy. Vasectomies are covered in the Physician’s office only; any other facility charge associated with a vasectomy will be denied.

40. Treatment of **Substance Abuse**.

41. Medical **supplies** that are Medically Necessary for treatment, including, but not limited to, an electronic heart pacemaker, surgical dressings, casts, splints, and crutches.

42. **Surgeon’s fees** for the performance of surgical procedures, including necessary related postoperative care by a Physician, subject to the Reasonable and Customary fees in his area. Charges for **multiple surgical procedures** are subject to the following provisions:

   a. If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Allowable Charge that is allowed for the primary procedures; 50% of the Allowable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered “incidental” and no benefits will be provided for such procedures;

   b. If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon’s primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Allowable Charge for that procedure; and

   c. If an assistant surgeon is required, the assistant surgeon’s covered charge will not exceed 20% of the primary surgeon’s allowance.

43. Treatment of **Temporomandibular Joint syndrome**, whether surgical or nonsurgical.
Utilization Management Company Phone Number
Please refer to the Employee ID card for the Cost Management Services phone number.

The patient or family member must call this number to receive certification of certain cost management services. This call must be made at least 3 days in advance of services being rendered, or within 48 hours or on the first business day after an emergency.

Failure to precertify required medical services will result in the application of the Utilization Management Penalty, if any, shown in the Schedule of Medical Benefits.

Utilization Management
Utilization Management ("UM") is a program designed to help ensure that all Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before medical and/or surgical services are provided:

- Inpatient Confinements
- Morbid Obesity-related procedures, including Bariatric Surgery
- Organ Transplants
- Outpatient Services (limited to the list below):
  - Chemotherapy/Radiation therapy
  - Diagnostic test(s) with a cumulative total of over $1,000
  - Durable Medical Equipment over $2,500
  - Injectable medications over $1,000 (when administered in a Physician's office or in conjunction with Home Health services)
  - Psychological and neuropsychological testing
  - Surgical procedures over $1,000

(b) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician;

(c) Certification of services and planning for discharge from a medical care facility or cessation of medical treatment; and

(d) Retrospective review of the Medical Necessity when precertification or concurrent review/discharge planning has not been secured.
This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

The UM organization's staff cannot and does not verify benefits or eligibility. The UM organization's staff cannot and does not ensure that all plan requirements are met or will be met on the date services are rendered. The UM program's purpose is strictly the verification of Medical Necessity and the appropriateness of care.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification
Before a Participant enters a medical care facility on a non-emergency basis, the Utilization Management administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a medical care facility is one that can be scheduled in advance.

The Utilization Management program is set in motion by a telephone call from the Participant. Contact the Utilization Management administrator at the telephone number on your ID card at least 3 days before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered employee or retiree,
- The name, social security number and address of the covered employee or retiree,
- The name of the Employer,
- The name and telephone number of the attending Physician,
- The name of the medical care facility, proposed date of admission and proposed length of stay, and
- The diagnosis and/or type of surgery.

If there is an emergency admission to the medical care facility, the patient, patient’s family member, medical care facility or attending Physician must contact the utilization management administrator within 48 hours or on the first business day after the admission.
It is important to remember that, if a claimant needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The claimant should obtain such care without delay.

The Utilization Management administrator will determine the number of days of medical care facility confinement authorized for Medical Necessity.

Precertification is designed to assist with your hospital stay, not to determine which benefits will be payable. To find out which benefits are payable, please refer to the appropriate sections of this Summary Plan Description.

Under the Newborns’ and Mothers’ Health Protection Act of 1996, 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 following a vaginal delivery, or 96 hours following a cesarean section. Notification is still encouraged at the time of admission, and is required for any Hospital stay that is in excess of the minimum length of stay. Failure to notify the UM administrator of any stay that is in excess of the minimum length of stay will result in application of the penalty shown in the Highlights to the Hospital expenses for the excess days not certified.

**Concurrent review, discharge planning.** Concurrent review of a course of treatment and discharge planning from a medical care facility are parts of the Utilization Management program. The Utilization Management administrator will monitor the Participant’s medical care facility stay or use of other medical services and coordinate with the attending Physician, medical care facilities and Participant either the scheduled release or an extension of the medical care facility stay or extension, or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Participant to receive additional services or to stay in the medical care facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

**Case Management**
Case Management is a program whereby a Case Manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The Case Manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient’s attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient,
- contacting the family to offer assistance and support,
- monitoring Hospital or Skilled Nursing Facility,
- determining alternative care options, or
- assisting in obtaining any necessary equipment and services.

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

The Case Manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan will consider care outside its normal benefit limitations if the use of an alternative treatment plan results in savings for the Plan and is endorsed by the Participant. The objective of this service is to direct the patient toward the most appropriate care in a cost-effective environment. The Plan Administrator, attending Physician, patient and, in some circumstances, the patient's family must all agree to the alternate treatment plan.

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

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

**Retrospective Utilization Management**

When Hospital precertification or continued stay review/discharge planning has not been secured, the UM organization may elect to use retrospective Utilization Management. Retrospective utilization management is the process in which the UM organization evaluates Inpatient, acute care hospitalizations which were not reviewed during the confinement. Using the established medical criteria for Hospital precertification and concurrent review/discharge planning, the UM organization will determine retrospectively the Medical Necessity and appropriateness of Inpatient hospitalization and treatment plan.
PRESCRIPTION DRUG BENEFITS

Using Your Prescription Drug Card
As a Participant in the Plan, you will receive an ID card that allows you to purchase prescription drugs through the prescription drug card program. If you present this card to a participating retail pharmacy when buying prescription drugs covered by the Plan or purchase eligible prescription drugs through the mail-order program, you will be charged as shown in the Highlights.

A current list of participating pharmacies is available, without charge, through the website located at www.myGilsbar.com. If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, please contact your Employer. If you do not have your prescription drug card with you when buying eligible prescription drugs from a participating pharmacy, you must pay the full price of the prescription drug and submit a claim form to the prescription drug card company for reimbursement. These expenses are reimbursable only by the prescription drug card company. These claim forms may be obtained from your Personnel or Human Resources Department. Any claim submitted to Gilsbar, L.L.C. for these expenses will be returned to you with the proper form for reimbursement by the prescription drug card company.

Outpatient prescription drugs purchased from a non-participating pharmacy are not covered under the Plan.

Covered Prescription Drug Card Expenses
Covered prescription drug card expenses are the Reasonable and Customary charges for prescription drugs purchased from a pharmacy participating in the prescription drug card system. Such drugs and medicines are eligible for coverage only if they are used to treat an Illness or Injury of a Participant in the Plan and can be obtained from a licensed pharmacist with a written prescription from a Physician and do not exceed the Allowable Charge. They are limited to the following:

1. Prescription drugs, including, but not limited to, pre-natal vitamins and vitamins with fluoride;

2. Compounded medications of which at least one ingredient is a prescription drug in a therapeutic amount;

3. Injectable insulin, including insulin syringes and needles, and diabetic supplies furnished on written prescription of a Physician.

Covered expenses may not exceed a 90-day supply (30-day supply for Specialty medications). The amount may not be more than the amount normally prescribed by your Physician.
An expense will be considered to be “incurred”, for purposes of this benefit, at the time the drug or medication is received from the pharmacist.

Exclusions and Limitations
Charges for the following are excluded unless specifically covered by the Plan or as required by federal law:

1. Administration: Any charge for the administration or injection of any drug or medication.
2. Anorexiants or any drug or medication used as an appetite suppressant.
3. Blood or blood plasma.
4. Consumed on site: Any drug or medication which is consumed or administered at the place where it is dispensed.
5. Contraceptives or contraceptive devices of any kind, except as required by law or as specifically covered under this Plan.
6. Cosmetic purposes: Drugs used for cosmetic purposes, such as hair growth stimulants or growth hormones; also, Retin-A for a Participant over age 25.
7. Devices of any type, even though they may require a prescription order (including but not limited to therapeutic devices, artificial appliances, support garments and other similar devices, regardless of their intended use).
8. Diagnostic agents.
9. Experimental/investigational: Drugs labeled: “Caution–limited by federal law to investigational use,” or experimental drugs even though a charge is made to the Participant.
10. FDA: Any drug that is not approved by the Food and Drug Administration or that is prescribed for non-FDA-approved uses.
11. Immunization agents or biological sera, except for immunizations covered by the Plan that are required by federal law.
12. Infertility: Any drug or medication related to or used in the treatment of infertility.
13. **Injectables** & supplies: A charge for hypodermic syringes and/or needles, injectable medications or any prescription directing administration by injection for any medication or treatment other than insulin, preventive immunizations, female contraceptives as required by federal law, as specifically covered under the Specialty Drug benefit, or otherwise herein.

14. **Inpatient medication**: Any drug or medication which is to be taken by or administered to the Participant, in whole or in part, while he is a patient in a Hospital, rest home, sanitarium, Skilled Nursing or Extended Care Facility, convalescent Hospital, nursing home or similar institution which operates on its premises, a facility for dispensing pharmaceuticals.

15. **Medical exclusions**: Any drug or medication otherwise excluded by the medical plan.

16. **No charge**: Any drug or medication which may be properly received without charge under any local, state or federal program, including Worker’s Compensation.

17. **No prescription**: Any drug or medication lawfully obtainable without a prescription order of a Physician, except insulin.

18. **Refills**: Filling or refilling of a prescription in excess of the number prescribed by the Physician, or the filling or refilling of a prescription after one year from the order of the Physician.

19. **Smoking deterents or smoking cessation medications or supplies**, except as required by Federal law.

20. **Vitamins**, except pre-natal vitamins and vitamins with fluoride that require a prescription.
SHORT TERM DISABILITY BENEFITS

Note: Elected officials who are covered under the Plan are not eligible to receive short term disability benefits.

If a Covered Employee becomes Totally Disabled (as defined by the Plan) and is unable to perform all of the duties of his/her job, the Covered Employee will be eligible for Short Term Disability benefits provided he or she is under the regular care of a Physician and all terms and conditions of this program have been met.

Short Term Disability Definitions

Benefit Period shall mean the length of time (number of days) during which disability benefits are payable.

Covered Employee shall only include employees that have met all probation requirements or have been employed for a six month period, whichever requirement period is the earliest.

Received Medical Treatment means that the Covered Employee consulted a licensed Physician, or was taking medication for the disabling condition.

Regular Physician Care means the Covered Employee is being seen by his/her Physician on a regular basis at a frequency deemed appropriate for the disabling condition and at intervals necessary for the Physician to verify the continuing state of disability. For the purpose of this benefit, the Covered Employee must be seen by his/her Physician a minimum of once every thirty days.

Total Disability and Totally Disabled means a condition present whereby a person is unable to engage in duties of their regular occupation at their normal place of employment for their regularly scheduled amount of hours, or is unable to perform the normal activities of a person of like age and sex who is in good health, as a result of a non-occupational injury or illness, and is under the regular care and attendance of a Physician who certifies the person's disability, and the person is not performing work of any kind for compensation or profit.

Waiting Period means the number of consecutive days a Covered Employee must be totally disabled before benefit payments begin.

Weekly Earnings shall mean the basic weekly compensation averaged over the most recent twelve week period, exclusive of overtime, bonuses or commissions, or any other compensation
outside of their employment through the County. Disability benefit payments will not be paid during any period when an employee would not have normally received a paycheck.

Requirements to Establish a Short Term Disability Claim

a. The disabled employee must submit a disability claim form to the Benefit Services Manager, completed by the employee, the employer and the attending Physician. All three sections must be completed and signed by the persons indicated. The initial claim form must be submitted within ninety days of the date the disability began.

b. In order for benefit eligibility to be established, the employee may be required to furnish copies of their medical records.

c. Any employee claiming disability may be subject to medical review at the Benefit Services Manager’s request. Case review may be made by the Utilization Management company and the employee may be required to submit to a medical evaluation for the purpose of a second opinion.

d. During the course of the disability benefit period, periodic requests will be made for updated medical information and/or a medical evaluation to establish continued disability status.

e. Disability benefits will begin after the longer of exhaustion of all paid leave or 45 calendar days of Total Disability.

f. If a disabled employee returns to full-time work for ten days or less during his/her Waiting Period, and then becomes disabled for the same condition, the Waiting Period will be extended by the number of days the employee returned to work (plus any weekends in between).

g. If a disabled employee returns to full-time work for more than ten days during his/her Waiting Period, and then becomes disabled for the same condition, the employee will be required to satisfy a new Waiting Period in its entirety.

h. If an employee returns to work for at least one full day and becomes disabled for a new and totally unrelated condition, a new Waiting Period must be satisfied and a new benefit period may be payable.

Benefit Calculations

a. The disability benefit will be calculated at sixty percent of the Covered Employee’s Weekly Earnings. Disability benefit payments will not be affected by statutory or cost of living increases. Benefits payable are subject to the minimum and maximum amount stated in the Schedule of Benefits, if any.
b. Disability benefits will be payable through (a) the one hundred thirty fifth day of disability, (b) until the employee returns to work, (c) until the Covered Employee is eligible for the Arizona State Long Term Disability benefits, or (d) until the Covered Employee is no longer disabled, whichever occurs first.

c. Disability benefits shall be reduced by income received from any of the following sources:

- Disability benefits provided by no-fault auto insurance;
- Social Security disability benefits;
- Rehabilitation Income;
- Any salary, wages, commission or similar compensation payments;
- Loss of time benefits provided by any other group insurance contract.

If any of the above sources of income is received in a lump sum, the offset amount will be prorated over the number of weeks for which it represented. In no event will the benefits payable under this Plan be less than one hundred dollars per week after the above offsets are applied. Disability benefit payments will not be paid during any period when an employee would not have normally received a paycheck.

Benefits will not be payable concurrently with Retirement Benefits.

**Short Term Disability Continuation of Benefits**

a. Disability benefits will continue to be paid for up to the maximum number of days indicated in the Schedule of Benefits, provided the Covered Employee is continuously and totally disabled and meets all the eligibility requirements of this Plan.

b. If during the course of a disability benefit period the employee returns to active full-time or part-time work for thirty days or less and then becomes disabled for the same or related condition, the recurrence will be considered a continuation of the original disability and therefore part of the same benefit period. A new Waiting Period will not be required and the benefits payable will be the remaining balance of the total allowable benefit days.

c. If the disabled employee returns to active employment for more than thirty days and becomes disabled due to the same or related condition, benefits will only be payable if the recurrence of the disability is separated by six months or more. Benefits will be subject to a new Waiting Period and a new benefit may be payable.
Short Term Disability Termination of Benefits
Benefits under this Plan will terminate at the time any of the following occurs:

a. The date the Covered Employee is no longer disabled; or

b. The date the Covered Employee fails to furnish the proper documentation that he/she continues to be disabled; or

c. The date the Covered Employee is no longer under the care of a Physician; or

d. The date the maximum number of benefit days has been paid; or

e. The date the Covered Employee is eligible for the Arizona State Long Term Disability Plan; or

f. The date the employee becomes eligible for retirement benefits.

Short Term Disability Limitations and Exclusions
Short Term Disability benefits will not be payable if the disability was caused by any of the following:

a. Injury or Illness which arises out of, or occurs in the course of any occupation or while working for wage or profit.

b. Any Injury or Illness for which the employee is entitled to benefits under the Workers Compensation Act or similar legislation.

c. An intentionally self-inflicted Injury or Illness.

d. War, whether declared or undeclared.

e. Civil disorder or riot.

f. An Injury or Illness sustained while incarcerated or Incurred as a result of being engaged in an illegal occupation, or sustained during the commission of, or the attempted commission of, an assault or a felony whether or not there is a criminal charge or a conviction of a crime, including injuries received while operating a motor vehicle in an illegal manner, driving while under the influence of drugs or alcohol, negligent driving, or driving at excessive speeds if the offense is defined as a felony by the criminal traffic code of the state in which the incident occurred.

g. Service in the Armed Forces of any Country.
Short Term Disability Survivor Benefit

In the event of a Covered Employee's death, benefits will continue to be paid to the Spouse of the Covered Employee for up to 30 calendar days, or until the end of the Benefit Period, whichever occurs first. In the event the Covered Employee does not have a Spouse, the Plan Administrator will determine to whom payment should be made.
GENERAL EXCLUSIONS AND LIMITATIONS

Note: See the Prescription Drug Benefit and Short Term Disability Benefit sections for additional exclusions and limitations specifically related to those expenses.

This section applies to all benefits provided under any section of this Summary Plan Description. This Plan excludes or limits coverage as described for the following, unless specifically covered by the Plan or as required by federal law:

Occupational Illness or Injury
Any Illness or Injury arising out of, or in the course of, employment with the Participant’s employer or self-employment, or Illness or Injury covered under the Worker’s Compensation Law or any similar legislation, are excluded.

Government Plan
Services or supplies furnished by or on behalf of the United States Government or any other government are excluded unless, as to such other government, payment of the charge is legally required.

Services or supplies are excluded to the extent benefits for them are provided by any law or governmental program under which the Participant is or could be covered, unless payment of the charge is legally required.

Unnecessary Services or Supplies
Any services or supplies not Medically Necessary for the care of the Participant’s Illness or Injury are excluded. Charges made by a Hospital to the extent that they are allocated to scholastic education or vocational training of the patient are also excluded. The Plan Administrator determines whether a service, treatment or supply is Medically Necessary.

Weekend Admissions
If admitted to the Hospital on a Friday, Saturday or Sunday, charges for these days will be excluded unless admitted due to an Emergency or if surgery is performed within 24 hours of admission.

Excess of Reasonable and Customary
The portion of any charge for any services or supplies that are in excess of the Reasonable and Customary charge or the Allowable Charge, as determined by the Plan Administrator, is excluded.
Mouth and Teeth Conditions
Medical Benefits for mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure or the alveolar process are excluded unless the charges are for the following:

1. Treatment or removal of malignant or benign tumors;

2. Treatment of an accidental Injury to a Sound, Natural Tooth, or for the setting of a jaw fracture or dislocation if the treatment begins within three months of the Accident; or

3. Hospital services, supplies and anesthesia for oral surgical procedures for which a doctor (M.D., D.O. or D.D.S.) provides satisfactory certification to the Plan Administrator that hospitalization is Medically Necessary.

Foot Conditions
Physicians’ services in connection with corns, calluses or toenails are excluded, unless the charges are for the partial or complete removal of the nail roots or Medically Necessary for diabetic care.

Vision Care
Medical Benefits for Physicians’ services in connection with eye refractions or any other examinations to determine the need for, or the proper adjustment of, eyeglasses or contact lenses are excluded, unless for the initial examination following cataract surgery. The charges for eyeglasses or contact lenses are excluded, unless for the initial set following cataract surgery. Radial Keratotomy, LASIK, and any surgical procedures to improve refractive errors such as nearsightedness, etc., are also excluded. This exclusion does not apply to any services otherwise covered under vision benefits, if any.

Cosmetic or Cosmetic Surgery
Charges in connection with Cosmetic Surgery and other services and supplies that are for Cosmetic purposes are excluded unless they are:

1. Incurred as a result of accidental Injury;

2. For correction of a congenital anomaly; or

3. For reconstruction of the breast on which a mastectomy was performed, or for surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications from all stages of a mastectomy, including lymphetasmas, in a manner determined in consultation with the attending Physician and the Participant.
Injury Due to Act of War
Any Illness or Injury due to war, declared or undeclared, or any act of war is excluded.

Routine or Preventive Care
Routine or preventive care, including but not limited to immunizations and Routine Physical Examinations, is excluded, except as otherwise specifically listed and included for coverage under this Plan.

Outpatient Well Baby or Well Child Care
Routine well baby or well child care, checkups and immunizations are excluded, except as otherwise specifically listed and included for coverage under this Plan.

Other General Exclusions
Charges for services, surgery, supplies or treatment for the following are not covered:

1. **Abortion**: Elective abortions are excluded unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest. However, complications from abortions, whether elective or non-elective, are covered.

2. **Administrative fees**, interest or penalties.

3. **Blood** and blood derivatives that are donated or replaced, including fees for administration.

4. **Claim filed late**: Charges for which the claim is received by the Plan after the maximum period allowed under this Plan for filing claims has expired.

5. **Claim form**: Completion of a claim form.

6. **Cochlear implants**.

7. **Complications from non-covered services**: Charges that result from complications arising from a non-covered illness or Injury, or from a non-covered procedure. However, complications from abortions, whether elective or non-elective, are covered.

8. **Contraceptive** substances or devices, except as required by federal law or as specifically covered under the Plan.
9. **Coordination of benefits**: Benefits available under the Plan that may be reduced or eliminated based upon the coordination of benefits or subrogation rules.

10. **Coverage not in force**: Charges incurred while coverage is not in force under the Plan.

11. **Custodial care**.

12. **Deductible**: Charges that are not payable due to the application of any specified deductible, copayment, or coinsurance provision of this Plan.

13. **Durable medical equipment**: Replacement of durable medical equipment within five years unless approved by the Plan Administrator.

14. **Education**, training, bed and board while confined to an institution that is primarily a school or other institution for training, or instruction in alternate life patterns, except for diabetes self-management training, listed in the Medical Benefits section.

15. **Electrical power**, water supply, sanitary waste disposal systems, saunas, hot tubs or swimming pools or their installation, or any similar expense associated with a residence.

16. **Equipment**: Air conditioners, dehumidifiers, air purifiers, heating pads, hot water bottles, home enema equipment, rubber gloves and any equipment or supplies not Medically Necessary.

17. **Experimental or Investigational**: Treatment, services, equipment, new technology, drugs, procedures or supplies considered Experimental or Investigational at the time the procedure is performed or service or supply is provided. Routine patient costs associated with participation in approved Clinical Trials shall not be considered Experimental or Investigational for qualified individuals.

18. **Family member**: Services or supplies provided by a member of the Participant’s immediate family or by an individual residing in the Participant’s home.

19. **FDA**: Any drug, service, or supply that is not approved by the Food and Drug Administration or that is prescribed or performed for non-FDA-approved uses.

20. **Felony**: Treatment received, including the use of ambulance, for an Injury or Illness sustained while incarcerated or Incurred as a result of being engaged in an illegal occupation, or sustained during the commission of, or the attempted commission of, an assault or a felony whether or not there is a criminal charge or a conviction of a crime, including injuries received while operating a motor vehicle in an illegal manner, driving while under the influence of drugs or alcohol, negligent driving, or driving at excessive speeds if
the offense is defined as a felony by the criminal traffic code of the state in which the incident occurred.

21. **Fertilization**: Any means of artificial fertilization, including but not limited to artificial insemination, in-vitro fertilization or gamete intra-fallopian transfer. Services of a surrogate mother are also excluded.

22. **Food Supplements**: Food, mineral and nutritional supplements unless deemed Medically Necessary and prior approval has been obtained from the Utilization Management company.

23. **Foreign Travel**: Care, treatment or supplies out of the U.S. if travel is for the purpose of obtaining medical services.

24. **Genetic testing** or treatment, unless the results are specifically required for a medical treatment decision on the member, or as required by federal law or specifically covered by this Plan.

25. **Hair loss**: Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

26. **Hypnosis** (except where used in lieu of anesthesia), biofeedback, somnambular or environmental therapy.

27. **Infertility**: All specific treatments to correct infertility, including but not limited to treatment of infertility and sterility (except elective surgery for sterilization). However, diagnostic testing to determine infertility is covered as described in the Medical Benefits section.

28. **Learning disabilities/developmental disorders**: Charges (including mental health care) related to treatment or testing of learning disabilities, developmental disorders, dyslexia, autism or mental retardation, or any similar conditions. However, medications and office visits to monitor medications for these conditions are covered.

29. **Medicare**: Benefits available under the Plan that may be reduced or eliminated based upon the coordination of benefits with Medicare when Medicare is the primary payor. This limitation may apply to Participants aged 65 or older, and is subject to federal regulation.

30. **Newborn care**: Hospital care or Physician care of a newborn prior to discharge from Hospital, except in cases of Illness or as specifically listed for coverage under this Plan.

31. **Not legally required to pay**: Any item for which the Participant is not legally required to pay, or for which a charge would not have been made if the Participant did not have this coverage.
32. **Not listed**: Any items not listed in “Covered Expenses.”

33. **Not necessary**: Diagnostic services or treatments performed in connection with research studies, pre-marital examinations or any examination not necessary for the diagnosis of an Illness or Injury, unless specifically listed and included for coverage under this Plan.

34. **Oral statements**: Charges which are Incurred based upon oral statements made by anyone involved in the administration of the Plan that are in conflict with the benefits described in this Summary Plan Description.

35. **Organ transplants**: Organ transplants other than those specified as covered under the Plan; or organ transplants that are Experimental or Investigational or which are not approved by the FDA; and

   Donor-related health care services and supplies, except as otherwise specifically listed and included for coverage under the Plan or unless the donor is a covered Participant under the Plan.

36. **Personal** or convenience items.

37. **Prior to or after coverage**: Services or supplies that were rendered or received prior to or after any period of coverage under this Plan, except as specifically provided in this Summary Plan Description.

38. **Prison**: Charges for services received while confined in a prison, jail or other penal institution.

39. **Private duty nursing**.

40. **Radioactive contamination**: An Injury or Illness caused as a result of radioactive contamination.

41. **Room and board** for any other room at the same time the patient is being charged for use of a special care unit.

42. **Sales tax** on prescription drugs or on any other covered items.

43. **Scheduled visit**: Failure to keep a scheduled medical visit.

44. **Sexual dysfunctions**, penile implants, sex transformations, gender dysphoria or inadequacies, and sex therapy.
45. **Sleep disorders**: Care and treatment for sleep disorders, unless deemed Medically Necessary.

46. **Sterilization reversal**: Reversal of previous sterilization treatments or surgeries.

47. **Telephone** conversations with a Physician.

48. **Travel expenses**, even if prescribed by a Physician, unless otherwise specifically covered under this Plan in connection with organ transplants.

49. **VAX-D** therapy.

50. **Violation of law**: The sale, use or administration of any supplies, services or treatment, which is in violation of the law, regardless of whether it would otherwise be an eligible expense under the Plan.

51. **Vision therapy** (nonsurgical treatment to the eye muscles).

52. **Vitamins** (except pre-natal vitamins prescribed by a Physician), minerals, nutritional food supplements, or any over-the-counter items, whether or not prescribed by a Physician, unless specifically covered herein.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).
WHEN YOU HAVE A CLAIM

Before submitting a claim, review this Summary Plan Description and the bills you have accumulated. Be sure you are submitting itemized bills for which benefits are payable.

The Benefit Services Manager may periodically request a General Information Verification Form to verify continued eligibility for benefits. If you need a General Information Verification Form, you may download one from the Gilsbar web site at www.myGilsbar.com or you may notify your Personnel or Human Resources Department.

If you or a Covered Dependent has to go to the Hospital, get duplicate Medical/Dental Family Claim Forms from your Personnel Department or Gilsbar’s web site in advance. Sign the forms and send them to the Benefit Services Manager at the address listed on your ID card.

Keep a separate running record of expenses for yourself and each Covered Dependent.

Save all bills, including those being accumulated to satisfy a deductible. In most instances, they will serve as evidence of your claim.

Submit the original bill, not a copy. Each bill must be complete and itemized and should show the patient’s full name, date or dates the service was rendered or purchase was made, nature of the Illness or Injury, and type of service or supply furnished. Drug store cash register receipts or labels from containers are not sufficient proof of a claim.

Attach all itemized bills to the fully completed claim form and send all claims Incurred to the name and address shown on your ID card.

All claims, including those first mailed to the Preferred Provider Organization, must be received by Gilsbar, L.L.C. no later than 12 months after the date the expense is Incurred. A claim received after this deadline will be covered only if the Plan Administrator, or Benefit Services Manager acting on the instructions of the Plan Administrator, finds that there was a reasonable cause for the delay. Contact Gilsbar, L.L.C. to be sure the Claims Department has received all submitted claims.
CLAIMS PAYMENT AND APPEALS

Assignability
Benefits for Covered Expenses may be assigned by a Participant to the provider; however, if those benefits are paid directly to the Participant, the Plan will have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant and the assignee, has been received before the proof of loss is submitted.

Claims Procedure
A description of the Plan’s process for handling claims and appeals for health benefits follows. The times listed are maximum times only. A period of time begins at the time the claim is filed in accordance with the Plan’s procedures, which are described below. “Days” means calendar days.

There are three types of health claims under this Plan and each has a specific timetable for approvals or denials: Pre-service Claim, Concurrent Claim, and Post-service Claim. The definitions and procedures for the three types of health claims are:

Pre-service Claim – a claim for a benefit under the Plan where prior approval for any part of the benefit is a condition to receiving the benefit. If a Participant makes a request for information on a charge or benefit (or a request for a determination of Medical Necessity) for which prior approval is not required by the Plan, that informational request or determination is not a pre-service claim. If a Participant needs medical care for a condition which could seriously jeopardize his life, health or ability to regain maximum function or which would subject him to severe pain that cannot be adequately managed without care or treatment, there is no need to seek or obtain approval in advance of obtaining medical care. The Participant should obtain such care without delay and contact the Utilization Management (UM) organization within 48 hours, or on the first business day following a Hospital admission.

Concurrent Claim – a claim that arises when the Plan has approved the Medical Necessity of an ongoing course of treatment to be provided over a period of time or number of treatments, and either:

1. the Plan determines that the course of treatment should be reduced or terminated, or
2. the Participant requests extension of the course of treatment beyond that which was approved.

Remember, if the Plan does not require approval, then there is no need to contact the UM organization to request an extension of that treatment.
Pre-service and Concurrent Claims are deemed to be filed with the Plan when the request for approval is made and received by the UM organization or Benefit Services Manager in accordance with the Plan's procedures.

Post-service Claim – a request for a Plan benefit or benefits that is a request for payment under the Plan for covered medical services already received by the Participant.

If the Plan contracts with a PPO network and you receive care through an in-network (PPO) provider, you will not need to file a medical claim. On your first visit to your network provider, you will sign a form to assign benefits to that provider, and they will file the claims on your behalf.

You will be responsible for filing your own claims if you use providers that do not participate in the PPO network, although some out-of-network providers may file claims on your behalf.

A Post-service Claim is deemed to be filed with the Plan on the date it is received by the Benefit Services Manager, containing the following information:

1. A properly completed Form HCFA or Form UB92 or successor forms, or an Electronic Data Interchange (EDI) file or other standard billing format;
2. The date of service;
3. The name, address, telephone number and tax identification number of the provider of the services or supplies;
4. The place where the services were rendered;
5. The diagnosis and procedure codes;
6. The amount of charges and repricing information;
7. The name of the Plan;
8. The name of the Covered Employee or Covered Retiree;
9. The name of the patient; and
10. Any Physician's notes, accident details, employment status, coordination of benefits information, or other information needed to adjudicate the claim.

When the information referenced above is provided, the claim is considered a “Clean Claim”. The Plan will determine if enough information has been submitted to enable proper consideration of the claim. If the claim is not a Clean Claim, the Plan may deny the claim or may take an extension of time in order to request additional information. This additional information must be received by the Benefit Services Manager within 45 days from the date the Participant or the authorized representative receives the request. Failure to respond within this time period may result in claims being denied or reduced.
“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. This includes any reduction or failure to make payment based on the determination of a Participant’s ineligibility or a rescission of coverage due to fraud or intentional misrepresentation of material fact. It includes any reduction or failure to make payment resulting from the application of any utilization review, the application of any Plan exclusions, and the 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.

Timing of Notice of Benefit Determinations:

Pre-service Claim:

1. If the Participant has provided all the information needed to determine the Medical Necessity of the treatment, the Plan will notify the Participant of a benefit determination in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

2. If the Participant has not provided all the information needed to determine the Medical Necessity of the treatment, the Participant may be notified as to what specific information is needed as soon as possible, but not later than 15 days after receipt of the claim. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan and the Participant (if additional information was requested during the extension period).

3. If the Participant has failed to follow the Plan's procedures for filing a Pre-service Claim, the Participant will be notified of the failure and the proper procedures to be followed as soon as possible, but not later than 5 days following the failure.

4. Extensions. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Concurrent Claim:

1. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), it will do so before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow
the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

2. **Request by Participant for Extension of Treatment.** If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments, the request will be treated as a new Pre-service Claim or Post-service Claim and decided within the timeframe appropriate to that type of claim.

**Post-service Claim:**

1. If the Participant has provided all the information needed to process the claim, the Plan will notify the Participant of an Adverse Benefit Determination in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

2. If the Participant has not provided all the information needed to process the claim and additional information is requested during the initial processing period, the Participant may be notified of an Adverse Benefit Determination prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

3. **Extensions.** This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

**Form of Notice to Participant of Adverse Benefit Determinations**

Once the claim has been decided, the Plan Administrator will provide written or electronic notification of any Adverse Benefit Determination. The notice will state:

1. The reason or reasons for the Adverse Benefit Determination;
2. Reference to the Plan provisions on which the determination was based;
3. A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the Plan’s appeal procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the Participant’s right to bring a civil action following a denial of the appeal;
5. A statement that the Participant is entitled to request the diagnostic and treatment codes used and their meaning;

6. A statement that any rule, guideline, protocol, or criterion that was relied upon in making the Adverse Benefit determination will be provided free of charge to the Participant upon request;

7. If the denial is based on Medical Necessity, Experimental/Investigational Treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

**Procedure for Internal Appeals**

When a Participant receives an Adverse Benefit Determination, the Participant has the right to a full and fair review of the claim and Adverse Benefit Determination. More specifically, the Participant has 180 days following receipt of the notification in which to appeal the decision. The Participant must submit a written request for appeal to the Benefit Services Manager, including any written comments, documents, records, and other information relating to the claim. If the Participant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim that is in the possession of the Plan Administrator or the Benefit Services Manager.

A document, record, or other information will be considered relevant to a claim if it:

1. Was relied upon in making the benefit determination;
2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
3. Demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all Participants; or
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the individual’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is deemed to be filed in accordance with the procedures of the Plan, which are described in this section. It is the Participant’s responsibility to submit proof that the claim for benefits is covered and payable under the Plan’s provisions. Any appeal must include the following:

1. The name of the Covered Employee/Covered Retiree/Participant;
2. The Covered Employee’s/Covered Retiree’s/Participant’s social security number or Participant ID number (PID);

3. The group name or identification number;

4. All facts and theories supporting the claim for benefits, whether or not presented or available at the initial benefit decision. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal;**

5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

The review shall take into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not rely on the initial Adverse Benefit Determination and will be conducted by an independent party who is neither the individual who made the Adverse Benefit Determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Benefit Services Manager will consult with a health care professional who was not involved in the original benefit determination or the subordinate of that individual. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

In the event of an Adverse Benefit Determination on review, the Participant will receive written or electronic notice of determination. The notice will meet the requirements as described above.

The Plan Administrator will notify the Participant of the Plan’s benefit determination on review within the following timeframes:

*Pre-service and Concurrent Claims*: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

This Plan does not require prior approval for a Participant to receive urgent care; therefore, all urgent care claims will be handled as Concurrent or Post-service claims.
Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Procedure for External Review
If the Participant’s claim continues to be denied or if the Participant does not receive a timely decision, he or she may request an external review of the claim by an independent review organization (IRO), except where such request is limited by applicable law, that will review the denial and issue a final decision. This request for external review must be made within 4 months from the date of receipt of the notice of final internal adverse benefit determination or by the first of the fifth month following receipt of such notice, whichever occurs later.

In order for a claim to be eligible for external review, it must be a claim that involves:

1. Medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer; or

2. A rescission of coverage.

The Participant will be notified in writing within six business days as to whether their request is eligible for external review and whether additional information is necessary to process the request. If the Participant’s request is determined ineligible for external review, the notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process the Participant’s request, he or she may submit the additional information within the four month filing period, or within 48 hours, whichever occurs later.

The Participant will receive written notice from the assigned IRO of Participant’s right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Participant and the Plan no later than 45 days from the date the IRO receives a request for external review. The notice from the IRO will contain the reason(s) for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

If the IRO decides the claim is payable, the Plan will pay the claim but may seek later judicial review.

Responsibility for Deciding Claims and Appeals
The Plan Administrator shall be ultimately and finally responsible for adjudicating claims and for providing full and fair review of the decision on such claims in accordance with the provisions in this section. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them or to the extent the above IRO decision determines the claim
is payable. Processing claims in accordance with the Plan Document and Summary Plan Description may be delegated to Gilbar, L.L.C.

Decision on Appeal to be Final
The decision by the Plan Administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law.

No suit concerning the claim may be commenced until the appeal process set forth herein has been completed and the decision on the appeal has been rendered by the Plan Administrator or the IRO. The Participant has one year from that time to file suit. Suit may not be brought after the one-year period has passed.

Summary of Claims Procedure Timetables
This chart of the timetables is included for your convenience only. Details concerning any applicable time limits are contained elsewhere in this section, and we recommend that you review this section and applicable subsections carefully for complete information regarding the timetables that apply to your claim.

<table>
<thead>
<tr>
<th>Time Limits</th>
<th>Type of Claim</th>
<th>Post-Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Concurrent: To end or reduce</td>
<td></td>
</tr>
<tr>
<td></td>
<td>treatment prematurely</td>
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<tr>
<td></td>
<td>Concurrent: To deny your</td>
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</tr>
<tr>
<td></td>
<td>request to extend treatment</td>
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<tr>
<td></td>
<td>Post-Service</td>
<td></td>
</tr>
<tr>
<td>You'll be notified of determination as soon as possible, but no later than...</td>
<td>15 days from receipt of claim</td>
<td>Notification to end or reduce will allow time to finalize appeal before end of treatment</td>
</tr>
<tr>
<td>Extension period allowed for circumstances beyond the Benefit Services Manager's control...</td>
<td>15 days</td>
<td>n/a</td>
</tr>
<tr>
<td>If additional information is needed, you must provide it within...</td>
<td>45 days of date of extension notice</td>
<td>n/a</td>
</tr>
<tr>
<td>You must file your appeal within...</td>
<td>180 days of claim denial</td>
<td>Denial letter will specify filing limit</td>
</tr>
<tr>
<td>You'll be notified of the appeal decision as soon as possible but no later than...</td>
<td>30 days from receipt of appeal</td>
<td>15 days from receipt of appeal</td>
</tr>
</tbody>
</table>
### Time Limits

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Pre-Service</th>
<th>Concurrent: To end or reduce treatment prematurely</th>
<th>Concurrent: To deny your request to extend treatment</th>
<th>Post-Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your claim is eligible for external review, you must file the request within...</td>
<td>4 months from the date of receipt of the notice of final internal adverse benefit determination</td>
<td>4 months from the date of receipt of the notice of final internal adverse benefit determination</td>
<td>Treated as any other pre-service or post-service claim</td>
<td>4 months from the date of receipt of the notice of final internal adverse benefit determination</td>
</tr>
<tr>
<td>You'll be notified of a final decision by the IRO as soon as possible but no later than...</td>
<td>45 days from the date the IRO receives a request for external review</td>
<td>45 days from the date the IRO receives a request for external review</td>
<td>Treated as any other pre-service or post-service claim</td>
<td>45 days from the date the IRO receives a request for external review</td>
</tr>
</tbody>
</table>

### Appointment of Authorized Representative

A Participant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Participant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Participant must complete a form which can be obtained from Gilsbar, L.L.C. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

An Appointment of Authorized Representative Form may be obtained from [www.myGilsbar.com](http://www.myGilsbar.com) or by calling the number below and forms must be submitted to:

**Gilsbar, L.L.C.**  
Attention: Claims Dept.  
P.O. Box 998  
Covington, LA 70433  
Phone: 1-888-472-4352  
Fax: 985-898-1529

### Right of Recovery

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the Plan’s terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the covered person on whose behalf such payment was made.
A covered person, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum or deducted from future claims presented by the covered person for processing.

Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state’s health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the Plan shall be entitled to recover its litigation costs and actual attorneys’ fees incurred.

Subrogation, Reimbursement, and Third Party Recovery Provision

Payment Condition
1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “Participant(s)”)) or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively “Coverage”).

2. Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the
obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

3. In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan’s attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan’s discretion, if the Participant(s) fails to so pursue said rights and/or action.

2. If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan’s behalf and function as a trustee as it applies to those funds until the Plan’s rights described herein are honored and the Plan is reimbursed.

3. The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. If the Participant(s) fails to file a claim or pursue damages against:
   a. The responsible party, its insurer, or any other source on behalf of that party.
   b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
   c. Any policy of insurance from any insurance company or guarantor of a third party.
   d. Workers’ compensation or other liability insurance company.
   e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys’ fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan’s equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant(s)’ recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant’s obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan’s behalf and function as a trustee as it applies to those funds until the Plan’s rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts’ fees, attorneys’ fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan’s recovery without the prior, express written consent of the Plan.

3. The Plan’s right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any
lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan’s recovery will not be applicable to the Plan and will not reduce the Plan’s reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

**Participant is a Trustee Over Plan Assets**

1. Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he/she is required to:
   a. notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
   b. instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
   c. in circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
   d. Hold any and all funds so received in trust, on the Plan’s behalf, and function as a trustee as it applies to those funds, until the Plan’s rights described herein are honored and the Plan is reimbursed.

2. To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan’s interests, and without reduction in consideration of attorneys’ fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan’s interest on the Plan’s behalf.
Excess Insurance
1. If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan’s Coordination of Benefits section.

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

a. The responsible party, its insurer, or any other source on behalf of that party.
b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
c. Any policy of insurance from any insurance company or guarantor of a third party.
d. Workers’ compensation or other liability insurance company.
e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

Wrongful Death
In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan’s subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment. To the extent medical expenses incurred by the decedent, between the time of the incident that ultimately resulted in their death and the date of death, are not recoverable under the wrongful death law applicable to the claim, the Plan’s subrogation and reimbursement rights will not apply.

Obligations
1. It is the Participant’s/Participants’ obligation at all times, both prior to and after payment of medical benefits by the Plan:
a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan’s rights.

b. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.

c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.

d. To do nothing to prejudice the Plan’s rights of subrogation and reimbursement.

e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.

f. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.

g. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.

h. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.

i. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.

j. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

2. If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan’s attempt to recover such money from the Participant(s).

3. The Plan’s rights to reimbursement and/or subrogation are in no way dependent upon the Participant’s/Participants’ cooperation or adherence to these terms.

**Offset**

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant’s amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the
Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

**Minor Status**

1. In the event the Participant(s) is a minor as that term is defined by applicable law, the minor’s parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor’s parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor’s parents or court-appointed guardian.

**Language Interpretation**

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

**Severability**

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

The Plan contains a provision to prevent double payment for covered expenses. This provision works by coordinating the benefits under this Plan with other similar plans under which a Participant is covered, so the total benefits available will not exceed one hundred percent (100%) of the Allowable Charge. The expenses for services and supplies must be covered, at least in part, by one of the coordinating plans. This provision is commonly called “coordination of benefits.” Benefits payable under other similar plans include the benefits that would have been payable had proper claim been made for them.

If this Plan provides for coverage for eligible retirees, and you are a covered retiree, and you or a Covered Dependent are entitled to Medicare coverage (whether or not you are enrolled for such coverage), this Plan will be the secondary payor and will coordinate its benefits (as described in this section) with Medicare benefits as permitted by law.

As permitted by law, this Plan also will be the secondary payor and will coordinate its benefits with Medicare for Participants who are eligible to enroll in Medicare due to disability or End Stage Renal Disease (whether or not you are enrolled for such coverage). For Participants with End Stage Renal Disease, the Plan will pay the Allowable Charge for the first 90 days. After the first 90 days, the Plan will pay according to Medicare’s published fee schedule.

For the purposes of this coordination provision, the term “plan” means the following types of medical care benefits:

1. Coverage under a governmental plan or required or provided by law, including no fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation; and

2. Group insurance or other coverage for a group of individuals, other than school accident-type coverage for elementary school, high school and college students. This does not include any law or plan where benefits are provided after those provided by other plans.

In the event of a motor vehicle Accident, this Plan shall not be primary to any auto coverage such as medical, no fault, casualty or liability insurance that by its terms is immediately payable without the necessity of a finding of liability on the part of a third party. The Participant shall be responsible for identifying the motor vehicle Accident as the source of the Injury and completing any requested Accident report forms.

When a claim is made, the primary plan (as described below) pays its benefits without regard to any other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed the Allowable Charge. No plan pays more than it would otherwise pay without this coordination provision.
A plan without a coordination of benefits provision is always the primary plan. If all plans have such a provision:

1. The plan covering the patient as an active Participant (e.g., employee, member, subscriber) or a dependent of an active Participant, rather than as an inactive Participant (e.g., COBRA beneficiary, retiree, or TRICARE participant) or a dependent of an inactive Participant, is primary and the others are secondary (if the other plan does not have this provision and, as a result, the plans do not agree on the order of benefits, this provision is ignored);

2. If a child is covered under both parents’ plans, the parent whose birthday falls earlier in the Calendar Year is primary, or, if both parents have the same birthday, the plan covering the parent longer is primary; but when the parents are separated or divorced, their plans pay in this order:
   a. the plan of the parent with custody of the child;
   b. the plan of the Spouse of the parent with custody of the child;
   c. the plan of the parent not having custody of the child; and
   d. the plan of the Spouse of the parent not having custody of the child.

However, if a Qualified Medical Child Support Order (QMCSO) has established financial responsibility for the child’s health care expenses, the benefits of that plan are determined first.

If none of the preceding provisions determine the order of benefits, the benefits of the plan that covered a Participant longer are determined first.

If none of the preceding provisions of this section make it able to determine which plan is primary, the Allowable Charge shall be shared equally between the plans.
TERMINATION OF COVERAGE

Coverage will terminate for an employee at 11:59 P.M. on the last day of the month following the earliest of:

1. Date the Plan terminates;
2. Date employment terminates;
3. Date the employee ceases to be an Eligible Employee (unless the employee is in a Stability Period or Administrative Period);
4. Last day of the employee’s current Stability Period or the Administrative Period (if applicable), if the employee does not meet the requirements for future coverage as determined by the current Standard Measurement Period;
5. Date the employee chooses Medicare as his sole coverage;
6. Date the Fund or Trust terminates;
7. The end of the last period for which any required contribution was received;
8. Date of the employee’s death; or
9. The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information or intentional misrepresentation of a material fact to the Plan, including enrollment information.

Coverage for a dependent of an active employee will cease at 11:59 P.M. on the last day of the month following the earliest of:

1. Date the Plan terminates;
2. Date the employee’s coverage terminates;
3. Date the dependent becomes eligible for coverage as an employee;
4. Date the dependent enters active service with armed forces of any country;
5. Date the dependent ceases to be an Eligible Dependent (for any reason other than attaining the applicable age limit);
6. Date the dependent chooses Medicare as his sole coverage;
7. Date the Fund or Trust terminates;

8. For a dependent Spouse, on the date of divorce or legal separation;

9. For a dependent child/children, the end of the month of attainment of the applicable age limit;

10. The end of the last period for which any required contribution was received; or

11. The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information or intentional misrepresentation of a material fact to the Plan, including enrollment information.

**Coverage will terminate for a retiree at 11:59 P.M. on the last day of the month following the earliest of:**

1. Date the Plan terminates;

2. Date the Fund or Trust terminates;

3. The end of the last period for which any required contribution was received;

4. Date the retiree voluntarily elects to be terminated from the Plan;

5. Date of the retiree’s death; or

6. The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information or intentional misrepresentation of a material fact to the Plan, including enrollment information.

**Coverage for a dependent of a retiree will cease at 11:59 P.M. on the last day of the month following the earliest of:**

1. Date the Plan terminates;

2. Date of the retiree’s death; or

3. Date the dependent becomes eligible for coverage as an employee;

4. Date the dependent enters active service with armed forces of any country;
5. Date the dependent chooses Medicare as his sole coverage;

6. Date the Fund or Trust terminates;

7. For a dependent Spouse, on the date of divorce or legal separation;

8. For a dependent child/children, the date of attainment of the applicable age limit;

9. The end of the last period for which any required contribution was received; or

10. The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information or intentional misrepresentation of a material fact to the Plan, including enrollment information.

An employee or dependent whose coverage has terminated as described here may have rights to the continued coverage described in the next section, Continuation of Benefits.
CONTINUATION OF BENEFITS

Continuation of Coverage for Certain Public Safety Employees
Pursuant to AZ Revised Statute 38-961, eligible Public Safety Employees who are injured while on duty, to the extent that they cannot perform the functions of their position, may be eligible to continue their coverage under this Plan on the same conditions and with the same coverage as an actively-at-work Covered Employee. The Public Safety Employee must be receiving workers’ compensation benefits and meet established injury standards as determined by the Employer. Continuation of coverage will be offered for a six (6) month period, which may be extended at the Employer’s discretion, on an individual basis, for an additional six (6) months, for a maximum of one (1) year. The Employer and Covered Employee obligations under this continuation of coverage are governed by and interpreted account to AZ Revised Statute 38-961.

Reinstatement of Coverage
A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from the Plan’s COBRA coverage, the waiting period will not apply provided he meets all the other requirements of the definition of an Eligible Employee. Participants whose coverage is reinstated under this provision will receive credit for any portion of the Plan Year deductible and other cost sharing amounts that were met for that year while previously covered under the Plan. Benefit maximums for such Participants will be reduced by any amount paid by the Plan while the Participants were previously covered.

Continuation During Family and Medical Leave
The Family and Medical Leave Act of 1993 (“FMLA”) requires employers to provide unpaid, job-protected leave during any 12-month period to eligible employees for certain family and medical reasons. This Plan will comply with the law at all times. Please see the Plan Administrator for details of the FMLA policy adopted by the Employer when you need to take FMLA leave.

COBRA Continuation of Coverage
The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”). COBRA Continuation Coverage can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the Covered Employee. Coverage will end in certain instances, including if you or your dependents fail to make timely payment of premiums. You should check with your employer to see if COBRA applies to you and your dependents.
What is COBRA Continuation Coverage?
“COBRA Continuation Coverage” is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a “Qualifying Event.” Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your employer’s plan) are not considered for continuation under COBRA.

What is a Qualifying Event?
Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a “Qualified Beneficiary.” You, your Spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

If you are a Covered Employee (meaning that you are an employee and are covered under the Plan), you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a Covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

1. Your Spouse dies;
2. Your Spouse’s hours of employment are reduced;
3. Your Spouse’s employment ends for any reason other than his or her gross misconduct;
4. Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your Spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-Covered Employee dies;
2. The parent-Covered Employee’s hours of employment are reduced;
3. The parent-Covered Employee’s employment ends for any reason other than his or her gross misconduct;

4. The parent-Covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);

5. The parents become divorced or legally separated; or

6. The child stops being eligible for coverage under the plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to Arizona Local Government, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired employee’s Spouse, surviving Spouse, and dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Employer must give notice of some Qualifying Events
When the Qualifying Event is the end of employment, reduction of hours of employment, death of the Covered Employee, commencement of a proceeding in bankruptcy with respect to the employer, or the Covered Employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event.

You must give notice of some Qualifying Events
Each Covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail, hand delivery, or by facsimile to (602) 258-4762:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a Covered Employee (or former employee) from his or her Spouse;

2. Notice of the occurrence of a Qualifying Event that is an individual’s ceasing to be eligible as a dependent under the terms of the Plan;

3. Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration (“SSA”) to be disabled at some time before the 60th day of Continuation Coverage; and

5. Notice that a Qualified Beneficiary, with respect to whom a notice described in paragraph (4) above has been provided has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

Arizona Local Government
Plan Administrator
1115 Stockton Hill Road
Kingman, Arizona 86401
(928) 753-4700

A form of notice is available, free of charge, from the Plan Administrator and must be used when providing the notice.

**Deadline for providing the notice**

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;

2. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

3. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan’s SPD or the general notice, of both the responsibility to provide the notice and the Plan’s procedures for providing such notice to the Plan Administrator.

For the disability determination described in (4) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;

2. The date on which a Qualifying Event occurs;

3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan’s SPD or the general notice, of both the responsibility to provide the notice and the Plan’s procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or

2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan’s SPD or the general notice, of both the responsibility to provide the notice and the Plan’s procedures for providing such notice to the Plan Administrator.

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

Who can provide the notice
Any individual who is the Covered Employee (or former employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Covered Employee (or former employee) or Qualified Beneficiary, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required contents of the notice
The notice must contain the following information:

1. Name and address of the Covered Employee or former employee;

2. If you already are receiving COBRA Continuation Coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;
3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the Covered Employee or former employee, death of the Covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status);

4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;

5. In the case of a Qualifying Event that is Medicare entitlement of the Covered Employee or former employee, date of entitlement, and name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan;

6. In the case of a Qualifying Event that is a dependent child’s cessation of dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible dependent (for example, attained limiting age);

7. In the case of a Qualifying Event that is the death of the Covered Employee or former employee, the date of death, and name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan;

8. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA’s determination, and a copy of the SSA’s determination;

9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA’s determination; and

10. A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or legal separation or the SSA’s determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline; however, you must submit a copy of the decree of divorce or legal separation or the SSA’s determination within 30 days after the date you have provided the notice. The notice will be timely if you do so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until you have provided a copy of the decree of divorce or legal separation or the SSA’s determination.

Please note, if the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time...
period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the Covered Employee (or former employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

**Electing COBRA Continuation Coverage**
Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within 14 days of receiving the notice of your Qualifying Event. You then have 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the Plan Administrator determines that the Participant is not entitled to COBRA Continuation Coverage, the Plan Administrator will provide to the Participant an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

**How long does COBRA Continuation Coverage last?**
COBRA Continuation Coverage will be available up to the maximum time period shown below. Multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is “entitlement to Medicare,” the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the Covered Employee (or former employee), the Covered Employee’s (or former employee’s) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the Covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Continuation Coverage for his Spouse and children can last up
to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of
the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross
misconduct) or reduction of the Covered Employee's hours of employment, COBRA Continuation
Coverage generally lasts for only up to a total of 18 months. There are two ways in which this
18-month period of COBRA Continuation Coverage can be extended.

**Disability extension of 18-month period of COBRA Continuation Coverage**
If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and
you notify the Plan Administrator as set forth above, you and your entire family may be entitled to
receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29
months. The disability would have to have started at some time before the 60th day of COBRA
Continuation Coverage and must last at least until the end of the 18-month period of COBRA
Continuation Coverage. An extra fee may be charged for this extended COBRA Continuation
Coverage.

**Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage**
If your family experiences another Qualifying Event while receiving 18 months of COBRA
Continuation Coverage, the Spouse and dependent children in your family can get up to 18
additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the
second Qualifying Event properly is given to the Plan as set forth above. This extension may be
available to the Spouse and any dependent children receiving COBRA Continuation Coverage if the
Covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A,
Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible
under the Plan as a dependent child, but only if the event would have caused the Spouse or
dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. An
extra fee may be charged for this extended COBRA Continuation Coverage.

**Does COBRA Continuation Coverage ever end earlier than the maximum periods above?**
COBRA Continuation Coverage also may end before the end of the maximum period on the earliest
of the following dates:

1. The date your employer ceases to provide a group health plan to any employee;

2. The date on which coverage ceases by reason of the Qualified Beneficiary’s failure to make
timely payment of any required premium;
3. The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules). However, a Qualified Beneficiary who becomes covered under a group health plan which has a Pre-existing condition limit must be allowed to continue COBRA Continuation Coverage for the length of a Pre-existing condition or to the COBRA maximum time period, if less; or

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

Payment for COBRA Continuation Coverage
Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not postmarked (if mailed) or received by the Plan Administrator (if hand delivered) within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Two provisions under the Trade Act affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA Continuation Coverage within the election period will be allowed an additional 60-day period to elect COBRA Continuation Coverage. If the Qualified Beneficiary elects COBRA Continuation Coverage during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the Plan Administrator if you believe the Trade Act applies to you.

Additional Information
Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator, who is:

Arizona Local Government
Plan Administrator
1115 Stockton Hill Road
Kingman, Arizona 86401
(928) 753-4700
Current Addresses
In order to protect your family’s rights, you should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

USERRA Continuation of Coverage

May I continue participation while I am absent under USERRA?
The Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) is a federal law, under which you may elect to continue coverage under the Plan for yourself and your Covered Dependents, where:

1. They were Participants in the Plan immediately prior to your leave of absence for uniformed service; and

2. The reason for your leave of absence is due to active service in the uniformed services.

In addition, you must meet the following requirements:

1. You (or an appropriate officer of the uniformed service) must give advance written or verbal notice of your service to your Employer. This notice will not be required if giving it is precluded by military necessity or is otherwise impossible or unreasonable;

2. The cumulative length of this absence and all previous absences with your Employer by reason of your service in the uniformed service does not exceed five years (although certain exceptions apply to this five-year maximum requirement); and

3. You comply with the notice requirements set forth in “When will coverage continued through USERRA terminate?”

The law requires your Employer to allow you to elect coverage which is identical to similarly situated employees who are not on USERRA leave. This means that if the coverage for similarly situated employees and dependents is modified, coverage for the individual on USERRA leave will be modified.

What is the cost of continuing coverage under USERRA?
The cost of continuing your coverage will be:

1. For leaves of 30 days or less, the same as the contribution required from similarly situated employees;
2. For leaves of 31 days or more, up to 102% of the contribution required from similarly situated employees and your Employer.

Continuation applies to all coverage provided under this Plan, except for short and long-term disability, and life insurance, coverage.

**When will coverage continued through USERRA terminate?**

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date you fail to apply for, or return to, work for your Employer following completion of your leave. You must notify your Employer of your intent to return to employment within:

   a. For leaves of 30 days or less, or if you are absent from employment for a period of any length for the purposes of an examination to determine your fitness to perform service in the uniformed service, by reporting to the Employer:

      i. Not later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of your period of service and the expiration of eight hours after a period allowing for your safe transportation from the place of service to your residence; or

      ii. If reporting within such period is impossible or unreasonable through no fault of yours, then as soon as possible after the expiration of the eight-hour period referred to above.

   b. For leaves of 31 to 180 days, by submitting an application for reemployment with your Employer:

      i. Not later than 14 days after completing uniformed service; or

      ii. If submitting such application within that period is impossible or unreasonable through no fault of yours, then the next first full calendar day when submission of such application becomes possible.

   c. For leaves of more than 180 days, by submitting an application for reemployment with your Employer not later than 90 days after completing uniformed service.

   d. If you are hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service in the uniformed service, by reporting to, or submitting an application for reemployment with, your Employer (depending upon the length of your leave as indicated above), at the end of the period that is necessary for you to recover from such illness or injury. This period may not exceed two years, except
if circumstances beyond your control make reporting to your Employer impossible or unreasonable, then the two-year period may be extended by the minimum time required to accommodate such circumstances.

Continued coverage provided under this provision will reduce the maximum period allowed for continuation provided under COBRA.

**How will my coverage be reinstated on return from USERRA leave?**

The law also requires, regardless of whether continuation of coverage was elected, that your coverage and your dependents’ coverage be reinstated immediately upon your return to employment, so long as you comply with the requirements set forth above in “May I continue participation while I am absent under USERRA?” and, if your absence was more than 30 days, you have furnished any available documents requested by your Employer to establish that you are entitled to the protections offered by USERRA. Further, your separation from service or discharge may not be dishonorable or based upon bad conduct, on grounds less than honorable, absent without leave (AWOL), or ending in a conviction under court martial.

Upon reinstatement, an exclusion or waiting period may not be imposed if that exclusion or waiting period would not have been imposed had your coverage (or your dependents’ coverage) not terminated as a result of your service in the uniformed service. However, this does not apply to coverage of any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of your service in the uniformed services.

**NOTE:** For complete information regarding your rights under USERRA, contact your Employer.
PLAN ADMINISTRATION

The Plan Administrator
The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of Gilsbar, L.L.C., as the Benefit Services Manager to provide certain claims processing and other ministerial services, which the Benefit Services Manager may further delegate to others. The Plan Administrator’s relationship with Gilsbar, L.L.C. is governed by the Benefit Services Management Agreement. The Benefit Services Manager has no responsibility or obligation to Plan Participants, but only to the Plan and the Plan Administrator, as set forth in the Benefit Services Management Agreement.

An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Medically Necessary or Experimental and what charges are Reasonable and Customary), to decide disputes which may arise relative to a covered person’s rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the covered person is entitled to them.

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;

2. To determine all questions of eligibility, status and coverage under the Plan;

3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

4. To make factual findings;

5. To decide disputes which may arise relative to a covered person’s rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;

7. To keep and maintain the Plan documents and all other records pertaining to the Plan;

8. To appoint and supervise a benefit services manager to pay claims;

9. To perform all necessary reporting as required;

10. To establish and communicate procedures to determine whether MCSOs and NMSNs are QMCSOs;

11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and

12. To perform each and every function necessary for or related to the Plan’s administration.

Amendment and Termination
The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor’s directors and officers, which shall be acted upon as provided in the Plan Sponsor’s articles of incorporation or bylaws, as applicable, and in accordance with applicable federal and state law. Notice shall be provided as required. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his own discretion.

If the Plan is terminated, the rights of covered persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Expenses
All claims, expenses, or charges for the administration and operation of the Plan will be paid by the Plan and the trust, if any, that funds the Plan, or in the absence of a trust, by the Employer, as the Plan Sponsor.
Notices
All payments or notices of any kind to an employee, Participant, beneficiary or Plan official may be mailed to the address for that person last appearing on the records of the Plan Administrator. When such a notice is mailed by first class mail, it is deemed to have been (a) duly delivered on the date post-marked, and (b) duly received three calendar days after being deposited, postage prepaid, in the United States Mail. When such a notice is delivered in person, it is deemed to have been received the same day as delivery. Each Participant must keep the Plan Administrator notified of his current address. If there is doubt about the accuracy of an address, the Plan may give notice, by registered mail to any such person's last address, that payments and other mail are being withheld pending receipt of a proper mailing address from that person.

Invalidity
In the event that any provision in this Plan is deemed to be invalid or unenforceable, no other provision of this Plan shall be affected.

Other Statements
This written document and any later amendments to it constitute the complete and only statement of the Plan and cannot be changed by any oral or other written statement regarding the Plan.
HIPAA PRIVACY

The following is a description of certain uses and disclosures that may be made by the Plan of your health information:

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with HIPAA's Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
2. Modifying, amending or terminating the Plan.

“Summary Health Information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes
In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as Required by Law (as defined in the Privacy Standards);
- Ensure that any agents to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or group employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
• Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);

• Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

• If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

• Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
  - The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
    - Appropriate personnel of Human Resources
    - Appropriate personnel of Finance
    - County Manager
    - Plan Consultants
    - Office Manager
    - Appropriate personnel ACIP
  - The access to and use of PHI by the individuals described above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
  - In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or
solicit bids from prospective issuers. “Plan Administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- The Plan documents have been amended to incorporate the above provisions; and
- The Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Benefit Services Manager, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI
With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.
HIPAA SECURITY

Effective April 20, 2005 (April 20, 2006 for small health plans as defined by 45 C.F.R. § 160.103), the following section will be added to the Plan. It is intended to bring the Arizona Local Government Employee Benefit Trust (“Plan”) into compliance with the requirements of 45 C.F.R. § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162 and 164 (the regulations are referred to herein as the “HIPAA Security Standards”) by establishing Plan Sponsor’s obligations with respect to the security of Electronic Protected Health Information.

Accordingly, the following is hereby included in the Plan effective on the applicable date shown above:

1. Definitions

**Electronic Protected Health Information** – The term “Electronic Protected Health Information” has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

**Security Incident** – The term “Security Incident” has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

2. Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

- Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
• Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

• Plan Sponsor shall report to the Plan any Security Incident of which it becomes aware as described below:
  ▪ Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan’s Electronic Protected Health Information; and

  ▪ Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis at renewal, or more frequently upon the Plan’s request.
EXEMPTION FROM MENTAL HEALTH & SUBSTANCE USE DISORDER PARITY

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is “self-funded” by the employer, rather than provided through a health insurance policy. The Arizona Local Government (AZLGEBT) has elected to be exempt from the following requirement:

Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefit and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The exemption from this Federal requirement was in effect for the Plan Year beginning July 1, 2010 and ending June 30, 2011. This election has been renewed for subsequent Plan Years.

If you have any questions regarding this election to exempt AZLGEBT from the requirements of the Mental Health Parity and Addiction Equity Act, please feel free to contact your employers Human Resources or Benefits Department.
HIPAA NOTICE OF PREEXISTING CONDITION EXCLUSION AND SPECIAL ENROLLMENT

IMPORTANT NOTICE

(PLEASE READ THOROUGHLY)

for Employees of Apache County, Gila County, Graham County, Greenlee County, La Paz County, Santa Cruz County, County Supervisors Association, Arizona Association of Counties, and Arizona Counties Insurance Pool

Regarding Your Rights Concerning Pre-Existing Condition Exclusions and Special Enrollment Provisions under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that provides for many important changes in your health plan concerning pre-existing conditions, enrollment in the Plan, and the portability and availability of coverage.

Two significant areas of change are pre-existing condition exclusions and enrollment provisions. A preexisting condition is any physical or mental condition (regardless of the cause of the condition) for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period (unless your Plan states otherwise) ending on your enrollment date. Your enrollment date is the first day of coverage or, if there is a waiting period, the first day of the waiting period. Under the law, a pre-existing condition exclusion period may not be imposed on any enrollee under age 19 and may not be longer than 12 months (18 months for a late enrollee, but only if your Plan allows late enrollees). Furthermore, the pre-existing period imposed by the Plan will be reduced or eliminated by prior, creditable health coverage you had, provided you did not have a break in coverage of 63 days or more immediately prior to your enrollment in this Plan. You are entitled to a certificate of creditable coverage from your prior health plan that will show evidence of any coverage under that plan. If necessary, your Plan Administrator will assist you in obtaining a certificate from your prior plan. This notice makes no determination as to whether you or your dependents have a pre-existing condition. However, if you are now in a pre-existing period and you have any prior creditable coverage, it is important that you submit a certificate of creditable coverage to your Plan Administrator. It may reduce your pre-existing period. Failure to timely submit a valid certificate or other acceptable documentation of creditable coverage may result in the denial of claims related to a pre-existing condition. Note: For plan years beginning on or after January 1, 2014, there are limitations on plans imposing preexisting condition exclusions. Pursuant to the Patient Protection and Affordable Care Act, such exclusions will become prohibited beginning on the first day of the plan year that occurs on or after January 1, 2014. Due to this change, certificates of creditable coverage will be phased out and no longer issued beginning December 31, 2014.
Another provision significantly affects enrollment. For example, if you decline enrollment for yourself or your dependents because of other health insurance coverage, such as your spouse's group health plan, you "may" in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends, and you meet certain other important conditions described in the Summary Plan Description. Termination of other coverage must also meet certain qualifying reasons such as exhaustion of COBRA or state law continuation rights, loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment or reduction in hours, or because employer contributions for other coverage cease.

Also, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you "may" be able to enroll yourself, your spouse, and your newly acquired dependents, provided you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, and you meet certain other important conditions described in the Summary Plan Description.

If you have any questions concerning this notice please contact your Plan Administrator.
HIPAA NOTICE OF SPECIAL ENROLLMENT

IMPORTANT NOTICE

(PLEASE READ THOROUGHLY)

for Employees of Apache County, Gila County, Graham County, Greenlee County, La Paz County, Santa Cruz County, County Supervisors Association, Arizona Association of Counties, and Arizona Counties Insurance Pool

Regarding Your Rights Concerning Special Enrollment Period under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents’ other coverage). However, you must request enrollment within 30 days after you or your dependents’ other coverage ends (or after the employer stops contributing towards the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you and your dependent are covered under Medicaid or a state children’s health insurance program and you lose eligibility for such coverage, you may request coverage for yourself and your dependent child, and you may be able to enroll yourself and your dependent in this Plan if you request enrollment within 60 days of losing such coverage.

To request special enrollment or obtain more information, contact:

Arizona Local Government
1115 Stockton Hill Road, Suite 101
Kingman, Arizona 86401
(928) 753-4700
IMPORTANT NOTICE

(PLEASE READ THOROUGHLY)

Regarding Your Rights Concerning Reconstructive Surgery Following a Mastectomy Under the

Women’s Health and Cancer Rights Act of 1998

Dear Plan Participant:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

Note: These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your Plan Administrator.
GRAMM-LEACH-BLILEY PRIVACY NOTICE

NOTICE OF PRIVACY POLICY
Information Only — No Response Necessary

Dear Policyholder:

Federal legislation called the Gramm-Leach-Bliley Act requires that we send you annual notice of our privacy policy. This policy outlines how the Arizona Local Government Employee Benefit Trust may collect and use information about you.

PRIVACY POLICY – ARIZONA LOCAL GOVERNMENT EMPLOYEE BENEFIT TRUST

We collect nonpublic personal information about you from the following sources:

- Information we receive from you on applications and other forms, such as name, address, social security number and previous insurance coverage;
- Information about your transactions with us or our affiliates, such as claims history and premium payments; and
- Information about you from others, including providers of services to you, such as previous employment, previous insurance coverage and claims detail.

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law. We may disclose information we collect as described above to companies that perform services on our behalf. For example, we provide information on approved claims to the specialist company that prints and mails checks.

We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

We appreciate the opportunity to serve you by providing quality insurance and benefit programs and other financial services. If you have any suggestions about improving our privacy policies, I hope you'll feel free to call us. As always, thank you for allowing us to serve you.

Sincerely,

Arizona Local Government
1115 Stockton Hill Road, Suite 101
Kingman, Arizona 86401
(928) 753-4700
NOTICE OF PREMIUM ASSISTANCE UNDER MEDICAID AND CHIP PROGRAMS

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in the following State, you may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility –

<table>
<thead>
<tr>
<th>State</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td><a href="http://www.azahcccs.gov/applicants">http://www.azahcccs.gov/applicants</a></td>
<td>(Outside of Maricopa Co.): 1-877-764-5437</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Maricopa Co.): 1-602-417-5437</td>
</tr>
</tbody>
</table>

To see if any more States have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:


NOTICE OF PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Arizona Local Government Employee Benefit Trust (AZLGEBT) and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or Participating Provider) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. It has determined that the prescription drug coverage offered by AZLGEBT is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
Your current medical coverage pays for other health expenses in addition to prescription drugs. If you and/or your dependents enroll in a Medicare drug plan, you and/or your dependents will still be eligible to receive medical and prescription drug benefits through AZLGEBT. If you and/or your dependents enroll in a Medicare drug plan, in general, the following guidelines listed below apply. If you are an active Member, or the covered dependent of an active Member, you are required to obtain your outpatient prescription drug benefits through your AZLGEBT plan first. You can then file on a secondary basis with your Medicare drug plan.

If you are a COBRA participant, or the covered dependent of a COBRA participant, you are required to obtain your outpatient prescription drugs through your Medicare drug plan first. Secondary coverage is not available through AZLGEBT.
Important: You can only waive prescription drug coverage by waiving the entire AZLGEBT medical/prescription plan coverage for yourself and your dependents. Remember, if you do waive your AZLGEBT coverage, you can only re-enroll in the AZLGEBT medical plan coverage during the next Open Enrollment Period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with AZLGEBT and don’t join a Medicare drug plan within sixty-three (63) continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go sixty-three (63) continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...
Contact the person listed below for further information. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through AZLGEBT changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not
you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender:
Arizona Local Government
1115 Stockton Hill Road, Suite 101
Kingman, Arizona 86401
(928) 753-4700
OTHER INFORMATION

Plan Name  Arizona Local Government Employee Benefit Trust

SFP Number  S2696

State of Organization  Arizona Local Government is organized under the laws of the State of Arizona.

Plan Sponsor  Arizona Local Government
1115 Stockton Hill Road, Suite 101
Kingman, Arizona 86401
(928) 753-4700

Tax Identification Number  86-0765362

Plan Administrator  Arizona Local Government
1115 Stockton Hill Road, Suite 101
Kingman, Arizona 86401
(928) 753-4700

Plan Affiliates/Subsidiaries  None

Benefit Services Manager  Gilsbar, L.L.C.
P.O. Box 998
Covington, LA  70434
Telephone (985) 892-3520 or (800) 445-7227
Fax (985) 898-1500

Type of Plan and Administration  This Plan is a self-funded group medical cost indemnity plan; claims are processed by a claims payment company (the Benefit Services Manager), separate from the Plan Sponsor but under the direction of the Plan Administrator.

Plan Year  July 1 – June 30

Plan Cost  Employer shares the cost of employee and dependent coverage under this Plan with the Covered Employees.

The level of any employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of employee contributions.
Benefits

Plan benefits are provided by Arizona Local Government.

Agent for Service of Legal Process

Service of legal process may be made upon the Plan Administrator.

Plan is Not an Employment Contract

The Plan shall not be deemed to constitute a contract between the Employer and any employee or to be a consideration for, or an inducement, or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement which may be made by the Employer with the bargaining representatives of any employees.

Effective Date

This Plan was adopted by Arizona Local Government effective July 1, 2014, and has been restated in this updated Plan Document and summary Plan description. The effective date of this amendment of the Plan is July 1, 2016.