Effective January 1, 2011, the Summary Plan Description is amended as noted below:

Page HCP-16, the section titled “Dependent Defined,” is deleted in its entirety and replaced with the following section wording:

Dependent Defined

Eligible dependents include any of the following:

- Legal spouse of the opposite sex.

- **Effective September 1, 2010,** a dependent child is any of the employee’s or retiree’s children under the age of 26 (whether married or unmarried), who is a:
  
  - Son or daughter; or
  
  - Stepson or stepdaughter; or
  
  - **Legally adopted child** or child placed for adoption with the employee or retiree (proof of adoption or placement for adoption may be requested). Placed for adoption means the assumption and retention by the employee/retiree of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child’s placement for adoption terminates upon the termination of such legal obligation.

In addition to dependent children (as noted above), the following individuals are also considered to be dependent children under this Plan:

- **Disabled adult child:** A dependent child age 26 or older (who is unmarried) who is physically or mentally unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months and with a disability that existed prior to the attainment of the Plan’s age limit and who is eligible for tax-free health coverage as a “qualifying child” or “qualifying relative” under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively. Proof of the disability must be submitted to the Plan Administrator or its designee, Benefits Services, within 31 days of the date the dependent reaches the age at which coverage normally ends. If coverage is extended, proof of disability will be required from time to time; or

- An individual under age 26, who is married or unmarried, with respect to whom the employee or retiree has legal guardianship under a court order (proof of guardianship may be requested).

**Children not eligible for coverage:** A foster child, a spouse of a dependent child (e.g., son-in-law, daughter-in-law) and a child of a dependent child (e.g., grandchild) are not eligible for coverage under the Plan.

With the exception of a dependent child who is permanently and totally disabled, coverage for a covered individual shall terminate at the pay period in which the individual attains age 26.

See also the section on Qualified Medical Child Support Orders (QMCSO) later in this chapter.
Page HCP-17, the section titled “Proof of Dependent Status,” is deleted in its entirety and replaced with the following section wording:

PROOF OF DEPENDENT STATUS

Specific documentation to substantiate dependent status will be required by the Plan and may include a birth certificate, marriage license, proof of the dependent’s age, along with the Social Security number of the dependent(s) you wish to add to the Plan, and any of the following:

- **Marriage**: Copy of the certified marriage certificate.
- **Birth**: Copy of the certified birth certificate.
- **Stepchild**: the birth certificate plus marriage certificate.
- **Adoption or placement for adoption**: Court order paper signed by the judge.
- **Legal guardianship**: A copy of your court-appointed legal guardianship documents and a copy of the certified birth certificate along with proof that the dependent is a tax-qualified dependent, such as proof of the same principal place of residence, personal income tax return showing the name.
- **Disabled dependent child**: Current written statement from the child’s physician indicating the child’s diagnoses that are the basis for the physician’s assessment that the child is currently mentally or physically disabled (as the term “disabled” is defined in this Handbook) and is incapable of self-sustaining employment as a result of that disability; and dependent chiefly on you and/or your spouse for support and maintenance. The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan’s definition of dependent child.
- **Qualified Medical Child Support Order (QMCSO)**: Valid QMCSO document or National Medical Support Notice.

Page HCP-118-19, the section titled “Student Status Verification Process,” is deleted in its entirety:

Page HCP-33, the following statement is added to the section on “When Coverage Ends” to follow directly after the section heading as noted below:

**When Coverage Ends**

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage except when contributions are not timely paid, or in cases of fraud or intentional misrepresentation of material fact.

Page HCP-33, any reference to a General Overall Lifetime Maximum Medical Plan Benefit is deleted throughout the pages 7 through 166.

HCP-64, any reference to a separate Behavioral Health deductible for Behavioral health services is deleted throughout the pages 7 through 166. Eligible Behavioral Health benefits accumulate toward the deductible of the appropriate medical plan option.
HCP-64, in the “Schedule of Medical Benefits,” in the Behavioral Health row, under the EPO Plan column, the text is deleted in its entirety and replaced with the following wording:

Outpatient visits and psych testing:
No deductible, 100% after a $15 copay per visit.

Inpatient:
100% after a $100 copay per admission.

Page HCP-77, in the “Schedule of Medical Benefits,” the row title “Wellness (Preventive) Program Well-Child Examinations and Immunizations,” is deleted in its entirety and replaced with the following row:

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Explanations and Limitations</th>
<th>EPO Plan</th>
<th>$300/$600 PPO Plan</th>
<th>$1,000/$2,000 PPO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness (Preventive) Program</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Well-baby/well-child care, including childhood immunizations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult wellness services, including routine physical examinations.</td>
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<tr>
<td>Tobacco cessation (stop-smoking) assistance</td>
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<td></td>
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<tr>
<td><strong>EPO Plan:</strong></td>
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<tr>
<td>• Copay applies to office visit only; facility charges paid at 100%.</td>
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</tr>
<tr>
<td>• Child wellness (under age 18 years) includes routine physical exams, X-rays, labs, and childhood immunizations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Adult wellness (age 18 and older) includes physical exams, X-rays, labs, OB/GYN exams, all immunizations, colon exams, prostate/testicular exams, mammograms (age 40+), annual Pap smears (age 18+), PSA tests (age 50+) and colonoscopies (age 50+). These services performed under these age ranges are covered as any other illness.</td>
<td></td>
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<tr>
<td><strong>PPO Plans:</strong></td>
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</tr>
<tr>
<td>• Child wellness (birth through 2 years old) includes but is not limited to routine physical exams, well-baby exams, X-rays, labs and childhood immunizations.</td>
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<td></td>
</tr>
<tr>
<td>• Adult wellness (age 3 years and older) includes but is not limited to physical exams, X-rays, labs and all immunizations. For individuals age 19 and older, benefits are payable to a maximum of $500 per calendar year at the copay or coinsurance noted to the right, thereafter Plan pays 10% of eligible wellness expenses. This maximum does not apply to mammograms (age 40+), annual Pap smears (age 18+), PSA tests (age 50+), and colonoscopies (age 50+).</td>
<td></td>
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</tr>
<tr>
<td>• Stop-smoking prescription medication is payable under the Prescription Drug Program described in the Drugs row of this Schedule. Outpatient stop-smoking program costs are reimbursed at 100%, no copay, no deductible.</td>
<td></td>
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</tr>
</tbody>
</table>
GRANDFATHERED HEALTH PLAN UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (THE AFFORDABLE CARE ACT)

This group health plan believes that the medical plans offered under the SRP Health Care Program are “grandfathered health plans” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to SRP Benefits Services PAB242 at 602-236-3600 or 1-800-491-8846 (press 0).

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or http://www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Page HCP-146, the definition of Dependent Child is deleted in its entirety and replaced with this new definition:

Dependent Child: A dependent child is any of the employee’s or retiree’s children under the age of 26 (whether married or unmarried), who is a:

- Son or daughter; or
- Stepson or stepdaughter; or
- Legally adopted child or child placed for adoption with the employee or retiree (proof of adoption or placement for adoption may be requested). Placed for adoption means the assumption and retention by the employee/retiree of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child’s placement for adoption terminates upon the termination of such legal obligation.

In addition to dependent children (as noted above), the following individuals are also considered to be dependent children under this Plan:

- Disabled adult child: A dependent child age 26 or older (who is unmarried) who is physically or mentally unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months and with a disability that existed prior to the attainment of the Plan’s age limit and who is eligible for tax-free health coverage as a “qualifying child” or “qualifying relative” under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively. Proof of the disability must be submitted to the Plan Administrator or its designee, Benefits Services, within 31 days of the date the dependent reaches the age at which coverage normally ends. If coverage is extended, proof of disability will be required from time to time; or
- An individual under age 26, who is married or unmarried, with respect to whom the employee or retiree has legal guardianship under a court order (proof of guardianship may be requested).

Children not eligible for coverage: A foster child, a spouse of a dependent child (e.g., son-in-law, daughter-in-law) and a child of a dependent child (e.g., grandchild) are not eligible for coverage under the Plan.

With the exception of a dependent child who is permanently and totally disabled, coverage for a covered individual shall terminate at the pay period in which the individual attains age 26.
This Amendment #1 to the Salt River Project (SRP) Health Care Program Summary Plan Description was duly adopted by the Plan Administrator on the 4th of October, 2011.

David B. Waechter  
Plan Administrator (print name)

[Signature]
Plan Administrator (signature)
AMENDMENT #2 to the
SALT RIVER PROJECT (SRP) HEALTH CARE PROGRAM
As described in the Health Care Program section of the SRP Handbook. The SRP Handbook was amended and restated effective January 1, 2010, and serves as Summary Plan Description for the program, and is incorporated by reference into the plan documents comprising the Salt River Project Insured and Self-Insured Health and Life Plans.

Effective January 1, 2012, the Health Care Program section of the SRP Handbook is amended as noted below:

Page HCP-77, in the “Schedule of Medical Benefits,” the row title “Weight Loss Assistance,” is deleted in its entirety and replaced with the following row:

<table>
<thead>
<tr>
<th>Schedule of Medical Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Description</td>
</tr>
</tbody>
</table>
| Weight Loss Assistance | • A weight loss program is reimbursed up to $250 per person per lifetime, not to include the cost for food.  
• See also the Dietitian and Nutritional Guidance rows in this Schedule of Medical Benefits.  
• Weight loss medication is payable at 50% up to $1,000 per person per year. Refer to the Drugs row in this Schedule of Medical Benefits. | 100% Program: 100%, no deductible | Program: 100%, no deductible | Program: 100%, no deductible | Program: 100%, no deductible | Program: 100%, no deductible |

Page HCP – 159, in the Definitions chapter of the Health Care Program section of the SRP Handbook, the term “Plan Administrator” is deleted in its entirety and replaced with the following definition:

Plan Administrator: The SRP Senior Director for Human Resources or their designee is the Plan Administrator and is the person or legal entity designated by the plan as the party who has the fiduciary responsibility for the overall administration of the plan.

Throughout the Health Care Program section of the SRP Handbook any reference to the SRP Benefits Manager is hereby deleted and replaced with a reference to the “SRP Senior Director for Human Resources or their designee” and any reference to the Plan Administrator being the “SRP Benefits Manager” is hereby deleted and replaced with the statement that the Plan Administrator is the “SRP Senior Director for the District’s Human Resources Services Department.”
This Amendment #2 to the Health Care Program section of the SRP Handbook is hereby adopted by the undersigned this 22nd day of March, 2012.

SALT RIVER PROJECT AGRICULTURAL IMPROVEMENT AND POWER DISTRICT

By

Its: President

By

Its: General Manager and Chief Executive Officer

SALT RIVER VALLEY WATER USERS' ASSOCIATION

By

Its: President

By

Its: General Manager
ABOUT THIS HANDBOOK

This Handbook (effective January 1, 2010) is designed as a reference and serves as the “Summary Plan Description” for several plans sponsored by the Salt River Project Agricultural Improvement and Power District (the “District”) and the Salt River Valley Water Users Association (the “Association”). It includes details about each benefit and outlines the steps you must take to receive full value from each of your benefits. Each benefit description has a table of contents, section headings and numerous subheadings to help you find the information that you need. The loose-leaf binder format will help you keep the Handbook up to date as benefits change and new pages or sections are distributed to you.

Because an explanation of the benefits can be difficult to understand, an effort has been made to write this Handbook in non-technical language.

IMPORTANT PROVISIONS

The following legal provisions need to be considered when reading and using this Handbook:

- **Conflict Between Plan Documents and Handbook**
  This Handbook is intended to summarize your benefits. For insured programs, the insurance contract or policy serves as the plan document. For self-insured plans, separate plan documents may exist. While this Handbook is intended to be accurate, the official plan documents contain all the specific provisions. For certain plans, this Handbook serves as the official plan document. If a separate plan document exists for a particular plan, the terms of the plan document will supersede the terms of this handbook that discuss such plan. You may obtain a copy of any plan document from Benefits Services on request. Benefits Services reserves the right to charge you a copying fee.

- **SRP’s Right to Amend, Terminate or Add to This Handbook**
  SRP reserves the right to amend, terminate or add to the policies, procedures or benefits contained in this Handbook. You will be provided with any material modifications in the form of replacement pages. Those replacement pages will have a new date on the bottom.

  In addition, with respect to any benefit plan or insurance coverage described in this Handbook, SRP’s reservation applies to all participant classes, retired or otherwise. SRP’s reservation includes the right to change the terms of participation and coverage, the cost of any coverage, and the percentage, if any, of the cost of any coverage that SRP and/or any current or retired SRP employee, or his/her dependent(s), pays. Subject to applicable collective bargaining agreements, the amendment, termination or addition of any policy, procedure or benefit described in this Handbook does not require prior consultation, notice or consent of you or your dependents or beneficiaries.

- **No Guarantee of Employment**
  The benefits described in this Handbook do not create a contract between you and SRP. Nothing in this Handbook or any benefit plan described in this Handbook says or implies that your participation in a benefit plan described in this Handbook is a guarantee of continued employment. Subject to applicable collective bargaining agreements, the General Manager of SRP is the only person authorized by SRP to alter the at-will nature of the relationship between SRP and you or to bind SRP to a contract of employment with you, and then only by a written contract of employment expressly designated as such, signed by the General Manager and approved by the Board.

- **Tax Advice**
  No SRP employee can be responsible for advising you on the tax effects of your participation in any benefit plan described in this Handbook. Because tax laws are complicated and constantly changing, you should consult a tax adviser if you have questions about how participation in any benefit plan described in this Handbook will affect your personal tax situation.

- **ERISA Rights**
  The Employee Retirement Income Security Act of 1974 (ERISA) applies to most of the benefits described in this Handbook. ERISA protects your rights as a participant in the benefit plans described in this Handbook to which it applies and also states the responsibilities of the Plan sponsors, Plan Administrators and trustees. Your legal rights under ERISA are described in the **ERISA Rights** section of this Handbook.
<table>
<thead>
<tr>
<th><strong>Information Needed</strong></th>
<th><strong>Who to Contact (Valley extensions, unless otherwise noted)</strong></th>
</tr>
</thead>
</table>
| **SRP Benefits Services** | - Questions about benefits of the SRP  
- Health Care Program  
- HIPAA Certificate of Creditable Coverage  
- Information about COBRA coverage  
Phone: (602) 236-3600 or 1 (800) 491-8846  
Mailing Address:  
SRP Benefits Services PAB242  
P. O. Box 52025  
Phoenix, AZ 85072-2025 |
| **SRP’s Intranet (HRNet) or Internet** | - Open Enrollment information  
- Forms  
- Access to provider directories  
- Personal information  
insidesrp/hrnet/benefits (Web address for internal access)  
www.srpnet.com/hronline (Web address for access outside of SRP) |
| **Claims Administrator for the SRP Medical PPO Option, EPO and SRP Hearing Aid Benefit** | - Post-service claims and appeals for medical and hearing aid benefits  
- Claim forms  
- Claims status for covered benefits  
- Eligibility for coverage  
- SRP Health Care Program benefit information  
- Utilization review  
Mailing Address:  
Gilsbar, INC  
2100 Covington Centre  
Covington, LA 70433  
Phone: (877) 841-4777  
www.myGilsbar.com |
| **Claims Administrator and Provider Network for the SRP Dental Program** | - Participating dental network  
- Claim forms  
- Claims status for covered benefits  
- Eligibility for coverage  
- Benefit Information  
- Post-service dental claims and appeals  
Mailing Address:  
Delta Dental of Arizona  
5656 W. Talavi Blvd.  
Glendale, AZ 85306  
Phone: (800) 352-6132 or (602) 588-3993  
Mailing Address:  
Delta Dental of Arizona  
Attn: Claims Department  
P.O. Box 43026  
Phoenix, AZ 85080 |
| **SRP Medical PPO Option: Medical Network** | - Preferred PPO providers  
- Additions/deletions of network providers  
Blue Cross/Blue Shield of Arizona  
www.azblue.com |
<table>
<thead>
<tr>
<th>Information Needed</th>
<th>Who to Contact (Valley extensions, unless otherwise noted)</th>
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</thead>
<tbody>
<tr>
<td><strong>Prescription Drug Program for the SRP Medical PPO Option</strong></td>
<td>CVS Caremark</td>
</tr>
<tr>
<td>• Retail network pharmacies</td>
<td><strong>Customer Service:</strong> (800) 770-8014, option 3</td>
</tr>
<tr>
<td>• Mail order service</td>
<td><strong><a href="http://www.caremark.com">www.caremark.com</a></strong></td>
</tr>
<tr>
<td>• Payment for out-of-network Prescriptions (direct member reimbursement)</td>
<td><strong>Mailing Order Service:</strong></td>
</tr>
<tr>
<td>• Prescription drug information</td>
<td>CVS Caremark</td>
</tr>
<tr>
<td>• ID cards for Medical PPO and prescription drugs</td>
<td>P.O. Box 94467</td>
</tr>
<tr>
<td></td>
<td>Palatine, IL 60094-4467</td>
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<tr>
<td></td>
<td><strong>Customer Service Mail Order:</strong> (877) 889-3402</td>
</tr>
<tr>
<td><strong>Direct Member Reimbursement for Out-of-Network Claims</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Employee Assistance Program (EAP)</strong></td>
<td><strong>SRP EAP counselor</strong></td>
</tr>
<tr>
<td>• EAP counseling and referral services are available from either the SRP EAP counselor or CONTACT behavioral health counselors.</td>
<td>(602) 236-5503</td>
</tr>
<tr>
<td></td>
<td><strong>EAP counselors</strong></td>
</tr>
<tr>
<td></td>
<td>(888) 882-0771</td>
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<tr>
<td></td>
<td><strong><a href="http://www.guidanceresources.com">www.guidanceresources.com</a></strong></td>
</tr>
<tr>
<td><strong>SRP Behavioral Health Program</strong></td>
<td><strong>WEBID:</strong> SRP10</td>
</tr>
<tr>
<td>• Authorization for outpatient and inpatient mental health and substance abuse services</td>
<td></td>
</tr>
<tr>
<td>• Pre-service, concurrent and urgent care behavioral health appeals</td>
<td><strong>Mailing Address:</strong></td>
</tr>
<tr>
<td></td>
<td>ComPsych</td>
</tr>
<tr>
<td></td>
<td>NBC Tower 13th Floor</td>
</tr>
<tr>
<td></td>
<td>455 N. Cityfront Plaza Drive</td>
</tr>
<tr>
<td></td>
<td>Chicago, IL 60611</td>
</tr>
<tr>
<td></td>
<td><strong>Phone:</strong> (888) 882-0771</td>
</tr>
<tr>
<td><strong>EDS Prepaid Dental Plan</strong></td>
<td><strong>Employers Dental Services (EDS)</strong></td>
</tr>
<tr>
<td>• ID Cards</td>
<td><strong>Customer Service:</strong> (800) 722-9772</td>
</tr>
<tr>
<td>• Changing dental providerseals</td>
<td><strong><a href="http://www.mydentalplan.net">www.mydentalplan.net</a></strong></td>
</tr>
<tr>
<td>• Customer service issues</td>
<td></td>
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<tr>
<td>• Plan Information</td>
<td><strong>Mailing Address:</strong></td>
</tr>
<tr>
<td>• Dental claims and appeals</td>
<td>EDS Grievance and Appeals Coordinator</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 36600</td>
</tr>
<tr>
<td></td>
<td>Tucson, AZ 85740-6600</td>
</tr>
<tr>
<td></td>
<td>(800) 722-9772, Fax: (520) 696-4311</td>
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<tr>
<td>Information Needed</td>
<td>Who to Contact (Valley extensions, unless otherwise noted)</td>
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</tr>
<tr>
<td><strong>SRP Vision Plan</strong></td>
<td><strong>Vision Service Plan (VSP)</strong></td>
</tr>
<tr>
<td>• Vision provider directory</td>
<td>Phone: (800) 877-7195</td>
</tr>
<tr>
<td><strong>Claims Administrator</strong></td>
<td><strong><a href="http://www.vsp.com">www.vsp.com</a></strong></td>
</tr>
<tr>
<td>• Post-service vision claims</td>
<td><strong>Mailing Address:</strong></td>
</tr>
<tr>
<td>• Post-service vision claim appeals</td>
<td>VSP Out-of-Network Provider Claims</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 997105,</td>
</tr>
<tr>
<td></td>
<td>Sacramento, CA 95899-7105</td>
</tr>
<tr>
<td></td>
<td><strong>Claims Appeals:</strong></td>
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<tr>
<td></td>
<td>VSP Member Appeals</td>
</tr>
<tr>
<td></td>
<td>333 Quality Drive</td>
</tr>
<tr>
<td></td>
<td>Rancho Cordova, CA 95670</td>
</tr>
<tr>
<td><strong>COBRA Administrator</strong></td>
<td><strong>Mailing Address:</strong></td>
</tr>
<tr>
<td>• COBRA questions</td>
<td>Gilsbar, INC</td>
</tr>
<tr>
<td>• COBRA premium payments</td>
<td>2100 Covington Centre</td>
</tr>
<tr>
<td></td>
<td>Covington, LA 70433</td>
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<tr>
<td></td>
<td><strong>Phone:</strong> (877) 841-4777</td>
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<tr>
<td></td>
<td><strong><a href="http://www.myGilsbar.com">www.myGilsbar.com</a></strong></td>
</tr>
<tr>
<td><strong>Tax Saver Accounts (TSA) Administrator</strong></td>
<td><strong>Mailing Address:</strong></td>
</tr>
<tr>
<td>• Medical reimbursement</td>
<td>Gilsbar, INC</td>
</tr>
<tr>
<td>• Dependent care assistance</td>
<td>2100 Covington Centre</td>
</tr>
<tr>
<td>Claims Administrator</td>
<td>Covington, LA 70433</td>
</tr>
<tr>
<td>• Post-service TSA claims and appeals</td>
<td><strong>Phone:</strong> (877) 841-4777</td>
</tr>
<tr>
<td></td>
<td><strong><a href="http://www.myGilsbar.com">www.myGilsbar.com</a></strong></td>
</tr>
<tr>
<td><strong>Plan Administrator for the SRP Health Care Program</strong></td>
<td><strong>Mailing Address:</strong></td>
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<tr>
<td></td>
<td>Plan Administrator</td>
</tr>
<tr>
<td></td>
<td>c/o SRP Benefits Services PAB242</td>
</tr>
<tr>
<td></td>
<td>P. O. Box 52025</td>
</tr>
<tr>
<td></td>
<td>Phoenix, AZ 85072-2025</td>
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<td></td>
<td><strong>Phone:</strong> (602) 236-3600 or (800) 491-8846 (Press 0)</td>
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</table>
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All page numbers listed have the prefix “HCP” and pertain to this section of the Handbook.

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Introduction to the SRP Health Care Program

SRP provides a wide variety of health care benefits and choices for eligible employees and dependents. For purposes of this discussion of the SRP Health Care Program, the term “SRP” includes the Salt River Project Agricultural Improvement and Power District (District), the Salt River Valley Water Users’ Association (Association), Papago Park Center, Inc. and New West Energy Corporation. These benefits are medical (including hearing aid and behavioral health care), dental and vision. All of these benefits, together with group term life insurance, are referred to as the Salt River Project Health and Life Plan. For more information about eligibility for health care program benefits, see Eligibility for Coverage in this section of the Handbook.

Choice of Medical and Dental Options

SRP offers a choice of medical coverage for eligible employees and dependents through one of two Preferred Provider Organization (PPO) plans or an Exclusive Provider Organization (EPO) plan. The Medical Plans for active employees cover hearing aid benefits also. SRP also offers a choice of dental coverage for eligible employees and dependents through one of two dental options. In addition, SRP offers eligible employees and dependents behavioral health, vision, Medical Reimbursement Tax Saver Account and Dependent Care Assistance Tax Saver Account benefits. These benefits are described in the SRP Health Care Program section of this Handbook.

Note: For purposes of the benefits described in this section of your Handbook, unless expressly stated to mean something else, the phrases “medical benefits,” medical coverage” and “medical options” include hearing aid and behavioral health benefits but do not include Medical Reimbursement Tax Saver Account benefits or the Dependent Care Assistance Tax Saver Account.

SRP Health Care Program Is Primarily Self-Insured

The SRP Health Care Program is composed of self-insured plans maintained separately by the Association and the District and the fully insured plans maintained jointly by the District and the Association. The sections of this Handbook that describe the self-insured portion of the SRP Health Care Program, and the actual self-insured plan documents, make up the plan document for the self-insured plans. The sections of this Handbook that describe the self-insured portion of the SRP Health Care Program serve as the summary plan description (the “SPD”) for the self-insured plans.

The applicable insurance policies and certificates of coverage make up the plan document for the insured plans. The sections of this Handbook that describe the insured portion of the SRP Health Care Program provide only general information about these plans. The certificates of coverage and other booklets available from each plan’s insurer serve as the summary plan descriptions for each insured plan.

- The self-insured benefits of the SRP Health Care Program include the SRP Medical PPO and EPO Option (including prescription drugs, behavioral health and hearing aid services), SRP Dental Program and the SRP Vision Plan. The claims for these benefits are paid by independent Claims Administrators.

- The fully insured benefits of the SRP Health Care Program include a prepaid Dental Plan option and the Employee Assistance Program (EAP).
Medical Reimbursement Tax Saver Account

If you are an eligible employee, you may elect to set aside before-tax dollars to pay unreimbursed health care expenses through a Medical Reimbursement Tax Saver Account. This benefit is provided through the Salt River Project Medical Reimbursement Tax Saver Plan and is described more fully in SRP Medical Reimbursement Tax Saver Plan in this section of the Handbook.

Dependent Care Tax Saver Account

If you are an eligible employee, you may elect to set aside before-tax dollars to pay dependent care expenses through a Dependent Care Tax Saver Account. This benefit is provided through the Salt River Project Dependent Care Assistance Plan and is described more fully in SRP Dependent Care Tax Saver Plan in this section of the Handbook.

Important Information About the SRP Health Care Program

This Handbook is effective January 1, 2010.

If you have declined coverage described in this Handbook, information pertaining to the coverage that has been declined does not apply to you. This section of the Handbook replaces any other plan summaries/SPDs previously distributed to you. If you have declined any coverage in this section of the Handbook, the benefits describing that declined coverage do not apply to you.

This section of the Handbook will help you understand and use the health care benefits provided by SRP. You should review it and show it to those members of your family who are or will be covered by the SRP Health Care Program. It will give all of you an understanding of the coverage provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan Administrator of the SRP Health Care Program. Be sure to read Exclusions and Limitations: SRP Medical PPO or EPO Option and Definitions in this section of the Handbook. Remember, not every expense you incur for health care is covered by the SRP Health Care Program.

Si usted no entiende la información en este documento, por favor de ponerse en contacto con personal del departamento de Beneficios en (602) 236-3600 o 1-800-491-8846.

Questions You May Have:

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact SRP Benefits Services at the phone number and address located on the Quick Reference Chart in this Handbook. As a courtesy to you, the Benefits staff may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. Your most reliable method is to put your questions into writing and fax or mail those questions to SRP Benefits Services and obtain a written response from them. In the event of any discrepancy between any information that you receive from SRP Benefits Services, orally or in writing, and the terms of this Handbook, the terms of this Handbook will govern your entitlement to benefits, if any.
Amendments to the SRP Health Care Program

As the SRP Health Care Program is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. Be sure to keep this SPD, along with notices of any changes, in a safe and convenient place where you and your family can find and refer to them.

**IMPORTANT NOTICE**

You or your dependents must promptly furnish to the Plan Administrator (contact Benefits Services) information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in status of a dependent child, Medicare enrollment or disenrollment, or the existence of other coverage.

Notify SRP Benefits Services promptly within 31 days, but no later than 60 days, after any of the above-noted events.

Failure to do so may cause you or your dependents to lose certain rights under the Plan or may result in your liability to the Plan if any benefits are paid to an ineligible person.

Eligibility for Coverage

**Employee Eligibility**

The following chart shows the health care program benefits that are offered to employees at SRP or an SRP-affiliated employer. To use the chart, locate your employee status in the first column and read across to the right to see the benefits offered to you. Refer to the Retirement Benefits section of this Handbook for information on health plan eligibility for retirees.

Temporary agency, contract and consulting persons are not considered to be SRP employees.
## SRP HEALTH CARE PROGRAM BENEFITS

✓ Indicates employee or retiree is eligible to enroll for the plan benefit

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<th>DENTAL PLAN OPTIONS</th>
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<th>EDS Prepaid Dental</th>
<th>SRP Hearing Aid</th>
<th>SRP Vision</th>
<th>SRP Behavioral Health</th>
<th>EAP</th>
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<td>District, Association, New West Energy Corp., Papago Park Center, PERA and provisional employees</td>
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<tr>
<td>Regular full-time and ½-time employees</td>
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<tr>
<td>Regular ½-time employees</td>
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<td>Full-time and ¾-time employees</td>
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<td>½-time employees</td>
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### When Coverage is Effective

When an eligible employee submits a completed enrollment form (which may be obtained from Benefits Services) within 31 days of his/her date of hire into a benefits-eligible position or within 31 days of the date he/she begins working in a benefits-eligible position (for initial enrollment), and pays any required contribution for coverage, then benefits coverage becomes effective as follows:

- For newly hired regular full-time, three-quarter-time and half-time District, Association, New West Energy Corp., Papago Park Center, PERA and provisional employees, coverage will become effective on the day your employment begins.
- For employees in a benefits-ineligible position who transition to a benefits-eligible position (a regular full-time, three-quarter-time or half-time position or a provisional full-time or half-time position), coverage will become effective on the date you are working in a benefits-eligible position.

For prepaid EDS Dental Plan coverage, you and any covered dependents must reside within the designated service area at the time of enrollment.

### Declining SRP Health Care Program Coverage

- If you are a regular full-time or three-quarter-time employee, you may only decline Dental Plan option coverage; to do so, you must submit to Benefits Services the completed portion of your enrollment form that pertains to declining coverage. Note that there is compensation paid to you if you waive/decline this coverage.
• If you are a **regular half-time employee**, you may decline medical (including behavioral health and hearing aid coverage), Vision Plan and Dental Plan option coverage; to do so you must submit to Benefits Services the completed portion of your enrollment form that pertains to declining coverage. Note that **no** additional compensation is paid to you if you waive/decline any coverage.

• If you are a **provisional half-time employee**, you may decline medical (including behavioral health and hearing aid coverage); to do so you must submit to Benefits Services the completed portion of your enrollment form that pertains to declining coverage. Note that **no** additional compensation is paid to you if you waive/decline any coverage. **Full-time provisional employees** may not decline Medical or Vision Plan coverage.

• If you are a **PERA full-time or three-quarter-time employee**, you may only decline medical (including behavioral health coverage and hearing aid coverage), Vision Plan and Dental Plan option coverage if you are covered by your spouse’s SRP Medical and Dental Plan option; to do so you must submit to Benefits Services the completed portion of your enrollment form that pertains to declining coverage. Note that **no** additional compensation is paid to you if you waive/decline any coverage.

• If you are a **PERA half-time employee**, you may decline District-sponsored medical (including behavioral health coverage and hearing aid coverage), Vision Plan and Dental Plan option coverage; to do so you must submit to Benefits Services the completed portion of your enrollment form that pertains to declining coverage. Note that **no** additional compensation is paid to you if you waive/decline any coverage.

Remember that a dependent may not be enrolled for coverage unless the employee is also enrolled.

If, at a later date, you want the coverage you declined for yourself, you may enroll only under the Special Enrollment provisions (when applicable) or during an Open Enrollment Period as described in this section of the Handbook. Enrollment forms may be obtained from and returned to Benefits Services.

**Dependent Eligibility**

If you elect health care coverage for yourself, you may also elect the same health care coverage for your eligible dependent(s), but only if:

• You submit a completed and signed written enrollment form (which can be obtained from Benefits Services) within 31 days of your employee eligibility date;

• The health care coverage you select for your dependent(s) is in effect for you, the employee, on that day; and

• You pay any required contribution for health care coverage of the dependent(s).

Your dependent(s) may not be enrolled for coverage unless you are also enrolled. Anyone who does not qualify as a dependent, as defined below, has no right to any coverage for benefits or services under the SRP Health Care Program. Specific documentation to substantiate dependent status may be required.

**COORDINATION OF BENEFITS WITH MEDICARE**

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

Need more help? See the **Quick Reference Chart** in the front of this section.
Dependent Defined

Eligible dependents include any of the following:

- Legal spouse of the opposite sex.

- For the period January 1, 2010, through August 31, 2010, a dependent child is defined as follows: An unmarried dependent child of yours, who is defined as any of the following children:

  1. A natural child, a stepchild or a legally adopted child of the employee or retiree or a child placed for adoption with the employee or retiree who:
     (i) Lives with you (has the same principal place of abode) for more than half the year;
     (ii) Does not provide more than half of his or her own support for the year and is not the qualifying child of any other person (qualifying child is defined in IRC Section 152[c]);
     (iii) If the employee or retiree is the legal guardian of a child who is not a “relative,” as listed in IRC Section 152(d)(2)(A) through (G), the child must, for the entire year, have the same principal place of abode as the employee or retiree and be a member of the employee’s or retiree’s household (proof of the same principal place of abode may be requested by the Plan); and
     (iv) Has not had his or her 19th birthday. A child may continue eligibility beyond the 19th birthday until the child reaches his or her 26th birthday, provided the child is a full-time student enrolled in an accredited college, university, trade school or technical school for 12 credit hours or more, or the equivalent (the number of credit hours constituting “full time” as defined by the school the dependent is attending). See SRP Student Status Verification Process in this section of the Handbook. Note that after August 31, 2010, the Plan will not impose a student status requirement for dependent children.

  2. A legally adopted child or a child who has been placed with you for legal adoption, regardless of whether the adoption has become final, is treated as a child and will qualify as a dependent if the individual satisfies the provisions of paragraph (1). The phrase “placed with you for legal adoption” means the assumption and retention by you of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child’s placement with you ends upon the termination of such legal obligation. Proof of adoption may be requested.

  3. A dependent child, regardless of age, who is physically or mentally unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. Proof of the disability must be submitted to the Plan Administrator or its designee, Benefits Services, within 31 days of the date the dependent reaches the age at which coverage normally ends. If coverage is extended, proof of disability will be required from time to time.

  4. A child who is eligible for coverage under this Plan by virtue of a Qualified Medical Child Support Order (QMCSO).

See the definitions of eligible dependent and Qualified Medical Child Support Order (QMCSO).
Effective January 1, 2010, if the Plan receives a written certification from a covered child’s treating physician that:

(1) The child is suffering from a serious illness or injury; and
(2) A leave of absence (or other change in enrollment) from a postsecondary institution is medically necessary and the loss of postsecondary student status would result in a loss of health coverage under the Plan, the Plan will extend the child’s coverage for up to one year. This maximum one-year extension of coverage begins on the first day of the medically necessary leave of absence (or other change in enrollment) and ends on the date that is the earlier of (1) one year later, or (2) the date on which coverage would otherwise terminate under the terms of the Plan.

Effective September 1, 2010, a dependent child is any of the employee’s or retiree’s children under the age of 26 (whether married or unmarried), who is a:

- Son or daughter;
- Stepparent or stepdaughter;
- Legally adopted child or child placed for adoption with the employee or retiree (proof of adoption or placement for adoption may be requested).

In addition to dependent children (as noted above), the following individuals are also considered to be dependent children under this Plan:

- A dependent child age 26 or older (who is unmarried) who is physically or mentally unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months and who is eligible for tax-free health coverage as a “qualifying child” or “qualifying relative” under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively. Proof of the disability must be submitted to the Plan Administrator or its designee, Benefits Services, within 31 days of the date the dependent reaches the age at which coverage normally ends. If coverage is extended, proof of disability will be required from time to time; or
- An individual under age 26, who is married or unmarried, with respect to whom the employee or retiree has legal guardianship under a court order (proof of guardianship may be requested).

Children not eligible for coverage: A foster child, a spouse of a dependent child (e.g., son-in-law, daughter-in-law) and a child of a dependent child (e.g., grandchild) are not eligible for coverage under the Plan.

With the exception of a dependent child who is permanently and totally disabled, coverage for a covered individual shall terminate at the pay period in which the individual attains age 26.

See also the section on Qualified Medical Child Support Orders (QMCSO) later in this chapter.

PROOF OF DEPENDENT STATUS

Specific documentation to substantiate dependent status will be required by the Plan and may include proof that the dependent is a tax-qualified dependent, such as proof of the same principal place of residence, personal income tax return showing the name and Social Security number of the dependent(s) you wish to add to the Plan, and any of the following:

- **Marriage:** Copy of the certified marriage certificate.
- **Birth:** Copy of the certified birth certificate.
- **Adoption or placement for adoption:** Court order paper signed by the judge.
- **Full-time student status (when applicable):** Birth certificate (if not already on file) and written verification from the school of the child’s full-time status (as defined by the school the student is attending) as noted in the Student Status Verification Process below. Effective August 31, 2010, the Plan will no longer impose a requirement for children to maintain a student status in order to be eligible for coverage.

- **Legal guardianship:** A copy of your court-appointed legal guardianship documents and a copy of the certified birth certificate.

- **Disabled dependent child:** Current written statement from the child’s physician indicating the child’s diagnoses that are the basis for the physician’s assessment that the child is currently mentally or physically disabled (as the term “disabled” is defined in this Handbook) and is incapable of self-sustaining employment as a result of that disability; and dependent chiefly on you and/or your spouse for support and maintenance. The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan’s definition of dependent child.

- **Qualified Medical Child Support Order (QMCSO):** Valid QMCSO document or National Medical Support Notice.

### Student Status Verification Process

- Full-time student status verification must be submitted to SRP at the locations listed under SRP Student Status Verification on the Quick Reference Chart in the front of this section of the Handbook. (Note that effective August 31, 2010, the Plan will no longer impose a requirement for children to maintain a student status in order to be eligible for coverage.)

- To avoid loss of coverage for your dependent, **student status verification must be submitted twice a year for traditional semesters. Students attending a school that follows nontraditional sessions (quarters or trimesters) will need to submit verification for each quarter/trimester.**

  - Verification for the semester covering September through December should be received by August 31 of that year to avoid any interruption of coverage.
  - Verification for the semester covering January through August should be received by December 31 of the prior year in order to avoid any interruption of coverage.
  - Verification for nontraditional semesters will need to be sent in prior to the first day of classes.

The verification can be provided in one of two forms:

- A signed letter from the registrar or dean of students verifying full-time student status; or
- A copy of the current semester’s official class schedule verifying the name of the student, name of the school, semester attending and full-time status and/or total credit hours (a copy of a receipt showing a dollar amount paid for classes will not suffice).

If your child will be age 19 mid-semester, submit student verification at least two weeks prior to his or her 19th birthday.

If your child’s coverage terminates under your Plan due to a loss of full-time student status, you can add them back on to your coverage if they return to school in the future, as long as they are not married and are enrolled full time. Their coverage will begin the first day of classes.

You should contact Benefits Services within 31 days from the date when your dependent is no longer a full-time student or when your dependent is married or reaches age 26. Coverage ends on the earlier of the 15th or last day of the month after the end of the pay period in which your dependent either is no longer a full-time student or is married or reaches age 26.

Employees have the sole responsibility to ensure that student status verification is received by...
Benefits Services each semester in a timely fashion.

Questions about student status verification can be directed to Benefits Services at the telephone number listed on the Quick Reference Chart in the front of this section of the Handbook.

Effective January 1, 2010, if the Plan receives a written certification from a covered child’s treating physician that:

1. The child is suffering from a serious illness or injury; and
2. A leave of absence (or other change in enrollment) from a postsecondary institution is medically necessary and the loss of postsecondary student status would result in a loss of health coverage under the Plan, the Plan will extend the child’s coverage for up to one year. This maximum one-year extension of coverage begins on the first day of the medically necessary leave of absence (or other change in enrollment) and ends on the date that is the earlier of (1) one year later, or (2) the date on which coverage would otherwise terminate under the terms of the Plan.

Eligibility for Coverage Under Qualified Medical Child Support Orders (QMCSOs)

If you are eligible to participate in the SRP Health Care Program, the Program will also provide health care coverage for your child when required by a Qualified Medical Child Support Order (QMCSO), as defined under Section 609(a) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time. The law requires health care plans to establish written procedures to determine whether a court order is a QMCSO and to administer benefits accordingly. Contact the Plan Administrator or its designee, Benefits Services, for more information on these procedures.

A Qualified Medical Child Support Order (QMCSO) is a child support order of a court or state administrative agency that usually results from a divorce or legal separation, that has been received by the SRP Health Care Program and that:

- Provides for child support with respect to a dependent child of a participant or an employee eligible to participate in the SRP Health Care Program;
- Indicates the name and last known mailing address of the participant or eligible employee and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the SRP Health Care Program or the manner in which such type of coverage is to be determined; and
- States the period for which the QMCSO applies.

An order is not a QMCSO if it requires the SRP Health Care Program to provide any type or form of benefit or any option that the program does not otherwise provide, or if it requires an employee who is not eligible to participate in the program to provide coverage for a dependent child, except as required by a state’s Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law. If the Plan Administrator of the SRP Health Care Program receives a National Medical Support Notice issued pursuant to section 401(b) of the Child Support Performance and Incentive Act of 1998 that is appropriately completed and satisfies paragraphs (3) and (4) of section 609(a) of ERISA, the Notice is deemed to be a QMCSO.
Upon receipt of an order issued by a court or state administrative agency with respect to health care coverage for any dependent child of a participant in the SRP Health Care Program, the Plan Administrator or its designee will notify the participant, each child specified in the order, and any other party acting on behalf of the child of the receipt of the order and the program’s procedures for determining whether the order is a QMCSO. The Plan Administrator or its designee will then determine whether the order is a QMCSO as defined by federal law and will notify the parents and each child specified in the order and any other party acting on behalf of the child of its determination. If the Plan Administrator or its designee determines that the order is a QMCSO, the notification will explain the procedures to be followed to enroll the dependent child(ren) in the SRP Health Care Program. The determination will be binding on the participant, the other parent, the child and any other party acting on behalf of the child.

The SRP Health Care Program will accept a Special Enrollment of the dependent child(ren) specified by the QMCSO from either the employee or the custodial parent. If an employee is eligible to participate but is not a participant in the SRP Health Care Program when the QMCSO is received and if the QMCSO orders the employee to provide coverage for the dependent child(ren) of the employee or his/her spouse, the SRP Health Care Program will accept a Special Enrollment of the eligible employee and the dependent child(ren) specified by the QMCSO. Coverage of the employee and the dependent child(ren) will become effective on the earlier of the first day or the 16th day of the month following the date the completed and signed enrollment form is received by Benefits Services. Coverage of the dependent child(ren) under a QMCSO will be subject to all terms and provisions of the SRP Health Care Program, or limits on the selection of a Medical Plan option and requirements for authorization of services, as permitted by applicable law.

No coverage will be provided for any dependent child under a QMCSO unless the applicable employee contributions for that dependent child’s coverage are paid and all of the requirements for coverage of that dependent child have been satisfied. Coverage of a dependent child under a QMCSO will terminate when coverage of the participant parent terminates for any reason, including failure to pay any required contributions, subject to the dependent child’s right to elect COBRA Continuation Coverage if that right applies. For additional information regarding the procedures for administration of QMCSOs, contact SRP Benefits Services at the phone number noted on the Quick Reference Chart.

Limitations on Enrollment

- You and your dependents must enroll in the same SRP-sponsored medical or dental option.
- If you are both a full-time or three-quarter-time employee and a dependent of another SRP employee (e.g., husband and wife), each SRP employee must elect SRP employee-only health care coverage.
- If a dependent child’s parents are both eligible for SRP health care coverage, either parent, but not both, may elect dependent health care coverage for the child.
- Your dependent may not be enrolled for coverage unless you, the employee, are also enrolled.
- The Medical Plan options in the SRP Health Care Program do not have a pre-existing condition limitation.
Enrollment Options

There are three opportunities to enroll for benefits under this Plan: Initial Enrollment for new employees or employees who become benefits-eligible during the year, Special Enrollment and Open Enrollment. These enrollment opportunities are discussed in detail below.

Initial (New Employee) Enrollment

Enrolling for Coverage

You must enroll no later than 31 days after the date on which you are eligible for coverage by submitting a completed and signed written enrollment form that may be obtained from and returned to the Plan Administrator or its designee, Benefits Services. If you want dependent coverage, you must enroll your eligible dependents at the same time.

- If you want to set aside before-tax money in a Medical Reimbursement Tax Saver Account or a Dependent Care Assistance Tax Saver Account, you must also enroll in this benefit each year by signing and returning a completed enrollment form to the Plan Administrator or its designee, Benefits Services, within 31 days of your date of hire. Coverage will be effective the date the enrollment form is submitted.

- **FAILURE TO ENROLL WITHIN 31 DAYS:** If you are a regular full-time or three-quarter-time employee and you do not return your completed and signed enrollment form within 31 days of your date of hire, you will be defaulted to employee-only medical coverage in the lowest-deductible SRP Medical PPO Option and employee-only dental coverage in the SRP Dental Program. You will be defaulted to employee-only coverage for the SRP-sponsored behavioral health and vision benefit. You will not be enrolled in a Medical Reimbursement Tax Saver Account or a Dependent Care Assistance Tax Saver Account for that plan year. If you have eligible dependents, they will not receive SRP-sponsored health care coverage. This default coverage may not be changed until the next Open Enrollment Period, unless a Special Enrollment opportunity exists (see Special Enrollment in this section of the Handbook).

  **Note:** The same “Failure to Enroll” rules apply to employees who are in a benefits-ineligible position who transition to a benefits-eligible position.

- If you are a half-time employee and you do not return your completed and signed enrollment form within 31 days of your date of hire, you will not be able to enroll yourself and/or your eligible dependents until the next Open Enrollment Period, unless a Special Enrollment opportunity exists (see Special Enrollment in this section of the Handbook).

- Enrollment in the SRP-sponsored vision coverage is automatic for regular full-time, three-quarter-time and half-time employees and their eligible dependents who enroll in a Medical Plan option.

Start of Coverage Following Initial Enrollment

- For newly hired regular full-time, three-quarter-time and half-time employees, coverage begins on the date of hire, provided you submit a completed and signed enrollment form to the Plan Administrator or its designee, Benefits Services, within 31 days of your date of hire. Coverage of your enrolled spouse and/or dependent child(ren) begins on the date your coverage begins.

- For employees in a benefits-ineligible position (e.g., work less than 20 hours a week) who transition to a benefits-eligible position (a regular full-time, three-quarter-time or half-time position or a provisional full-time or half-time position), coverage begins the date you are working in a benefits-eligible position, provided you submit a completed and signed enrollment form to the Plan Administrator or its designee, Benefits Services, within 31 days of the day your benefits-eligible position begins. Coverage of your enrolled spouse and/or dependent child(ren) begins on the date your coverage begins.
• For employees who are rehired, see Rehired Employees in this section of the Handbook.

• If you are defaulted into coverage because you failed to complete an Initial Enrollment form in a timely manner, the default coverage will be effective on the date of hire.

Special Enrollment

Newly Acquired Spouse and/or Dependent Child(ren)

• If you are enrolled for coverage and if you acquire a spouse by marriage, or if you acquire any dependent children by birth, adoption or placement for adoption*, you must request enrollment for your newly acquired spouse and/or any dependent child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption. Enrollment forms may be obtained from the Plan Administrator or its designee, Benefits Services.

• If you are not enrolled for coverage and if you acquire a spouse by marriage, or if you acquire any dependent children by birth, adoption or placement for adoption, you must request enrollment for yourself and/or your newly acquired spouse and/or any dependent child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption. If you, the employee, are not already enrolled for coverage, you must enroll yourself in order to enroll a newly acquired dependent.

• If you did not enroll your spouse and/or dependent child(ren) for coverage within 31 days of the date on which the spouse and/or dependent child(ren) became eligible for coverage, and if you subsequently acquire a dependent child by birth, adoption or placement for adoption, you must request enrollment for your spouse and/or your newly acquired dependent child and/or any dependent children no later than 31 days after the date of your newly acquired dependent child’s birth, adoption or placement for adoption. If you, the employee, are not already enrolled for coverage, you must enroll yourself in order to enroll a newly acquired dependent.

• To request enrollment, you must call or visit Benefits Services within 31 days to start the enrollment process.

• If you want to set aside before-tax money in a Medical Reimbursement Tax Saver Account or a Dependent Care Assistance Tax Saver Account, you must enroll in this benefit by signing and returning a completed enrollment form to the Plan Administrator or its designee, Benefits Services, within 31 days of the date of the event that created the Special Enrollment opportunity.

*Placement for adoption refers to the date you first become legally obligated to provide full or partial support of the child you plan to adopt.

Loss of Other Coverage

If you did not request enrollment under this Plan for yourself, your spouse and/or any dependent child(ren) within 31 days after the date on which coverage under the Plan was previously offered because you or they had health care coverage under another group health plan or health insurance policy, including COBRA Continuation Coverage, certain types of individual health insurance, Medicare or other public program; and you, your spouse and/or any dependent child(ren) lose coverage under that other group health plan or health insurance policy, you may request enrollment for yourself and/or your spouse and/or any dependent child(ren) within 31 days after the termination of their coverage under that other group health plan or health insurance policy if that other coverage terminated because of:

• Loss of eligibility for that coverage, including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment, or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause);
• Termination of employer contributions toward that other coverage (an employer’s reduction but not cessation of contributions does not trigger a Special Enrollment right);
• The health insurance was provided under COBRA Continuation Coverage, and the COBRA coverage was “exhausted”;
• Moving out of an EPO service area if EPO coverage terminated for that reason and, for group coverage, no other option is available under the other plan;
• The other plan ceasing to offer coverage to a group of similarly situated individuals;
• The loss of dependent status under the other plan’s terms;
• The termination of a benefit package option under the other plan, unless substitute coverage is offered; or
• The loss of eligibility due to reaching the lifetime benefit maximum on all benefits under the other plan. For Special Enrollment that arises from reaching a lifetime benefit maximum on all benefits, an individual will be allowed to request Special Enrollment in this Plan within 31 days after a claim is denied due to the operation of a lifetime limit on all benefits.

See also Enrollment Procedures in this section of the Handbook for more information.

COBRA Continuation Coverage is “exhausted” if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:
• Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
• When the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
• When the individual no longer resides, lives or works in a service area of an EPO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
• Because the 18-month, 29-month or 36-month period of COBRA Continuation Coverage has expired.

You and your dependents may also enroll in this Plan if you (or your eligible dependents):
• Have coverage through Medicaid or a state Children’s Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment in this Plan within 60 days after the Medicaid or CHIP coverage ends; or
• Become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment in this Plan within 60 days after you (or your dependents) are determined to be eligible for such premium assistance.

Start of Coverage Following Special Enrollment

If a completed and signed written enrollment form has been submitted to the Plan Administrator or its designee, Benefits Services, on a timely basis, your coverage, your spouse’s coverage and/or the coverage of any of your other dependent child(ren) is effective on the earlier of the first day of the month or the 16th day of the month following the date the SRP Health Care Program receives the completed and signed written enrollment form, subject to the following exceptions:
• If the event that creates the Special Enrollment opportunity is the birth of a dependent child, coverage is effective as of the date of the dependent child’s birth. If the mother is already eligible under this Plan, newborns or newly adopted newborn children are covered for the first 31 days after birth; however, coverage ends after the 31st day
unless the newborn is properly enrolled in the SRP Health Care Program by submitting a completed and signed enrollment form to the Plan Administrator or its designee, Benefits Services, and paying any required contribution of coverage.

- If the event that creates the Special Enrollment opportunity is the adoption or placement for adoption of a dependent child, coverage is effective as of the date of the dependent’s adoption or placement for adoption.

- If the individual requests enrollment within 60 days of the date of the Special Enrollment opportunity related to Medicaid or a state Children’s Health Insurance Program (CHIP), generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity.

- Individuals enrolling during Special Enrollment have the same benefit plan options, same costs and same enrollment requirements as other similarly situated individuals who are eligible for benefits.

### Failure to Enroll During Special Enrollment

— Very Important Information —

If you fail to request enrollment for yourself and any of your eligible dependents within 31 days (or as applicable, 60 days) after the date on which you and they first become eligible for Special Enrollment, you will not be able to enroll your eligible dependents until the next Open Enrollment Period.

### Open Enrollment Period

The Open Enrollment Period is the period of time designated by the Plan Administrator or its designee, Benefits Services, in the fall of each year during which eligible employees may make the elections specified below. You must use one of the following enrollment methods:

- Online on the Internet at www.srpnet.com/about/benefits
- Online on SRP’s Intranet at insidesrp/hrnet

Watch for mailings to your home. If you have questions, contact Benefits Services at (602) 235-3600.

### Elections Available During Open Enrollment Period

During the Open Enrollment Period, you may elect for yourself and your eligible dependents to:

- **Enroll** in one of the medical and/or dental options offered by the SRP Health Care Program;
- **Add or drop** eligible dependents to the medical and/or dental options you select for yourself;
- **Change** medical and/or dental options;
- **Set aside before-tax money** in a Medical Reimbursement Tax Saver Account or Dependent Care Assistance Tax Saver Account; or
- **Enroll in or drop** Short-Term Disability (STD) coverage or change your waiting period for STD coverage.
Restrictions on Elections During Open Enrollment Period

• No dependent may be covered unless you are covered.
• You and all your covered eligible dependents must be enrolled for the same medical and dental option.
• If a dependent child’s parents are both eligible for SRP health care coverage, either parent, but not both, may elect dependent health care coverage for the child.

Effective Date for Coverage Following Open Enrollment Period

All changes in or discontinuance of coverage will become effective on the first day of the calendar year following the Open Enrollment Period.

Failure to Make a New Election During Open Enrollment Period

If you have been enrolled for coverage and you fail to make a new election during the Open Enrollment Period, you will be considered to have made an election to retain the same medical, vision and dental coverage you had during the preceding plan year. However, if you want to set aside before-tax money in your Medical Reimbursement Tax Saver Account or Dependent Care Assistance Tax Saver Account, you must also enroll in this benefit through HR Online during each Open Enrollment Period. Otherwise, you will not be able to participate in the Tax Saver Account for the upcoming year.

Failure to Enroll During Open Enrollment Period

— Very Important Information —

If you fail to enroll yourself and/or any of your eligible dependents during Open Enrollment, you will not be able to enroll yourself and/or them until the next Open Enrollment Period, unless your eligible dependents qualify for Special Enrollment as described in Special Enrollment in this section of the Handbook.

Late Enrollment

The only late enrollment process in the SRP Health Care Program is the annual Open Enrollment Period described in Open Enrollment Period in this section of the Handbook. If you and/or any of your eligible dependents are not entitled to Special Enrollment as described in Special Enrollment in this section of the Handbook, you may enroll only yourself and/or any of your eligible dependents once a year during the annual Open Enrollment Period.

Changing Elections Mid-Year

Government regulations generally require that your Plan coverage (medical, dental, vision, Medical Reimbursement Tax Saver Account and Dependent Care Assistance Tax Saver Account) remain in effect throughout the plan year (January 1 through December 31 under this Plan), with changes only allowed during the annual Open Enrollment Period. However, under the circumstances discussed in this section of the Handbook and when permitted by law, you may be able to make some changes during the year (mid-year). The allowed changes may permit you to add or remove family members from your Plan. Generally, you will not be able to change to a different plan option mid-year.
Changes in Status

You may be able to make some changes mid-year if the Plan Administrator or its designee, SRP Benefits Services, determines that (1) you, your spouse or your dependent child(ren) has a change in status and (2) the change you want to make is consistent with a change in status that affects eligibility for coverage. The following events are considered a change in status under the SRP Health Care Program:

1. **Change in legal marital status**, including marriage, divorce, annulment or death of a spouse.
2. **Change in number of dependents**, including birth, adoption, placement for adoption or death of a dependent child.
3. **Change in employment status or work schedule**, including the start or termination of employment by you, your spouse or any dependent child, a strike or lockout, change in worksite or the start of or return from an unpaid leave of absence. In addition, any change in the employment status of you, your spouse or your dependent that results in that individual losing or gaining eligibility under the SRP Health Care Program or the plan of a family member may constitute a change in status affecting your benefit needs.
4. **Change in dependent status under the terms of the SRP Health Care Program**, including becoming or ceasing to be an eligible dependent on account of attainment of age, student status or a similar circumstance.
5. **Change of place of residence** of you, your spouse or any dependent child that impairs eligibility for benefits.

Other Changes

You may also make changes in your coverage for the following reasons:

6. **Changes to conform to court orders**: With respect to a court order resulting from a divorce, legal separation, annulment or change in legal custody that requires health care coverage for your child or dependent foster child, including a Qualified Medical Child Support Order (QMCSO):
   - You may change your coverage under the SRP Health Care Program to the extent necessary to cancel coverage for the dependent child if the order requires your spouse, former spouse or other individual to provide coverage for the dependent child and that coverage is in fact provided.
   - The Plan Administrator will allow you to change your coverage to the extent necessary to provide court-ordered coverage for an eligible child of yours under the SRP Health Care Program.

7. **Changes corresponding with Special Enrollment rights**: You may change your coverage under the SRP Health Care Program as described in Special Enrollment: Loss of Coverage in this section of the Handbook.

8. **Changes corresponding with entitlement to Medicare or Medicaid**: If you, your spouse or any dependent child becomes entitled to coverage under Medicaid or Medicare (except for coverage solely under the program for distribution of pediatric vaccines) or loses eligibility for coverage after becoming entitled to Medicare or Medicaid coverage, you may make a corresponding change to the individual’s coverage under the SRP Health Care Program.

Need more help? See the [Quick Reference Chart](#) in the front of this section.
Changes Limited to Medical, Dental, Vision and Dependent Care Tax Savers Coverage

You may also make changes for the following reasons:

9. **Change because of loss of coverage under certain group health plans:** You may add yourself, your spouse or your dependent child to the SRP Health Care Program if you, your spouse or your dependent child loses coverage under a group health plan sponsored by a governmental or educational institution, including:
   - A state Children’s Health Insurance Program (CHIP) or Medicaid under Title XXI of the Social Security Act;
   - A medical care program of an Indian Tribal government, as defined in section 7701(a)(40) of the Indian Health Service, or a tribal organization;
   - A state health benefits risk pool; or
   - A foreign government group health plan.

10. **Changes in spouse’s, former spouse’s or dependent child’s coverage:** You may make a change in coverage if it is on account of and corresponds with a change made under a plan of your spouse, former spouse or dependent child for one of the following reasons:
    - If the change is permitted under federal cafeteria plan regulations; or
    - If the plan of the spouse, former spouse or dependent child’s employer permits participants to make an election for a period of coverage that is different from the plan year under the SRP Health Care Program.

11. **Changes in cost of coverage:** You may make a change in coverage if your elective contributions to the cost of a benefit option significantly increase or decrease during a plan year (and in the case of the Dependent Care Assistance Tax Saver Plan, the cost change is imposed by a dependent care provider who is not related to you):
    - In the event of a significant cost increase, you may prospectively change your election to either (i) make a corresponding increase in your elective deferrals, (ii) revoke your election and, in lieu thereof, to receive on a prospective basis coverage under another benefit option providing similar coverage, or (iii) drop coverage if no other benefit option providing similar coverage is available; or
    - In the event of a significant cost decrease, you may prospectively change your election to either (i) make a corresponding decrease in your elective deferrals, or (ii) change your election to the benefit option with a decrease in cost. In addition, an eligible employee who was not previously a Participant may elect to participate in the Plan and receive coverage under the benefit option with the significant decrease in cost.

12. **Curtailment of coverage:** If your coverage (or the coverage for your spouse or dependents) under a benefit option is significantly curtailed or ceases during a plan year, you may change your election so as to prospectively receive coverage under another benefit option that provides similar coverage (coverage under a benefit option is significantly curtailed only if there is an overall reduction in coverage to plan participants so as to constitute reduced coverage to participants generally). In addition, if you (or your spouse or dependents) have a significant curtailment that results in a complete loss of coverage under the benefit option (including the elimination of a benefit option), you may drop coverage if no similar benefit option is available.

13. **Addition of new coverage option:** If during a plan year a new benefit option is added or an existing benefit option is significantly improved, you may revoke your existing benefit election and, in lieu thereof, elect on a prospective basis coverage under the new or improved benefit option. In addition, an eligible employee who was not previously a
Participant may elect to participate in the Plan and receive coverage under the benefit option that was added or significantly improved.

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

- Any change you make to your coverage must be determined by the Plan Administrator or its designee, Benefits Services, to be in compliance with governing federal regulations and the plan; and
- You must notify the Plan Administrator or its designee, Benefits Services, in writing within 31 days of the occurrence of one of the events described in this section. Otherwise, you will have to wait until the next Open Enrollment Period to make your changes in coverage.

**Start of Coverage Following Election Change**

If a completed and signed written Enrollment and Change form has been submitted to the Plan Administrator or its designee, Benefits Services, on a timely basis, your change in coverage is effective prospectively (except for newborns and adopted children as noted below) on the earlier of the first day of the month or the 16th day of the month following the date the SRP Health Care Program receives the completed and signed written Enrollment and Change form subject to the following exceptions:

- If the event that allows a change in election is the birth of a dependent child, coverage is effective as of the date of the dependent child’s birth. If the mother is already eligible, newborns or newly adopted newborn children are covered for the first 31 days after birth; however, coverage ends after the 31st day unless the newborn is properly enrolled in the Plan by submitting a completed and signed form to the Plan Administrator or its designee, Benefits Services, and paying any required contribution for coverage.

- If the event that allows a change in election is the adoption or placement for adoption of a dependent child, coverage is effective as of the date of the dependent’s adoption or placement for adoption.

**Rehired Employees**

If you were in a benefits-eligible position and cease to be an employee and within 31 days return to work in the same calendar year, the benefit election you had before you terminated will be reinstated. Participation will be effective the day you return to work in a benefits-eligible position.

If you were in a benefits-eligible position and cease to be an employee and return to work in a benefits-eligible position more than 31 days following the termination but in the same calendar year, you will have the option of:

- Reinstating the benefit election for the remaining portion of the plan year as you had before you terminated; or
- Making a new benefit election for the remaining portion of the plan year.

Participation will be effective the day you return to work in a benefits-eligible position. The rules set forth in this section apply to medical, dental, vision, Medical Reimbursement Tax Saver Account and Dependent Care Assistance Tax Saver Account elections.

If you were in a benefits-ineligible position and return to work in a benefits-ineligible position within or more than 31 days following the termination, you will not be eligible for benefits.

If you were in a benefits-ineligible position and return to work in a benefits-eligible position within or more than 31 days following the termination, you must make a new election for benefits. See the Initial Enrollment provisions in Eligibility for Coverage in this section of the Handbook.

Need more help? See the **Quick Reference Chart** in the front of this section.
Moving Outside the Service Area

If you are enrolled for coverage in an Exclusive Provider Organization (EPO) that provides benefits for covered services within a specified geographic service area and you move your residence to a place outside that service area, then you may enroll in any alternative coverage provided by SRP, if you:

- Submit a completed and signed enrollment form within 31 days after moving out of the service area; and
- Pay any required contribution for the coverage.

Your coverage will be effective the date you sign the enrollment form.

“Service area” means the counties in which the PPO/EPO network is licensed to market its products and services.

Cost of Coverage

In most instances, your share of the cost of the SRP-sponsored medical, dental, vision, Medical Reimbursement Tax Saver Account and Dependent Care Assistance Tax Saver Account coverage is paid from the first two paychecks of each month through automatic, before-tax payroll deductions under the provisions of Section 125 of the Internal Revenue Code. This arrangement offers you both convenience and tax savings. Tax savings include Social Security taxes, if your earnings for the year are less than the Social Security wage base, as well as federal and state income taxes.

Amounts deducted from your paycheck on a before-tax basis cannot be deducted on your income tax return. However, since current tax rules require that health care expenses exceed 7.5% of adjusted gross income in order to be deductible, most employees save more money through before-tax payroll deductions. Consult your personal tax adviser for tax advice.

If you are eligible for SRP-sponsored health care benefits, you will be required to pay your share of the cost of SRP-sponsored medical, dental, vision Medical Reimbursement Tax Saver Account and Dependent Care Assistance Tax Saver Account coverage on an after-tax basis in the following instances:

- While on any type of unpaid leave of absence for which payroll deductions cannot be taken; or
- After termination of employment for any reason.

Medical coverage (including behavioral health coverage): SRP currently shares the cost of SRP-sponsored medical coverage with regular full-time, three-quarter-time and regular half-time employees and their eligible dependents.

Dental coverage: SRP currently shares the cost of SRP-sponsored dental coverage with regular full-time, three-quarter-time and regular half-time employees and their eligible dependents.

Hearing aid coverage: Hearing aid coverage is part of the Medical Plan coverage for all regular full-time, three-quarter-time and half-time employees and any eligible dependents enrolled in SRP-sponsored medical coverage. PERA employees are not eligible to receive hearing aid benefits.

Vision care: SRP currently shares the cost of the SRP-sponsored vision care coverage with regular full-time, three-quarter-time and half-time employees and their eligible dependents.

Medical Reimbursement Tax Saver Accounts: If you are eligible for a Medical Reimbursement Tax Saver Account benefit and elect to participate, you are responsible for the entire cost of the benefit.
Dependent Care Assistance Tax Saver Accounts: If you are eligible for a Dependent Care Assistance Tax Saver Account benefit and elect to participate, you are responsible for the entire cost of the benefit.

Coverage During Disability Leave
If you are disabled and eligible for benefit payments under SRP’s Long-Term Disability group insurance policy (generally after 90 calendar days), you and your eligible dependents may continue to receive the same SRP-sponsored health care coverage as you did when the disability leave began. You will continue to pay the same amount for the coverage as you were paying when the disability leave began. This coverage is available through the earlier of the 15th day or the last day of the month in which your disability leave ends (a maximum of 12 months from the date the disability leave began).

Cost of Coverage
While disabled, your share of the cost of coverage will be taken out of your accrued sick leave and vacation leave pay on a before-tax basis every two weeks until the earlier of:

- The date you used up all of your accrued sick and vacation leave; or
- The date six months from the date your disability leave began.

After that, you will be responsible for paying your share of the cost of the coverage monthly on an after-tax basis until the coverage ends at the earlier of the 15th or the end of the month in which your disability leave ends (a maximum of 12 months from the date the disability leave began).

If you are still disabled 12 months from the date your disability leave began, your SRP employment will end. In addition, your SRP-sponsored health care coverage and that of your covered eligible dependents will end.

Electing COBRA for Continued Coverage
If you do not qualify for Social Security Disability Income or you are not approved for Long-Term Disability benefits under SRP’s group insurance policy by the time your SRP employment ends, you and each of your eligible covered dependents may elect under COBRA to continue, temporarily and at your own expense, the SRP-sponsored health care coverage you were participating in when your SRP employment ended. For more information, see COBRA Continuation Coverage in this section of the Handbook.
Long-Term Disability Benefits and SSDI

If you have qualified for Social Security Disability Income (SSDI) and have been approved for Long-Term Disability benefits under SRP’s group insurance policy by the time your SRP employment ends, you and your eligible covered dependents may elect to:

- Continue under COBRA, temporarily and at your own expense, the SRP-sponsored health care coverage you were participating in when your SRP employment ended; or
- Receive the SRP-sponsored health care coverage for disabled former employees described in the next paragraph. For more information, see COBRA Continuation Coverage in this section of the Handbook.

Disabled Former Employees

Currently, under the SRP-sponsored health care coverage for disabled former employees, as a disabled former employee, you and your eligible dependents may elect to receive the same health care coverage you had when your SRP employment ended, but you are responsible for the entire cost of the coverage minus a subsidy based on the following service lengths:

- Under 10 years — no subsidy
- At least 10 years and less than 20 years — $25 per month until age 65
- At least 20 years — $50 per month until age 65

Currently, if timely elections and payments are made, as a disabled former employee, your SRP-sponsored health care coverage continues until the earlier of the date you no longer qualify for Social Security Disability Income or the date you no longer qualify for Long-Term Disability benefits under SRP’s group insurance policy. If you elect SRP-sponsored health care coverage for disabled former employees and later decide to terminate your coverage, you may not re-enroll.

If an employee is retirement eligible at any time during or at the end of the 12-month maximum period of disability leave, the employee may elect retiree medical coverage, which will be effective on the earlier of the first or the 16th day of the month in which you sign a retirement election form. See also COBRA Continuation Coverage in this section of the Handbook.

To receive the SRP-sponsored health care coverage for disabled former employees, both you and your dependents, who are enrolled in SRP-sponsored health care coverage when your SRP employment ends, must timely elect the SRP-sponsored health care coverage for disabled former employees and also timely waive COBRA Continuation Coverage for health care benefits.

As a disabled employee or disabled former employee participating in SRP-sponsored health care coverage, you may elect to enroll in a different SRP-sponsored health care option during any annual Open Enrollment Period. If you and your eligible dependents are enrolled in the SRP Medical PPO or EPO Plan Option when you go on disability leave, you will not be permitted to enroll in a different Medical Plan option (i.e., different deductible and stop-loss options) until the first Open Enrollment Period, if any, occurring after the date you went on disability leave. If you are enrolled in an SRP-sponsored medical or dental option that pays “cash back,” when you go on disability leave you no longer will receive it.

SRP-sponsored coverage may be canceled if payments are not received within a 31-day grace period after the due date or if elections are not made on a timely basis.

If, as a disabled former employee, you die and at the time of your death you have dependents who are enrolled in the SRP-sponsored health care coverage for disabled former employees, the surviving dependents’ coverage will end on the last day of the month in which you died.

Need more help? See the Quick Reference Chart in the front of this section.
However, under COBRA Continuation Coverage, the surviving dependents may elect to continue, temporarily and at full cost without the subsidy, the same SRP-sponsored health care coverage they were enrolled in when you died. For more information, see COBRA Continuation Coverage in this section of the Handbook.

Coverage During Leave Under the Family and Medical Leave Act of 1993 (FMLA)

If you have worked for SRP for 12 months and at least 1,250 hours during the past 12 months, you are entitled by law to up to 12 weeks (or in some cases 26 weeks as applicable) each year of unpaid family or medical leave for specified family or medical purposes, such as the birth or adoption of a child, or to provide care for a spouse, child or parent who is seriously ill, or for your own serious illness that makes you unable to perform your job duties. SRP uses a rolling 12-month period measured backward from the date an employee uses any FMLA leave as of the first day of the leave of absence.

- While you are on such a family or medical leave, you can keep benefit coverage for yourself and your dependents in effect by continuing to pay your required contributions, if any, during that period.
- If you will not be paid while you are on family or medical leave, you may pay your contributions as they come due on the dates they would have been paid if you were at work. Unused sick and vacation time will be used to pay your contributions; thereafter you will be billed once a month.
- If you do not keep your coverage while you are on family or medical leave and you return to work promptly at the end of that leave, your benefit coverage will be reinstated without any additional limits or restrictions imposed on account of your leave. This is also true for any of your dependents that were covered by the SRP Health Care Program at the time you took your leave. If you were making contributions to a Medical Reimbursement Tax Saver Account or Dependent Care Assistance Tax Saver Account before your leave began, you are not required to reinstate that coverage when you return to work.
- Of course, any changes in the SRP Health Care Program’s terms, rules or practices that went into effect while you were away on that leave will apply to you and your dependents in the same way they apply to all other employees and their dependents. To find out more about your entitlement to family or medical leave as required by federal and/or state law, and the terms on that you may be entitled to it, contact your Human Resources Representative. Additional information about FMLA is available under the Employee Guidelines section of this Handbook.

Coverage During Leave Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)/Leave for Military Service

If you go into active military service for up to 31 days, you can continue your benefit coverage during that leave period as long as you continue to timely pay your contributions for that coverage during the period of the leave. If you go into active military service for more than 31 days, you may be able to continue your benefit coverage under USERRA for you and your spouse and dependents at your own expense for up to 24 months (provided that your USERRA continuation election is made on or after December 10, 2004). When your coverage under this Plan terminates because of your reduction in hours due to your military service, you and your eligible dependents may also have COBRA rights. See also the COBRA Continuation Coverage in this section of the Handbook. There are important differences between USERRA and COBRA coverage, however,
so questions regarding your entitlement to this leave and to the continuation of benefit coverage should be referred to your Human Resources Representative. At its discretion, SRP may provide enhanced USERRA benefits.

Benefits for Survivors of Active Employees

In the event of your death, your dependents may be eligible for the following benefits:

- **Unused sick and vacation pay:** Unused sick leave and earned vacation are paid to your surviving spouse, or to your estate if you are single at the time of death.

- **Group medical/dental/vision coverage**
  
  » If you were **not eligible for retirement at the time of death**, your eligible dependents may continue to be covered by the group health care program (medical including prescription drug, behavioral health, and hearing aid, along with dental and vision) for up to 36 months when COBRA coverage is elected. See COBRA Continuation Coverage in the SRP Health Care Program section of this Handbook for more information.

  » If you were **eligible for retirement**, group medical eligibility will continue for your surviving spouse’s lifetime or until remarriage and for your children as long as they qualify as eligible dependents. Survivors are required to pay the full group premium when due in order to continue this coverage.

  » **401(k) Plan:** See the 401(k) section of this Handbook for more details on survivor benefits.

  » **Retirement Plan:** See the SRP Retirement Benefits section of this Handbook for more information. See also SRP Retirement Benefits section of this Handbook for more information on Benefits for Survivors of Retired Employees.

When Coverage Ends

Employee Health Care Coverage

**Coverage will end on the earlier of** the 15th or last day of the month after the end of the pay period in which the first of the following occurs:

- Your SRP employment ends and you are not eligible for a severance benefit under the SRP Salaried Severance Plan or the SRP Hourly Severance Plan;
- You move to a benefits-ineligible position (e.g., working less than 20 hours a week);
- You cease to make any required contributions for your coverage (if any);
- You die;
- If you are a half-time employee, you elect not to (or fail to timely elect to) participate in the SRP Health Care Program; or
- The SRP Health Care Program terminates.
Spouse Health Care Coverage
Coverage will end on the earlier of the 15th or last day of the month after the end of the pay period in which the first of the following occurs:

- Employee coverage ends;
- The spouse no longer satisfies the eligibility requirements set forth under the definition of spouse in Definitions in this section of the Handbook;
- Contributions required for your spouse’s coverage cease; or
- The spouse dies.

Dependent Health Care Coverage
Coverage for your dependent child under a Qualified Medical Child Support Order (QMCSO) and for other covered dependent children will end on the earlier of the 15th or last day of the month after the end of the pay period in which the first of the following occurs:

- Employee coverage ends;
- Except for dependents under a QMCSO, the child no longer satisfies the eligibility requirements set forth under the definition of dependent in Definitions in this section of the Handbook;
- For dependents under a QMCSO, the expiration of the period of coverage stated in the QMCSO;
- Contributions required for your child’s coverage cease; or
- The dependent child dies.

Note: Termination of retiree coverage is discussed in the Retirement Benefits section of this Handbook.

Disabled Former Employees
See the discussion pertaining to disabled former employees in Coverage During Disability Leaves in this section of the Handbook for information on when health care coverage for you and your eligible dependents will end.

Salaried or Hourly Severance Plan
If you leave SRP and are covered under the SRP Salaried Severance or the SRP Hourly Severance Plan, see Continuation of Coverage Due to Severance in this section of the Handbook for information on when health care coverage for you and your eligible dependents will end.

Dependent Survivor of Retiree
Refer to the Retirement Benefits section of this Handbook for information on when health care coverage for your dependent survivor(s) will end.
HIPAA Certification of Creditable Coverage When Coverage Ends

When your coverage ends, you and/or your covered dependents are entitled by law to and will automatically be provided (free of charge) with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. Such a certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your covered dependent(s) has ended. You can present this certificate to your new employer/health plan to offset a pre-existing condition limitation that may apply under that new plan or use this certificate when obtaining an individual health insurance policy to offset a similar limitation.

Procedure for Requesting and Receiving a Certificate of Credible Coverage

A certificate will be provided upon request for such a certificate that is received by the Plan Administrator within two years after the date coverage ended under this Plan. The request must be mailed, faxed or e-mailed to the Plan Administrator and should include the names of the individuals for whom a certificate is requested (including spouse and dependent children) and the address where the certificate should be mailed. The address, fax number and e-mail of the Plan Administrator are on the Quick Reference Chart in the front of this section of the Handbook. A copy of the certificate will be mailed by the Plan to the address indicated. See Continuation Coverage in this section of the Handbook for an explanation of when and how certificates of coverage will be provided after COBRA coverage ends.

Continuation of Coverage

Temporary Continuation of Coverage After SRP Health Care Coverage Ends

COBRA: Anytime you or any of your eligible dependents lose SRP-sponsored health care coverage, for reasons other than your gross misconduct, you and your eligible dependents may elect COBRA Continuation Coverage to temporarily continue health care coverage at your own expense. For more information, see COBRA Continuation Coverage in this section of the Handbook.

Conversion option: As an alternative to COBRA Continuation Coverage, you and each of your dependents who lose EDS Dental Plan coverage may be able to convert to an individual non-group policy, if available. The individual policy may contain different provisions than are available through the EDS Dental Plan coverage. If COBRA Continuation Coverage is elected, this conversion option also may be exercised at the end of the COBRA Continuation Coverage period. Questions regarding the conversion option should be referred to the Plan Administrator or its designee, Benefits Services.

Continuation of Coverage Due to Severance

If you are terminated from SRP and are eligible for a severance benefit under the SRP Salaried Severance Plan or the SRP Hourly Severance Plan but you are not eligible to participate in the SRP retiree medical program, as described in the Retirement Benefits section of this Handbook, you may continue to receive the same SRP-sponsored health care coverage for yourself and your eligible dependents as you were enrolled in before your SRP employment ended. This coverage is available through the last day of the month in which your severance period ends.

The coverage will be identical, at the time it is being provided, to the SRP-sponsored health care coverage provided to active employees who have made the same coverage elections. You will
pay the same cost for the coverage as active employees who have made the same coverage elections. For more information, see the SRP Salaried Severance Plan and the SRP Hourly Severance Plan sections of this Handbook.

If your severance period is less than 18 months, you and your eligible dependents may elect COBRA Continuation Coverage and continue to receive the same health care coverage as you were receiving at the time of the election for the period of time between the last day of the month in which your severance period ends and the last day of the month in which the date 18 months after your severance date occurs. During this COBRA Continuation Coverage period, you and your eligible dependents are responsible for timely payment of the COBRA premium. For more information, see COBRA Continuation Coverage in this section of the Handbook.

Your portion of the cost of elected health care coverage and that of your eligible dependents must be paid on an after-tax basis. If you and your eligible dependents are entitled to health care coverage after the calendar year in which your severance date occurs, you and your eligible dependents will participate in Open Enrollment under the same terms and conditions as active employees, except that the elected coverage must be paid on an after-tax basis and once the severance period ends, you and your eligible dependents will be responsible for the total cost of the elected coverage plus the administrative fee.

If you are enrolled in a health care option that provides you with “cash-back,” you will not receive it after your severance date. In addition, you and your eligible dependents will not have an opportunity to change the deductible or enroll in a different plan until the first Open Enrollment Period, if any, occurring during the severance period.

As a severed employee, if you also are eligible to participate in the SRP retiree medical program, as described in the Retirement Benefits section of this Handbook, you and your eligible dependents may elect either COBRA Continuation Coverage for medical including behavioral health benefits or coverage for these benefits under the SRP retiree medical program. You and your eligible dependents may elect COBRA Continuation Coverage for the benefits not covered (currently, dental, vision and Medical Reimbursement Tax Saver Account benefits) under the SRP retiree medical program, except for hearing aid benefits. For more information, see COBRA Continuation Coverage in this section of the Handbook.

Continuation of Limited Coverage During Retirement

For information on benefits during retirement, refer to the Retirement Benefits section of this Handbook.

Information for Employees Eligible for the SRP Retiree Medical Program

For information on benefits during retirement, refer to the Retirement Benefits section of this Handbook.
COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments require that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health care coverage (called “Continuation Coverage”) at group rates in certain instances where the employer-sponsored health care coverage would otherwise end.

In general, SRP must offer to employees and their eligible dependents continued participation in the SRP-sponsored group health coverage (medical including behavioral health, Employee Assistance Program, hearing aid, dental, vision and Medical Reimbursement Tax Saver Account coverage) when such coverage would otherwise end because of certain events called “qualifying events.”

This notice is a summary of rights and obligations under COBRA.
Since this is only a summary, actual rights will be governed by the provisions of the law itself.

This summary is intended to inform you and your eligible dependents of your rights and obligations under COBRA with respect to SRP-sponsored health care coverage.

Definitions Pertaining to COBRA

The following terms are defined to help you and your spouse understand this discussion of your COBRA rights:

- A qualified beneficiary is any individual who has SRP-sponsored health care coverage the day before a qualifying event takes place by virtue of being a covered employee, the spouse of the covered employee or the dependent child of the covered employee.

A child of the covered employee or retiree who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee’s or retiree’s period of employment, is entitled to the same rights under COBRA as an eligible dependent child.

A person who becomes the new spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a “qualified beneficiary.” This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new spouse is not entitled to elect COBRA for him/herself.

- A covered employee is any individual who has or had SRP-sponsored health care coverage by virtue of the individual’s current or previous SRP employment. In addition to active employees, the term “covered employees includes retirees and Board and Council members.

- A qualifying event is an event shown in the chart on the following page. A qualified beneficiary is entitled to COBRA Continuation Coverage when a qualifying event occurs and, as a result of the qualifying event, the health care coverage of that qualified beneficiary ends. A qualifying event triggers the opportunity to elect COBRA Continuation Coverage when a qualified beneficiary loses health care coverage under the SRP Health Care Program. If a qualified beneficiary has a qualifying event but does not lose his/her health care coverage under the SRP Health Care Program (e.g., employee continues working even though enrolled in Medicare), the qualified beneficiary is not eligible for COBRA Continuation Coverage.
**Duration of COBRA Continuation Coverage**

As noted in the chart below, the maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which qualifying event occurs, measured from the date the qualifying event occurs. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months (for a total of 29 months) under certain circumstances of disability or up to 18 months if certain second qualifying events take place. These extensions are described below. The period of COBRA Continuation Coverage may also be cut short for the reasons listed in When COBRA Continuation Coverage Ends in this section of the Handbook.

| Qualifying Event Causing SRP-Sponsored Health Care Coverage to End | Duration of COBRA for Qualified Beneficiaries (See text following this chart for more information.) |
|---|---|---|
| Covered Employee terminated (for other than gross misconduct). | 18 months | 18 months | 18 months |
| Covered Employee has reduction in hours worked (making employee ineligible for the same coverage). | 18 months | 18 months | 18 months |
| Covered Employee dies. | N/A | 36 months | 36 months |
| Covered Employee becomes divorced (or legally separated). | N/A | 36 months | 36 months |
| Dependent Child ceases to have Dependent status. | N/A | N/A | 36 months |
| Retiree coverage is terminated or coverage is substantially eliminated within one year before or after SRP files for bankruptcy reorganization under Chapter 11 of the federal Bankruptcy Act. | Retiree: For Life | Entitled to COBRA for the life of the retiree and if spouse survives the retiree, for 36 months after the retiree’s death. | Entitled to COBRA for the life of the retiree and if child survives the retiree, for 36 months after the retiree’s death. |
Extension of COBRA Continuation Coverage Period for Disability

An 18-month COBRA Continuation Coverage period for termination of employment or a reduction in hours may be extended an additional 11 months (29 months total from the date of the qualifying event) if (i) a qualified beneficiary with respect to that event is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of the continuation coverage period, and (ii) the disability continues to the end of the initial 18-month period. If the disability extension applies with respect to a qualifying event, it applies with respect to each qualified beneficiary entitled to continuation coverage because of that qualifying event.

To receive this additional continuation coverage, the qualified beneficiary must notify SRP’s COBRA Administrator in writing of his/her disability within 60 days after the later of (i) the date of the determination of disability by the Social Security Administration, (ii) the date of the qualifying event, or (iii) the date coverage is lost due to the qualifying event. However, this notice must be provided before the end of the 18-month continuation coverage period. This notice must include a copy of the Social Security Administration determination letter, the name of the disabled qualified beneficiary, the date that the qualified beneficiary became disabled and the date that the Social Security Administration made its determination. The qualified beneficiary must also notify SRP’s COBRA Administrator in writing within 31 days after the date of any final determination by the Social Security Administration that the covered employee is no longer disabled under Title II or XVI of the Social Security Act. If a qualified beneficiary is no longer disabled under Title II or XVI of the Social Security Act, the qualified beneficiary, and each other qualified beneficiary entitled to continuation coverage with respect to the qualifying event, is no longer eligible for the additional 11 months of COBRA Continuation Coverage.

Extension of COBRA Continuation Coverage Period for Second Qualifying Event

An 18-month COBRA Continuation Coverage period for termination of employment or a reduction in hours may be extended an additional 18 months (36 months total from the date of the qualifying event) if certain second qualifying events (e.g., divorce, a dependent child ceasing to be a dependent or your death) occur during the first 18-month COBRA Continuation Coverage period. COBRA Continuation Coverage will not extend beyond 36 months from the date of the initial qualifying event. In addition, only those individuals who were qualified beneficiaries in connection with the first qualifying event and who are still qualified beneficiaries at the time of the second qualifying event are eligible for the extension.

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after you become entitled to Medicare, then the maximum coverage period for qualified beneficiaries (other than you, whose maximum coverage period will be 18 months) is 36 months from the date you became entitled to Medicare. For example, if you become entitled to Medicare eight months before the date on which your employment terminates, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of your Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Note: Medicare entitlement is not a qualifying event under this Plan, and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for spouses and dependents who are qualified beneficiaries.
Notice of Qualifying Event

COBRA requires a covered employee or other qualified beneficiary to inform the Plan Administrator, or its designee, of a divorce or a child ceasing to be a dependent child under the SRP-sponsored health care coverage within 60 days after the later of the date of the qualifying event or the date health care coverage would be lost because of the qualifying event. If SRP is not notified in writing of the occurrence of the qualifying event before the end of the 60-day period, then COBRA Continuation Coverage cannot be elected.

Other SRP officials or employees will usually notify the Plan Administrator of the employee’s death, termination of employment, reduction in hours or entitlement to Medicare. However, you or your family should also notify the Plan Administrator promptly if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Notice Procedure

Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail or fax your notice to the Plan Administrator (refer to the Quick Reference Chart in the front of this section of the Handbook for the appropriate address and fax number). If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state: (i) the name of the specific plan or plans under which you lost or are losing coverage, (ii) the name and address of the employee covered under the Plan, (iii) the name(s) and address(es) of the qualified beneficiary(ies), and (iv) the qualifying event and the date it happened. If the qualifying event is a divorce, your notice must include a copy of the divorce decree. You may obtain from the Plan Administrator a form that you are required to use to provide notices hereunder.

Notice of Right to Elect COBRA Continuation Coverage

When SRP is notified that a qualifying event has occurred, SRP will notify the COBRA Administrator, who will in turn notify each qualified beneficiary losing coverage of his/her right to elect COBRA Continuation Coverage. Refer to the Quick Reference Chart in the front of this section of the Handbook for the COBRA Administrator’s phone and address.

Electing COBRA Continuation Coverage

Under COBRA, each qualified beneficiary has independent election rights. This means that you, your spouse and your other eligible dependents, can make your own decisions regarding COBRA Continuation Coverage.

A qualified beneficiary has an election period of 60 days; the election period runs from the later of the date of the loss of SRP-sponsored health care coverage because of a qualifying event or the date of the notice of the qualified beneficiary’s right to elect COBRA Continuation Coverage. If a qualified beneficiary is incapacitated, other specific individuals may elect COBRA Continuation Coverage on his/her behalf. If this is the case, the Plan Administrator or its designee should be called for further information.

If a qualified beneficiary does not choose COBRA Continuation Coverage within 60 days after receiving the COBRA initial notice from the SRP Health Care Program, the qualified beneficiary will have no group health coverage from the SRP Health Care Program after the date the SRP-sponsored health care coverage ends.

Need more help? See the Quick Reference Chart in the front of this section.
Failure to Elect COBRA Continuation Coverage
In considering whether to elect COBRA, you should take into account that failure to continue your group health coverage will affect your future rights under federal law, as noted below:

a. You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and electing COBRA may help you not have such a gap; and

b. You will also lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA Continuation Coverage for the maximum time available to you.

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

Special Enrollment Rights
You have Special Enrollment rights under federal law that allows you to request Special Enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 31 days (or as applicable 60 days) after your group health coverage ends because of the qualifying events listed in this chapter. The Special Enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Description of COBRA Continuation Coverage
If a qualified beneficiary chooses COBRA Continuation Coverage, he/she will be entitled to the same health coverage that he/she had when the qualifying event occurred that caused his/her health coverage under the SRP Health Care Program to end, but the qualified beneficiary must pay for it as described in Paying for COBRA Continuation Coverage. A qualified beneficiary who elects COBRA Continuation Coverage must pay for the coverage (plus an administrative fee) monthly on an after-tax basis.

If there is a change in the health coverage provided by the SRP Health Care Program to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

A qualified beneficiary, who is entitled to COBRA Continuation Coverage for group health care after the calendar year in which the qualifying event occurs, may participate in the Open Enrollment Period for subsequent calendar years.

When COBRA Continuation Coverage is available in connection with your participation in a Medical Reimbursement Tax Saver Account (i.e., if the employee’s Tax Saver Account has a positive balance as of the date of the qualifying event), it will be on the same terms described above for group health coverage, except participation will be available only until the end of the plan year in which the qualifying event occurs. COBRA coverage will consist of the tax saver coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event).
Paying for COBRA Continuation Coverage

When a qualified beneficiary elects COBRA Continuation Coverage, the qualified beneficiary becomes responsible for paying the entire cost of the COBRA coverage and an administrative fee permitted under COBRA. If a qualified beneficiary’s COBRA 18-month continuation period is extended 11 months because of disability, as determined by the Social Security Administration, a qualified beneficiary may be charged 150% of the cost of the coverage for the last 11 months of the COBRA Continuation Coverage and an administrative fee permitted under COBRA.

A qualified beneficiary has 45 days from the date of the initial coverage election to make the first (retroactive) coverage payment. The first coverage payment must include any amounts that are due for periods of coverage that end before 45 days from the date of the coverage election. The 45-day period begins on the date the qualified beneficiary’s coverage election is sent to SRP’s COBRA administrator. After all back coverage payments are made, coverage payments will be due on a monthly basis.

After the above-described 45-day grace period for the initial premium payment, there is a grace period for subsequent premium payments of 30 days after the payment due date. Failure to make any payment will cause the qualified beneficiary’s health care coverage to be terminated retroactively to the date the payment was due.

Payment is considered made when it is postmarked.

Note: You will not receive an invoice (bill) for the initial COBRA premium payment or for the monthly COBRA premium payments. You are responsible for making timely payments for COBRA continuation coverage to the COBRA Administrator listed on the Quick Reference Chart.

**IMPORTANT**

There will be no invoices or reminders for COBRA premium payments. You are responsible for making sure that timely COBRA premium payments are made to the COBRA Administrator.

Addition of Newly Acquired Dependents

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

Loss of Other Group Health Plan Coverage

If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage, your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA health care plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage.
The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the spouse or dependent within 31 days after the termination of the other coverage. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Confirmation of Coverage Before Election or Payment of COBRA Continuation Coverage

- If a health care provider requests confirmation of coverage and you, your spouse or dependent child(ren) are within the COBRA election period but have not yet elected COBRA Continuation Coverage, COBRA Continuation Coverage will not be confirmed but with notice to the health care provider that the coverage will retroactively be reinstated to the date coverage was lost on account of the qualifying event if COBRA Continuation Coverage is timely elected.
- During the period of COBRA Continuation Coverage, if a health care provider requests confirmation of coverage but the payment required for COBRA Continuation Coverage has not been made and the grace period for that payment has not ended, COBRA Continuation Coverage will be confirmed but with notice to the health care provider that the coverage will be terminated retroactively to the date the payment was due if the payment is not timely made.

Coverage is not extended during the COBRA election period and the grace period for payment for coverage. The health care provider will be notified that no claims will be paid unless COBRA Continuation Coverage is timely elected and the amounts due are timely paid.

When COBRA Continuation Coverage Ends

The law provides that a qualified beneficiary’s COBRA Continuation Coverage will end for any of the following reasons:

- The qualified beneficiary has reached the end of the applicable 18-, 29- or 36-month period of COBRA Continuation Coverage;
- SRP no longer provides group health care coverage to any of its employees;
- The amount due for the qualified beneficiary’s coverage is not paid in a timely manner;
- The qualified beneficiary becomes covered under another group health care plan that does not contain a pre-existing condition exclusion or limitation that would apply to the qualified beneficiary;
- Subsequent to the date of the COBRA election the qualified beneficiary first becomes enrolled in Medicare;
- The lifetime benefit maximum is exhausted on all benefits;
- For cause on the same basis that the SRP Health Care Program terminates for cause the health care coverage of similarly situated non-COBRA beneficiaries (for example, on account of submission of a fraudulent claim); or
- During an extension of the maximum coverage to 29 months due to the disability of the qualified beneficiary, the disabled person is determined by the Social Security Administration to no longer be disabled.
Conversion at the End of COBRA Continuation Coverage
When COBRA Continuation Coverage ends, a qualified beneficiary may be able to enroll in an individual conversion dental care policy, if such policy is available under the EDS Dental Plan coverage. The individual conversion health care policy will contain different provisions than are available through the EDS dental coverage. A written application for conversion (if any) must be made within 31 days from the date of termination of COBRA Continuation Coverage. Questions regarding the conversion option should be referred to the Plan Administrator or its designee.

Sending Notices
COBRA notifications will be sent to a qualified beneficiary’s last known address. If a qualified beneficiary has changed marital status, or the qualified beneficiary or his/her spouse has changed addresses, please notify the COBRA Administrator, whose name and address are listed on the Quick Reference Chart in the front of this section of the Handbook.

FMLA and COBRA
Taking a leave under the Family and Medical Leave Act (FMLA) is not a COBRA-qualifying event. A qualifying event can occur after the FMLA period expires, if an employee does not return to work and thus loses coverage under his/her group health plan. Then the COBRA Continuation Coverage period is measured from the date of the qualifying event — in most cases, the last day of the FMLA leave. Note that if the employee notifies SRP that he/she is not returning to employment prior to the expiration of the maximum FMLA 12-week period, a loss of coverage could occur earlier.

HIPAA Certification of Creditable Coverage When Coverage Ends
When your coverage ends, you and/or your covered dependents are entitled by law to and will automatically be provided (free of charge) with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. Such a certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your covered dependents has ended. You can present this certificate to your new employer/health plan to offset a pre-existing condition limitation that may apply under that new plan or use this certificate when obtaining an individual health insurance policy to offset a similar limitation.

Procedure for Requesting and Receiving a Certificate of Credible Coverage
A certificate will be provided upon request for such a certificate that is received by the Plan Administrator within two years after the date coverage ended under this Plan. The request must be mailed, faxed or e-mailed to the Plan Administrator and should include the names of the individuals for whom a certificate is requested (including spouse and dependent children) and the address where the certificate should be mailed. The address, fax number and e-mail of the Plan Administrator are on the Quick Reference Chart in the front of this section of the Handbook. A copy of the certificate will be mailed by the Plan to the address indicated.

Questions About COBRA
If a qualified beneficiary has any questions about COBRA Continuation Coverage, he/she may call the COBRA Administrator, whose name and address are listed on the Quick Reference Chart in the front of this Handbook.

Need more help? See the Quick Reference Chart in the front of this section.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans like the SRP Self-Insured Health Benefits Plan (Plan), maintain the privacy of your personally identifiable health information called “protected health information,” or “PHI.”

A complete description of your rights under HIPAA’s Privacy Rule can be found in the Plan’s Privacy Notice, which was previously distributed to you and is available from SRP Benefits Services at the phone number listed on the Quick Reference Chart in the front of this section of the Handbook. The Privacy Notice is also available on the SRP Intranet (insidesrp/hrnet). Select HIPAA Privacy Act. Information about HIPAA’s Privacy Rule in this Handbook is not intended and cannot be construed as the Plan’s Privacy Notice.

The following terms are defined to aid your understanding of the next two subsections:

- The term “Plan Sponsor” means both (1) the Salt River Valley Water Users’ Association (the Association) with respect to the self-insured health care plan sponsored by the Association and (2) the Salt River Project Agricultural Improvement and Power District, New West Energy Corporation, Papago Park Center, Inc., and for some benefits, the Salt River Project Employees’ Recreational Association, Inc., the Salt River Project Employees’ Recreational Association Coronado Generating Station, Inc. and the Salt River Project Employees’ Recreational Association Navajo Generating Station, Inc. (collectively, the District) with respect to the self-insured health care plan sponsored by the District.
- The term “Privacy Rule” means the regulations adopted pursuant to HIPAA, titled “Standards for Privacy of Individually Identifiable Health Information” and set forth in 45 CFR part 160 and part 164, subparts A and E.
- The term “Protected Health Information” (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form. PHI does not include health information contained in employment records held by SRP in its role as an employer, including but not limited to health information needed to carry out SRP’s obligations under the Americans with Disabilities Act of 1990 (ADA), the Family and Medical Leave Act of 1993 (FMLA), the Occupational Safety and Health Act (OSHA) and similar laws; records relating to occupational illness/injury; records relating to disability, life and accidental death and dismemberment (AD&D) insurance eligibility; sick leave requests and justifications; drug screening results; and fitness-for-work tests.
- The term “SRP Self-Insured Health Benefits Plan,” or “Plan,” refers to the plans maintained separately by the District and the Association that provide self-insured Medical PPO Plan or EPO Plan options (including prescription drug, behavioral health and hearing aid benefits), and dental and vision benefits.

Protected Health Information

The Plan and the Plan Sponsor will not use or further disclose PHI without your written authorization except as necessary for treatment, payment, health plan operations and plan administration, payroll purposes, or as permitted or required by law. In accordance with HIPAA, the Plan requires all of its business associates to also observe the Privacy Rule. In particular, the Plan will not, without authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the PHI, receive an accounting of certain disclosures of the PHI and, under certain circumstances,
amend the PHI. You also have the right to file a complaint with the Plan or with the U.S. Department of
Health and Human Services if you believe your rights under HIPAA have been violated.

If you have questions about the privacy of your health information or you wish to file a complaint
under HIPAA, you may contact the Plan’s Privacy Officer at:

SRP Self-Insured Health Benefits Plan Privacy Officer
PAB242
P.O. Box 52025
Phoenix, AZ 85072-2025
(602) 236-3600 (press 0) or 1-800-491-8846 (press 0); fax: (602) 236-3606

Disclosure of Protected Health Information by Plan to Plan Sponsor

The provisions in this subsection allow the Plan to disclose certain PHI to the Plan Sponsor for
purposes permitted and under the conditions specified in the Privacy Rule.

A. Limitations on the use and disclosure of PHI: The Plan Sponsor may use and disclose
PHI received from the Plan only as permitted by this paragraph A and in accordance
with the Privacy Rule. The Plan Sponsor may use and disclose PHI received from the
Plan solely for purposes of performing the plan administration functions on behalf
of the Plan specified in this paragraph A. These functions include eligibility and
enrollment functions, quality assurance, claims processing, auditing, monitoring, trend
analysis and such other activities necessary to manage and operate the Plan, provided
these activities qualify as payment or health care operations functions under the
Privacy Rule. The Plan Sponsor may not use or disclose such PHI for any employment-
related functions, or any functions in connection with any other benefit or employee
benefit plan of the Plan Sponsor.

To the extent any health insurance issuer or HMO provides coverage to the Plan,
such HMO or health insurance issuer may disclose PHI to the Plan Sponsor, but only
as permitted in this subsection and the Privacy Rule, and consistent with the minimum
necessary standard in the Privacy Rule. PHI may be disclosed by the Plan to the Plan
Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has
been amended to incorporate the provisions contained in this paragraph A and that
the Plan Sponsor agrees to these provisions. Specifically, the Plan Sponsor agrees to:

• Not use or further disclose PHI received from the Plan other than as permitted by this
section or as required by law;
• Ensure that any agents, including a subcontractor, to whom it 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 the PHI for employment-related actions and decisions or in
connection with any other benefit or employee benefit plan of the Plan Sponsor, unless
authorized by the individual or disclosed in the Plan’s Privacy Notice;
• Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or
disclosures provided for in this subsection of which it becomes aware;
• Make the PHI available to the individual in accordance with the access requirements of
the Privacy Rule;
• Make the PHI available for amendment and incorporate any amendments to PHI in
accordance with the requirements of the Privacy Rule;
• Make available the information required to provide an accounting of PHI disclosures in
accordance with the requirements of the Privacy Rule;
• 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 Department of Health and Human Services for purposes of determining the Plan’s compliance with the Privacy Rule;

• 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 information when no longer needed for the purpose for which disclosure was made to it. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

• Ensure that adequate firewalls, as described in paragraph B below, are established to (1) identify the employees or classes of employee or other persons under the control of the Plan Sponsor who will have access to PHI received from the Plan; (2) restrict access to the PHI solely to these employees or workforce members and ensure that their access is only for purposes of performing plan administration functions on behalf of the Plan; and (3) provide a mechanism for resolving any issues of noncompliance by these employees or workforce members of the Plan Sponsor.

B. Firewalls: In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with the Privacy Rule, only the following employees will be given access to PHI received from the Plan:

1. The following employees of the Plan Sponsor will be given access to, and allowed to use, PHI received from the Plan solely for purposes of performing plan administration functions on behalf of the Plan.
   • Employees in, or contractors working under the direct control of, the Benefits and Health Services Department of the Plan Sponsor; and
   • The Workers’ Compensation Administrator and contractors working under the direct control of the Workers’ Compensation Administrator.

2. The following employees of the Plan Sponsor will be given access to, and allowed to use, PHI received from the Plan solely for purposes of performing plan administration functions on behalf of the Plan that relate to eligibility and enrollment:
   • Except as otherwise provided in paragraph B(1) above, employees in the Human Resources Services Department;
   • Employees in the Accounts Payable/Payroll Department whose job responsibilities include payroll functions;
   • Employees in the Information Systems Administrative Systems Department whose job responsibilities include design, operation and maintenance of the Plan Sponsor’s Human Resources Management System; and
   • Employees in the Financial Accounting Department who are responsible for payments to Plan contractors.

Any issues of noncompliance with these restrictions on the access to, and use of, PHI by employees described in this paragraph B will be subject to sanctions in accordance with the Plan Sponsor’s procedure for resolving issues of noncompliance, including disciplinary sanctions.

C. Effective April 21, 2005, in compliance with HIPAA Security regulations, the Plan Sponsor will:

• Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan;

• Ensure that the adequate separation discussed in paragraph B (Firewalls) above, specific to electronic PHI (also called ePHI), is supported by reasonable and appropriate security measures;
• Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
• Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

**SRP Medical PPO Option(s)**

A Preferred Provider Organization (PPO) is a network of medical providers (including physicians, hospitals, and laboratories) contracted with the SRP Medical PPO Option(s) to provide eligible expenses at agreed-upon discounted/reduced rates. The term “SRP Medical PPO Option” refers to separate District and Association plans that provide similar benefits to eligible employees and dependents of the sponsoring employer. If you chose one of the SRP Medical PPO Option(s), you may use services of in-network providers or out-of-network providers. You will, however, pay less money out of your pocket if you receive services from an in-network provider. The SRP Medical PPO Option(s) are self-funded. The description found here gives you an overview of your benefits under the Medical PPO Option(s).

**SRP Medical EPO Option**

An Exclusive Provider Organization (EPO) is a network of medical providers (including physicians, hospitals, and laboratories) contracted with the SRP Medical EPO Option to provide eligible expenses at agreed-upon discounted/reduced rates. The term “SRP Medical EPO Option” refers to a separate District and Association plan that provides similar benefits to eligible employees and dependents of the sponsoring employer. If you chose to enroll in the SRP Medical EPO Option, you may ONLY use services of in-network providers, except in the case of an emergency. **(Note:** Because out-of-network providers are not under any contract with the medical network, they may also bill you for any balance that may be due in addition to the amount payable by the Medical PPO or EPO, also called balance billing.)

- **Under the SRP Medical EPO Option, there is coverage ONLY when you use an EPO provider.** Contact the website of the EPO network as noted on the Quick Reference Chart.
- The only exception is if you have an emergency. In that case, you should use the nearest emergency room and later, send your claims to the EPO Claims Administrator, who will pay them according to how EPO provider claims are paid. **(Note:** Because out-of-network providers are not under any contract with the medical network, they may also bill you for any balance that may be due in addition to the amount payable by the Medical PPO or EPO, also called balance billing.)

The SRP Medical EPO Option is self-funded.

**In-Network and Out-of-Network Providers**

SRP Medical PPO Option(s) (Medical PPO) participants may obtain health care services from in-network providers or from out-of-network providers. SRP Medical EPO Option (Medical EPO) participants may obtain health care services only from in-network providers, except in case of an emergency.

**In-Network**

In-network health care providers are also called Preferred PPO or EPO providers. All in-network providers have agreements with the Medical PPO or EPO contracted medical network under which they provide eligible expenses for a favorable negotiated discount fee for Medical PPO or EPO participants. When a Medical PPO or EPO participant uses the services of an in-network
health care provider, except with respect to any applicable deductible, the Medical PPO or EPO participant is responsible for paying less out of their pocket than if they use the services of an out-of-network provider. The in-network health care provider accepts your deductible and coinsurance along with the Medical PPO’s or EPO’s allowed charges as payment in full.

- **Preferred PPO/EPO providers** have a contract with the medical network to give you and the Medical PPO and EPO a discount off their billed charges. Preferred PPO/EPO providers are generally not allowed to balance bill you for the difference in their billed charges and the amount paid by the Medical PPO or EPO. Preferred PPO/EPO providers are listed in the PPO/EPO directory. See the Quick Reference Chart in the front of this section of the Handbook for the name and phone number of the medical network used in the Medical PPO or EPO.

- **Wrap network**: Note that while there is a primary network of Preferred PPO providers within Arizona, for those PPO Plan participants who reside outside of Arizona, the Plan has contracted with one or more additional PPO networks. These additional PPO networks that exist outside of Arizona are sometimes called “wrap” networks. On your Medical Plan ID card, you may notice the logo for these wrap networks that helps identify the participant as a person who can access the discounts from the wrap network. The wrap networks pertain to PPO Plan participants only, not EPO Plan participants.

**Out-of-Network**
Out-of-network providers (also referred to as non-network, non-PPO, non-EPO, non-preferred, non-participating providers) have no agreements with the medical network and are generally free to set their own charges for the services or supplies they provide. The Medical PPO or EPO will pay the out-of-network provider or reimburse the Medical PPO or EPO participant at the allowed charge rate for eligible medically necessary services or supplies, subject to the deductible and out-of-network coinsurance. You must submit proof of claim before any reimbursement will be made to you.

Because out-of-network providers are not under any contract with the medical network, they may also bill you for any balance that may be due in addition to the amount payable by the Medical PPO or EPO, also called balance billing. You can avoid balance billing by using in-network providers. See the definition of balance billing in the Definitions chapter.

**Remember: SRP Medical EPO Option (Medical EPO) participants may obtain health care services only from in-network providers, except in case of an emergency.**

**Out of Area (OOA)**
“Out of area” is defined as residing 50 miles or more outside the PPO network service area. Participants that reside out of area will have their eligible claims paid according to the Schedule of Medical Benefits.

**Directory of In-Network Providers**
At least once each year, you can obtain a directory of in-network providers who are contracted with the medical network. The directory lists preferred PPO providers and EPO providers. There is no cost to you for the directory. If you lose or misplace your directory, you can obtain another at no cost by calling Benefits Services at the telephone number shown on the Quick Reference Chart in the front of this section of the Handbook.

Physicians and health care providers who participate as preferred PPO and EPO providers are added and deleted during the year. At any time, you can find out if a health care provider is an in-network provider by calling Benefits Services at the telephone number shown on the Quick Reference Chart, accessing the website of the medical network (also shown on the Quick Reference Chart), or through the SRP Intranet (insidesrp/hrnet).
When arranging hospital, medical, and related services, discuss the charges to be made with your doctor, the hospital, or others that will furnish treatment. If you have questions about how a specific procedure, treatment plan or fee will be covered, call the Claims Administrator in advance to discuss coverage. The phone number of the Claims Administrator is located on the Quick Reference Chart in the front of this section of the Handbook. **You are encouraged to call the Claims Administrator to verify a large expense before you incur it. It is also wise to confirm whether the provider you plan to visit is an in-network provider.**

Remember, any amounts from out-of-network providers that exceed allowed charges paid by the Plan are excluded from reimbursement and do not count toward the annual out-of-pocket limits. You can help control your health care costs by making sure only necessary services and tests are ordered as well as by using an in-network provider.

**Making the Most of Your Medical PPO/EPO**

*“Preferred” PPO Providers and EPO Providers*

Preferred PPO and EPO providers are medical providers (hospitals, physicians, laboratories, etc.) under contract with the medical network who have agreed to a special reduction in their normal fees/charges for Medical PPO and EPO participants. Because these providers offer the deepest discounts, the Medical PPO and EPO reimburse you the most when you use preferred providers. This means that you pay the least out of your own pocket when you use the services of a preferred PPO and EPO provider. You can find preferred providers listed in your directory of in-network providers.

The Medical PPO and EPO offer participants and their dependents who use preferred PPO providers these advantages:

- **Discounts** – The preferred PPO and EPO providers’ fees will be reduced from their standard billed fees.
- **No balance billing** – If a health care provider tries to bill you for the difference in cost between the charges on their bill and the amount allowed as payable under the Medical PPO and EPO, that “difference” is called balance billing. When you use the services of a preferred PPO or EPO provider, generally you will not be balance billed.* This means that you are not responsible for paying the difference between the total charges submitted by the provider and the amount considered allowable under the Medical PPO or EPO.

* Only in certain instances can in-network providers balance bill, such as when you have duplicate medical insurance coverage available from a first- or third-party liability carrier, like auto insurance. When there is liability coverage available for charges incurred by the employee or a covered dependent, the provider can balance bill the patient and/or the first- or third-party liability carrier.

- **No claim forms** – The preferred PPO and EPO providers will send their claim (bill) directly to the Claims Administrator, and therefore you will not have to submit a claim form. Payments are made directly to the preferred PPO and EPO providers.

- **SRP pays more of the provider’s fees** – To encourage you to use preferred PPO and EPO providers, the Medical PPO and EPO will reimburse a greater percentage of the provider’s bill than if you use an out-of-network provider.

Using a preferred provider can substantially reduce your out-of-pocket expenses for health care. The chart at the end of this section provides a representative cost comparison between in-network providers and out-of-network providers. (Your actual costs will vary depending upon whether your deductible has been met, you have reached your maximum annual out-of-pocket limit and what the actual allowed charges are for such services.)

Need more help? See the Quick Reference Chart in the front of this section.
As Medical PPO participants, you and your dependents will continue to enjoy full freedom of choice of doctor, hospital and any health care provider. You may use an in-network provider and an out-of-network provider on the same day. You make the choice of provider each time you need care.

**Remember: SRP Medical EPO Option (Medical EPO) participants may obtain health care services only from in-network providers, except in case of an emergency.**

Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross Blue Shield Association, does not provide administrative or claims payment services. The SRP Health Care Program has assumed all liability for claims payment based on the provisions and limitations stated in this plan document.

No provider network benefits are available from Blue Cross Blue Shield of Arizona outside of Arizona. Note that for PPO participants, coverage may be available through another network provider outside the state of Arizona.

**Non-Preferred, Non-Participating, Non-PPO/Non-EPO Providers, Out-of-Network Providers**

Any doctor or health care provider not contracted with the medical network is considered out-of-network.

- **No discounts offered:** These out-of-network providers will not extend a discount off their normal billed charges for the services they provide.
- **Providers may balance bill:** There is no contract with out-of-network providers and thus no way to prevent such providers from balance billing you for the difference between billed charges and the amount allowed as payable under the Medical PPO or emergency care services under the EPO Plan. See the definition of balance billing in the Definitions chapter.
- **Claim forms required:** If you use an out-of-network provider, you must obtain a claim form and send it along with the provider’s bill to the Claims Administrator, whose name and address are located on the Quick Reference Chart in the front of this section of the Handbook.
- **Less payment by SRP:** If your medical provider is not an in-network provider, the charges will not be discounted. This means that you will pay a greater out-of-pocket cost when you use the services of an out-of-network provider. Also, the Medical PPO pays a lower coinsurance for use of out-of-network providers. Note that the EPO pays for out-of-network providers only in the case of an emergency.

**Plan Design for the SRP Medical PPO and EPO Option(s)**

The following information outlines some basic provisions for the SRP Medical PPO Option (Medical PPO) and SRP Medical EPO Option (Medical EPO).

**Eligible Medical Expenses**

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

- Determined by the Plan Administrator or its designee to be “medically necessary,” but only to the extent that the charges are “allowed charges” (as those terms are defined in Definitions in this section of the Handbook);
- **Not services or supplies that are excluded** from coverage (as described in Exclusions and Limitations: SRP Medical PPO and EPO Option in this section of the Handbook); and
- **Services or supplies the charges for which are not in excess** of the general overall maximum Medical PPO and EPO benefit or any applicable limited overall and/or annual

Need more help? See the **Quick Reference Chart** in the front of this section.
The maximum Medical PPO and EPO benefits shown in the Schedule of Medical Benefits in this section of the Handbook.

Generally, the Medical PPO or EPO will not reimburse you for all eligible medical expenses. Usually, you will have to satisfy some deductibles and pay some coinsurance or make some copayments toward the amounts you incur that are eligible medical expenses.

However, once you have incurred a maximum out-of-pocket cost applicable to coinsurance, no further coinsurance will be applied. There are certain limited overall maximum benefits and annual maximum benefits applicable to each participant with respect to certain eligible medical expenses.

These features are outlined in the chart below and described in this section of the Handbook. Applicable limited overall and annual maximum benefits are described in the Schedule of Medical Benefits in this section of the Handbook.

### Non-Eligible Medical Expenses

The Medical PPO or EPO will not reimburse you for any expenses that are not eligible medical expenses. That means you are responsible for paying the full cost of all expenses that are:

- Not determined to be medically necessary;
- Determined to be in excess of the allowed charges;
- Not covered by the Medical PPO or EPO;
- In excess of any applicable limited overall and/or annual maximum benefits; or
- Payable on account of a financial penalty because of failure to comply with the Medical PPO’s utilization review requirements as described in Precertification: The Utilization Review (UR) Program in this section of the Handbook.

### Deductibles for the SRP Medical PPO Plan

The deductible is the amount you must pay each calendar year before the Plan pays benefits. The amount applied to the deductible is the lesser of billed charges or the amount considered to be an allowed charge under this Plan.

Each year, you (and not the Medical PPO) are responsible for paying all of your eligible medical expenses until you satisfy the annual deductible and then the Medical PPO begins to pay benefits. When additional eligible expenses exceeding the deductible amount are submitted, the Medical PPO will reimburse you for those expenses, above the deductible, at the appropriate coinsurance based on the type of expense, provider and PPO provision.

Deductibles are applied to eligible medical expenses in the order in which claims are received by the Medical PPO. Copayments do not accumulate to meet the deductible. Deductibles do not accumulate to meet an out-of-pocket maximum. Deductibles under the Medical PPO are accumulated on a calendar-year basis. Only eligible medical expenses can be used to satisfy the Medical PPO’s deductibles. As a result, non-eligible medical expenses and copays do not count toward the deductible.

Note that for the PPO Plan, both eligible PPO provider services and eligible non-PPO provider services accumulate to meet the calendar-year deductible for an individual or family.

### Type of Deductibles

Under the PPO Plan options, there are two types of deductibles: individual and family.

The individual deductible is the maximum amount one covered person has to pay toward eligible
medical expenses before Medical PPO benefits begin, even if the covered person has elected family coverage. The Medical PPO’s individual deductible varies depending on whether you select the high- or low-option design.

The **family deductible** is the maximum amount that a family of two or more is responsible for paying toward eligible medical expenses before Medical PPO benefits begin. The family deductible is met when the combined total of all eligible expenses submitted by two or more covered family members reaches the family deductible amount. The Medical PPO’s family deductible also varies according to whether you select the high- or low-option Plan design.

Each calendar year, you choose between various levels of individual and family deductibles and out-of-pocket limits.

**Expenses Not Subject to Deductibles**

For the Medical PPO Plan options, certain eligible medical expenses are not subject to deductibles. These expenses may be covered 100% by the Medical PPO, or they may be subject to copayments explained in **Copayment in this section of the Handbook**. See the Schedule of **Medical Benefits** in this section of the Handbook to determine when eligible medical expenses are not subject to deductibles.

A deductible does not apply to participants in the Medical EPO Plan.

**Copayment (Copay)**

A copayment (or copay, as it is sometimes called) is a set dollar amount that you (and not the Medical Plan) are responsible for paying when you incur an eligible medical expense. When copayments apply, generally there are no deductibles or coinsurance, unless the Medical Plan specifically provides otherwise. The Medical Plan’s drug copayments are indicated in the Schedule of **Medical Benefits** in this section of the Handbook.

Copayments do not accumulate to meet a deductible or the PPO Plan’s out-of-pocket maximum.

**Coinsurance**

Coinsurance is the term used to describe how you and the Medical PPO will split the cost of certain covered medical expenses. (Note that coinsurance does not apply to the Medical EPO Plan, as most benefits are paid at 100% or with a copayment.) Once you’ve met your annual deductible, the Medical PPO generally pays a percentage of the eligible medical expenses, and you (and not the SRP Medical PPO) are responsible for paying the rest. The part you pay is called the coinsurance. If you use the services of a health care provider that is a member of the medical network (preferred provider), you will pay less coinsurance and thus less money out of your pocket. See the Schedule of **Medical Benefits** in this section of the Handbook for information on the coinsurance amount for each type of covered service.

**Out-of-Pocket Maximum**

Out-of-pocket maximum refers to the maximum amount of coinsurance a Medical PPO participant must pay each year toward medical expenses before the Plan pays 100%. Each calendar year, after an individual or family has incurred a maximum out-of-pocket cost for coinsurance, no further coinsurance will apply to covered eligible medical expenses. As a result, the Medical PPO will pay 100% of all covered eligible medical expenses for the remainder of that calendar year, except for the out-of-pocket expenses listed below. The Medical PPO allows you to select the level of out-of-pocket maximum you want each year: high or low option.
(Note that the out-of-pocket maximum does not apply to the Medical EPO Plan, as most benefits are paid at 100% or with a copayment.)

Expenses applied toward the satisfaction of the PPO/OOA out-of-pocket maximum will be applied toward satisfaction of the non-PPO out-of-pocket maximum, and expenses applied toward the satisfaction of the non-PPO out-of-pocket amount will be applied toward satisfaction of the PPO/OOA out-of-pocket amount.

**Out-of-Pocket Expenses You Always Incur**

The Medical PPO never pays benefits equal to all the medical expenses you may incur. You are always responsible for paying for certain expenses for medical services and supplies yourself. Under the Medical PPO, each year you will be responsible for paying the following expenses out of your own pocket:

- Any plan deductible.
- Any applicable coinsurance, up to the out-of-pocket maximum.
- Any applicable copayments.
- All expenses for medical services or supplies that are not covered (excluded) by the Medical PPO.
- All charges in excess of the allowed charge determined by the Medical PPO.
- All charges in excess of the Medical PPO’s lifetime maximum, limited overall and/or annual maximum benefits of the Medical PPO.
- Any additional other amounts you have to pay because you failed to comply with the Utilization Review Programs described in Precertification: The Utilization Review (UR) Program in this section of the Handbook.
- All expenses incurred with respect to retail and mail-order prescription drugs.

**Maximum Plan Benefits**

There are three types of maximum amounts of benefits payable on account of medical expenses incurred by any covered plan participant under the Medical PPO or EPO.

- General overall (“lifetime”) maximum Medical Plan benefit;
- Limited overall maximum Medical PPO or EPO benefit; and
- Annual maximum Medical PPO or EPO benefit.

**General Overall (“Lifetime”) Maximum Medical Plan (PPO or EPO) Benefit**

A general overall (“lifetime”) maximum Medical Plan (PPO or EPO) benefit is the maximum amount of benefits payable by any of the Medical Plan options and any previous medical expense plan provided by SRP.

The description of the maximum as a “lifetime” maximum does not mean, nor should it be construed to mean, that the Medical Plan has any obligation to pay any benefits during the lifetime of the Medical Plan participant after coverage terminates.

The general overall (“lifetime”) maximum Medical Plan benefit is unlimited for you and each of your covered dependents.

**Limited Overall Maximum Medical PPO or EPO Benefits**

Certain eligible Medical PPO or EPO expenses are subject to limited overall maximums for each covered individual. Once the Medical PPO or EPO has paid the limited overall maximum plan...

Need more help? See the **Quick Reference Chart** in the front of this section.
benefit for any of those services or supplies on behalf of any covered individual, it will not pay any further benefits for those services or supplies on account of that covered individual. The services or supplies that are subject to limited overall maximum plan benefits (such as dietitian counseling) and the amounts of the limited overall maximum plan benefits are identified in the Schedule of Medical Benefits in this section of the Handbook.

Annual Maximum Medical PPO or EPO Benefit

The Medical PPO or EPO benefits for certain eligible medical expenses are subject to annual maximums per covered individual or family during each calendar year. Once the Medical PPO or EPO has paid the annual maximum plan benefit for any of those services or supplies on behalf of any covered individual or family, it will not pay any further benefits for those services or supplies on account of that individual or family for the balance of the calendar year. The services or supplies that are subject to annual maximum plan benefits are identified in the Schedule of Medical Benefits in this section of the Handbook.

Filing a Claim/Appealing a Denied Claim

See Claim Filing and Appeals Information in this section of the Handbook.

SRP Behavioral Health Program

Eligibility

The SRP Behavioral Health benefits are part of the self-insured Medical Plans maintained by the District and the Association that provide similar benefits to eligible employees and dependents of the sponsoring employer. The SRP Behavioral Health benefits are available to all SRP Medical PPO or EPO Option plan participants. This includes regular full-time, three-quarter-time and half-time employees of SRP and its affiliates, PERA, retirees, and provisional employees.

When Coverage Starts

Coverage for SRP Behavioral Health benefits starts on the date your SRP Medical Plan coverage begins and is not subject to any pre-existing condition limitations.

Administration

The SRP Behavioral Health benefits are administered under a contract with a professional behavioral health firm whose name, address and phone number are listed on the Quick Reference Chart in the front of this section of the Handbook. The behavioral health firm’s mental health and substance abuse professionals are available to assist you and your covered dependents with questions and treatment for any behavioral health needs. For a list of contracted behavioral health providers, call the SRP Behavioral Health Program at its phone number or website listed on the Quick Reference Chart in the front of this section of the Handbook.

The behavioral health firm contracts with a network of mental health and substance abuse providers and facilities, also called “in-network” providers. These in-network providers extend a discount to individuals who participate in the SRP Behavioral Health Program.

The behavioral health benefits are described in the Schedule of Medical Benefits in this section of the Handbook. Specific terms applicable to the SRP Behavioral Health Program (such as behavioral health disorder, behavioral health practitioners and behavioral health treatment) are defined in the Definitions section of this Handbook.

See the Precertification section for information on the services needing to be precertified and the penalty for failure to precertify. Check Exclusions and Limitations: SRP Medical PPO or EPO Option in this section of the Handbook to see if certain behavioral health services are excluded.
Employee Assistance Program (EAP)

In addition to the SRP Behavioral Health Program, SRP offers all employees and their dependents up to **10 free visits to an EAP counselor per person per calendar year**. Contact either of the EAP providers whose names and phone numbers are listed on the Quick Reference Chart in the front of this section of the Handbook.

The EAP counselors provide **confidential** information, assessment and referral services to employees and their dependents who are experiencing personal, family or work problems. Typical concerns called into the EAP counselor can involve relationship problems, marital problems, anxiety, depression, substance abuse, grief and loss, legal and financial problems, parent/child problems, domestic violence and work/family balance challenges. Employees often contact the EAP counselor to discuss work performance problems, burnout or co-worker conflicts.

Individuals who need support beyond the **10 free EAP visits** may be referred to the behavioral health providers available under the SRP Behavioral Health Program. There are no claims to be filed when using the EAP.

Refer also to the EAP information provided in the Employee Guidelines section of this Handbook.

Precertification: The Utilization Review (UR) Program

Note that for Medical EPO Plan participants, your EPO health care providers are responsible for performing the precertification process.

The SRP Medical Plan is designed to provide you and your eligible family members with financial protection from significant health care expenses. To enable the Medical Plan to provide coverage in a cost-effective way, the Medical Plan maintains a Utilization Review Program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, SRP is better able to afford to maintain the Medical Plan and all its benefits.

If you follow the procedures of the Medical Plan’s Utilization Review Program, you may avoid some out-of-pocket costs. However, if you don’t follow these procedures, the Medical Plan provides reduced benefits, and you’ll be responsible for paying more out of your own pocket.

Administration

The Medical Plan’s Utilization Review Program is administered by an independent professional Utilization Review Company (the UR Company, which includes a Medical Plan Utilization Review Program and a Behavioral Health Program for behavioral health services) operating under a contract with the Medical Plan. The name, address and telephone number of the UR Company appear in the Quick Reference Chart in the front of this section of the Handbook.

The health care professionals at the UR Company focus their review on the necessity and appropriateness of hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical or surgical services. To carry out their responsibilities under the Medical Plan, the UR Company has been given discretionary authority by the Plan Administrator to determine if a course of care or treatment is medically necessary with respect to the patient’s condition and within the terms and provisions applicable to the Medical Plan.
— Very Important Information —

Restrictions and Limitations of the Utilization Review Program

1. The fact that your physician recommends surgery, hospitalization, confinement in a health care facility, or that your physician or other health care provider proposes or provides any other medical services or supplies, doesn’t mean that the recommended services or supplies will be an eligible expense or be considered medically necessary for determining coverage under the SRP Medical Plan.

2. The Utilization Review Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage or guarantee payment of Medical Plan Benefits. The UR Company’s certification that a service is medically necessary doesn’t mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Medical Plan as described in this Handbook. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Medical Plan either in whole or in part.

3. All treatment decisions rest with you and your physician (or other health care provider). You should follow whatever course of treatment you and your physician (or other health care provider) believe to be the most appropriate, even if:
   - The UR Company does not certify a proposed surgery or other proposed medical treatment as medically necessary or as an eligible expense; or
   - The Medical Plan will not pay regular Medical Plan benefits for a hospitalization or confinement in a health care facility because the UR Company does not certify a proposed confinement; the benefits payable by the Medical Plan may, however, be affected by the determination of the UR Company.

4. With respect to the administration of the Medical Plan, the employer, the Medical Plan Claims Administrators and the UR Company are NOT engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the UR Company as medically necessary, or for the results if the patient chooses not to receive health care services that have not been certified by the UR Company as medically necessary.

Program Elements

The Medical Plan’s Utilization Review Program consists of:

Precertification review: A review of proposed health care services before the services are provided.

Case management: A voluntary program designed to provide assistance with the coordination of health care benefits for Medical PPO participants who may have complex, catastrophic or chronic care needs, such as multiple trauma, spinal cord injury, stroke, high-risk pregnancy, diabetes, asthma, high-risk newborns and chronic respiratory conditions. The case manager from the UR Company, hereafter referred to as the case manager, works in collaboration with the patient, the patient’s family, the physician or other health care providers, and SRP to assess, plan, implement, coordinate and evaluate the care options available to the patient.

Precertification Review

For the Medical PPO/EPO Plan options, precertification review is a procedure, administered by the UR Company (or for behavioral health services, by the SRP Behavioral Health Program), to ensure that admission and length of stay in a hospital or health care facility, surgery and other health care services are medically necessary.
What Services Must Be Precertified (Approved Before They Are Provided)
Under the Medical PPO or EPO Plans

(a) All elective hospital admissions (except admissions for delivery of a baby or an urgent/emergent admission), long-term acute care hospital admissions, and major organ and tissue transplant services need to be precertified (preapproved) by calling the UR Company before they are provided.

(b) Note that all elective behavioral health admissions must be precertified by contacting the SRP Behavioral Health Program, whose information is listed on the Quick Reference Chart in the front of this section of the Handbook.

(c) Durable medical equipment (DME) over $5,000 must be precertified.

(d) Implantable hearing devices (e.g., cochlear implant) must be precertified.

(e) All prosthetics over $5,000 must be precertified.

How to Request Precertification of Elective Hospital Admissions, Long-Term Acute Care Hospital Admissions and Major Transplant Services

You or your physician must call the UR Company at its telephone number shown on the Quick Reference Chart in the front of this section of the Handbook.

- Calls for elective services should be made at least 10 days before the expected date of service.
- The caller should be prepared to provide all of the following information: employer’s name; employee’s name; patient’s name, address, phone number and identification number; physician’s name and phone number or address; the name of any hospital, outpatient facility or any other health care provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.
- If additional information is needed, the UR Company will advise the caller. The UR Company will review the information provided and will let you, your physician and/or the hospital or other health care provider, and the Claims Administrator know whether the proposed health care services have been certified as medically necessary. The UR Company will usually respond to your treating physician or other health care provider by telephone within 15 days after it receives the request, and its determination will be confirmed in writing.
- If your admission or service is determined not to be medically necessary, you and your physician will be given information to pursue a UR appeal. See also Appealing a UR Determination in this section of the Handbook.

Emergency Hospitalization

If an emergency requires hospitalization, there may be no time to contact the UR Company or SRP Behavioral Health Program before you are admitted. If this happens, the UR Company or SRP Behavioral Health Program must be notified of the hospital admission within 48 hours. You, your physician, the hospital, a family member or a friend can make that phone call. This will enable the UR Company or SRP Behavioral Health Program to assist with discharge plans, determining the need for continued medical services, and/or advising your physician or other health care providers of the various recommendations, options and alternatives for your medical care.

Case Management

Case management is a voluntary program administered by the UR Company. Its medical professionals work with the patient, family, caregivers, health care providers, Claims Administrator and SRP to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly and/or high-technology services, and
when assistance is needed to guide patients through a maze of potential health care providers. See Restrictions and Limitations of the Utilization Review Program in this section of the Handbook.

**Working with the Case Manager**

Any Medical Plan participant, physician or other health care provider can request case management services by calling the UR Company at the telephone number shown on the Quick Reference Chart in the front of this section of the Handbook. In some cases, the UR Company may identify cases where the patient could benefit from case management services, and it will initiate services automatically.

The case manager of the UR Company will work directly with your physician, hospital and/or other specialized health care facility to assist in coordinating services and monitoring your progress. The case manager acts as an advocate for you and collaborates with your physician or other health care providers, and you and/or your family to assist in making plans for health care services, education and identification of available resources. You, your family or your physician may call the case manager at any time (at the telephone number shown on the Quick Reference Chart in the front of this section of the Handbook) to ask questions, make suggestions or offer information.

**Appealing a UR Determination (Appeals Process)**

You may request an appeal of any adverse review decision made during the precertification review process. The process to appeal an adverse review decision denial is described in Claim Filing and Appeals Information in this section of the Handbook.

**Penalty for Failure to Precertify**

**PPO Plan:** If you don’t follow the precertification review procedure(s), a penalty of $250 will be applied. This penalty will not be applied to meet your deductible or annual out-of-pocket maximum.

**EPO Plan:** If you don’t follow the precertification review procedure(s), a penalty of $250 will be applied. This penalty will not be applied to meet your deductible or annual out-of-pocket maximum.

**Information About Medicare Part D Prescription Drug Plans for People With Medicare**

If you and/or your dependent(s) are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D prescription drug benefits. It has been determined that the prescription drug coverage for the PPO Plan and EPO Plan options is “creditable.” “Creditable” means that the value of this Plan’s prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Because this Plan’s prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare prescription drug plan in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare prescription drug plan during Medicare’s annual enrollment period (November 15 through December 31 of each year).

You can keep your current medical and prescription drug coverage with this Plan, and you do not have to enroll in Medicare Part D. If, however, you keep this Plan coverage and also enroll in a Medicare Part D prescription drug plan, you will have dual prescription drug coverage and this Plan will coordinate its drug payments with Medicare. See the Coordination of Benefits chapter for more details on how the Plan coordinates with Medicare. If you enroll in a Medicare prescription drug plan, you will need to pay the Medicare Part D premium out of your own pocket.

Note that you may not drop just the prescription drug coverage under this Plan. That is because prescription drug coverage is part of the entire Medical Plan. Generally, you may only drop Medical Plan coverage at this Plan’s next Open Enrollment Period.
Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following three times:

- When they first become eligible for Medicare;
- During Medicare’s annual election period (from November 15 through December 31); or
- For beneficiaries leaving employer group health coverage, you may be eligible for a Special Enrollment Period in which to sign up for a Medicare prescription drug plan.

If you do not have creditable prescription drug coverage and you do not enroll in a Medicare prescription drug plan, you may have a late-enrollment fee on the premium you pay for Medicare coverage if and when you do enroll.

For more information about creditable coverage or Medicare Part D coverage, see the Plan’s Notice of Creditable Coverage (a copy is available from Benefits Services at its number on the Quick Reference Chart). See also www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

**Schedule of Medical Benefits**

A schedule of the Medical PPO’s and EPO’s medical benefits appears on the following pages in a convenient chart format. Each of the Medical Plan options’ (PPO’s and EPO’s) covered medical benefits is described in the first column. Explanations and limitations that apply to the covered benefits are shown in the second column. Specific differences in the benefits when they are provided in-network (by preferred PPO/EPO providers) and out-of-network are shown in the subsequent columns.

Physician and other health care practitioner services are listed first because this category of benefits applies to most (but not all) health care services covered by the Medical PPO or EPO. This is followed by descriptions, appearing in alphabetical order, of all other benefits for specific eligible expenses that are frequently subject to limitations and exclusions. Unless there is a specific statement in the Schedule of Medical Benefits in this section of the Handbook, all benefits shown are subject to the Medical PPO’s or EPO’s deductibles.

To determine the extent to which limitations apply to the benefits that are payable for any health care services or supplies you receive, you should also check to see if those services are listed separately in the Schedule of Medical Benefits in this section of the Handbook, even if they seem to be included in hospital services or physician and health care practitioner services, and you should also check Exclusions and Limitations: SRP Medical PPO or EPO Option in this section of the Handbook to see if they are excluded.
This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted. Certain services require precertification or else a financial penalty applies. IMPORTANT: Non-network providers are paid according to the allowed charge, as defined in the Definitions chapter, and could result in balance billing to you. If you reside outside the PPO service area (called out of area), non-network providers are payable at 80% instead of at the usual 70% coinsurance level.

**Lifetime Maximum Benefit**
- The lifetime maximum benefit is the maximum amount of benefits payable by any of the SRP-sponsored Medical Plan options and any previous medical expense plan provided by SRP.

**Deductible (Annual)**
- The deductible is the amount you must pay each calendar year before the Plan pays benefits. The amount applied to the deductible is the lesser of billed charges or the amount considered to be an allowed charge under this Plan.
- Under the PPO Plans, any eligible provider claim accumulates to meet the annual deductible.
- Participants who reside at least 50 miles outside the network service area (out of area) will have eligible claims adjudicated at 80% coinsurance instead of 70% coinsurance. See the row titled “Out of Area Provision” in this Schedule of Medical Benefits.

**Out-of-Pocket Maximum (Annual)**
- The out-of-pocket maximum only applies to the PPO Plan options, not the EPO Plan.
- Under the PPO Plans, certain services do not accumulate to the annual out-of-pocket maximum, including:
  - Any Plan deductible or copayment.
  - Any applicable coinsurance, up to the out-of-pocket maximum.
  - All charges for medical services or supplies that are not covered (excluded) by the Medical PPO Plans.
  - All charges in excess of the allowed charge (as defined in the Definitions chapter).
  - All charges in excess of the Medical PPO’s lifetime maximum, limited overall and/or annual maximum benefits.
  - Any additional other amounts you have to pay because you failed to comply with the utilization review programs described in Precertification: The Utilization Review (UR) Program in this Handbook.
  - Expenses incurred for retail and mail-order prescription drugs.

**Hospital Services (Inpatient)**
- Room and board facility fees in a semi-private room with general nursing services.
- Specialty care units (e.g., intensive care unit, cardiac care unit).
- Lab/X-ray/diagnostic services.
- Related medically necessary ancillary services (e.g., prescriptions, supplies).
- Newborn care.
- Elective hospitalizations (and long-term acute care admissions) are subject to precertification or else a financial penalty applies. All hospitalizations are subject to concurrent review. For details, see the Precertification: The Utilization Review (UR) Program in this section of the Handbook.
  - Room and board is limited to the semi-private room rate, or if the hospital has private rooms only, the private room rate billed.
  - EPO Plan: Routine inpatient newborn care is covered under the mother’s claim. If mother is not covered under the Plan, the newborn must be added to the Plan in order to be covered. The copay does not apply to the newborn delivery claims when the newborn is covered under this plan.
## SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted. Certain services require preauthorization or else a financial penalty applies. **IMPORTANT** Non-network providers are paid according to the allowed charge, as defined in the Definitions chapter, and could result in balance billing to you. If you reside outside the PPO service area (called out of area), non-network providers are payable at 80% instead of at the usual 70% coinsurance level.

### Benefit Description

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Explanations and Limitations</th>
<th>EPO Plan</th>
<th>$300/$600 PPO Plan</th>
<th>$1,000/$2,000 PPO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician and Other Health Care Practitioner Services</td>
<td>• Benefits are payable for professional fees when provided by a physician or other covered health care practitioner in an office, hospital, emergency room, urgent care center/facility or other covered health care facility location. &lt;br&gt; • Payable physicians and health care practitioner professional fees include: &lt;br&gt; » Surgeon, pathologist, radiologist &lt;br&gt; » Assistant surgeon (if medically necessary) &lt;br&gt; » Anesthesia provided by physicians and certified registered nurse anesthetists &lt;br&gt; » Podiatrist (DPM) &lt;br&gt; » Physician assistant (PA) &lt;br&gt; » Nurse practitioner (NP), certified nurse midwife (CNM) &lt;br&gt; » Audiologist &lt;br&gt; • Acupuncture is payable only as a means to administer anesthesia. &lt;br&gt; • Medical care is payable by a medicine man who has been certified by the Office of Native Healing Services, Navajo Health Authority, or a Northern Cheyenne or Crow medicine man (no deductible applies). &lt;br&gt; • Christian Science practitioner</td>
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<td></td>
<td>• The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of “surgery” in the Definitions section of this Handbook. &lt;br&gt; • Assistant surgeon fees (physician, physician assistant, registered nurse first assistant) will be reimbursed for medically necessary services to a maximum of 25% of the eligible allowed charge expenses payable to the primary surgeon. Certified surgical assistants (as that term is defined in the Definitions section of this Handbook) are not payable. &lt;br&gt; • Primary care physician (PCP) means a physician or other health care practitioner who practices general practice, family practice, internal medicine/internist, pediatrics or obstetrics/gynecology (OB/GYN). Osteopaths and chiropractors are also considered PCPs. All other physicians are considered specialists under this Plan. &lt;br&gt; • EPO Plan: Copay is per provider and applies to office visit charge, X-ray and lab services, injections, supplies, allergy testing and treatment, and minor office surgery. X-ray/lab sent to an independent lab from the physician’s office is included in the physician’s copay. &lt;br&gt; • Contraceptives administered in the office will be covered under the office visit. &lt;br&gt; • PPO Plans: No coverage for private duty nursing. &lt;br&gt; • EPO Plan: Private duty nursing is only covered for skilled nursing. Inpatient private duty nursing is not covered. &lt;br&gt; • Medicine man is payable to a maximum of $500 per family per calendar year. &lt;br&gt; • Routine foot care administered by a podiatrist is payable when medically necessary for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.</td>
<td>PCP office visit: 100% after a $15 copay per visit  &lt;br&gt; Specialist office visit: 100% after a $25 copay per visit  &lt;br&gt; All other eligible physician and health care practitioner services: 100%</td>
<td>90% after deductible met  &lt;br&gt; Non-network: 70% after deductible met  &lt;br&gt; Out of area: 80% after deductible met</td>
<td>100% after deductible met</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>• See Physician row in this Schedule of Medical Benefits regarding payment only when used as a means to administer anesthesia.</td>
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</table>
### SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted. Certain services require precertification or else a financial penalty applies. **IMPORTANT** Non-network providers are paid according to the allowed charge, as defined in the Definitions chapter, and could result in balance billing to you. If you reside outside the PPO service area (called out of area), non-network providers are payable at 80% instead of at the usual 70% coinsurance level.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Explanations and Limitations</th>
<th>EPO Plan (In-Network PPO Providers Only)</th>
<th>$300/$600 PPO Plan</th>
<th>$1,000/$2,000 PPO Plan</th>
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</table>
| **Allergy Services** | - Allergy services are covered only when ordered by a physician.  
- Desensitization injections are covered only when provided by a licensed health care practitioner.  
- Allergy antigen solution.  
- Allergy sensitivity testing, including skin patch or blood tests such as RAST or MAST.  
- Desensitization and hyposensitization (allergy shots given at periodic intervals).  
- Allergy service is covered only when ordered by a physician.  
- Desensitization injections are covered only when provided by a licensed health care practitioner.  
- Allergy antigen solution.  
- Allergy service is covered only when ordered by a physician.  
- Desensitization injections are covered only when provided by a licensed health care practitioner.  
- Allergy antigen solution. | Testing and treatment: 100%  
Office visit: Payable same as Physician Services row | Testing and treatment: 90% after deductible met  
Office visit: Payable same as Physician Services row | Testing and treatment: 90% after deductible met  
Office visit: Payable same as Physician Services row |
| **Ambulance Services** | - Expenses for ambulance services are covered only when those services are for an emergency, as that term is defined in the Definitions section of this Handbook.  
- No coverage for non-emergency transportation.  
- Ground vehicle transportation to the nearest appropriate facility as medically necessary for treatment of a medical emergency or acute illness, or for medically necessary inter-hospital transfers (e.g., transfers from one hospital to another hospital, or trip to and from one hospital to another in order to obtain a special test/procedure).  
- Air/sea transportation only as medically necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient’s health status. | 100% when authorized as medically necessary or when use is due to an emergency  
90% after deductible met | 90% after deductible met  
90% after deductible met | 90% after deductible met  
90% after deductible met |
| **Ambulatory Surgical Center** | - See the Outpatient (Ambulatory) Surgery Facility row in this Schedule of Medical Benefits. | | | |
SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted. Certain services require precertification or other financial penalty applies. IMPORTANT: Non-network providers are paid according to the allowed charge, as defined in the Definitions chapter, and could result in balance billing to you. If you reside outside the PPO service area (called out of area), non-network providers are payable at 80% instead of at the usual 70% coinsurance level.

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<tr>
<td>Behavioral Health Services</td>
<td>• Behavioral health services include EAP services, mental health services and substance abuse treatment.</td>
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<tr>
<td>EAP Services</td>
<td>• SRP offers up to 10 free visits to an EAP counselor per person per calendar year.</td>
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<td></td>
<td>• EAP notification/authorization will be required for all SRP EAP services.</td>
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<td>• EAP authorizations will be good for a 90-day period. However, you may request an extension if needed.</td>
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<td></td>
<td>• EAP claims filed WITHOUT notification/authorization WILL BE DENIED.</td>
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<tr>
<td></td>
<td>• Contact the EAP providers whose names and phone numbers are listed on the Quick Reference Chart in the front of this section of the Handbook.</td>
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</tr>
<tr>
<td>Outpatient and Inpatient Behavioral Health Services</td>
<td>• The benefits for outpatient and inpatient mental health and substance abuse services for both in-network and non-network providers are listed to the far right under the In-Network PPO Provider and Non-Network columns.</td>
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<tr>
<td>Blood Transfusions</td>
<td>• Blood transfusions and blood products and equipment for its administration.</td>
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<tr>
<td></td>
<td>• Covered only when ordered by a physician.</td>
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<tr>
<td></td>
<td>• Expenses related to autologous blood donation (patient's own blood) are covered prior to a covered surgery or treatment.</td>
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<tr>
<td></td>
<td>• Covered only when ordered by a physician.</td>
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<tr>
<td></td>
<td>• See the Wig/Hairpiece row in this Schedule of Medical Benefits for a description of when a wig or hairpiece is covered.</td>
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<tr>
<td></td>
<td>• Benefit payments may vary depending on the location in which the chemotherapy is delivered or received by the patient. For example, if chemotherapy is delivered in a hospital, the hospital services (inpatient) coverage applies; if it is delivered in a physician's office, see Physician's and Other Health Care Practitioners row in this Schedule of Medical Benefits.</td>
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</tr>
</tbody>
</table>
## Schedule of Medical Benefits

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted. Certain services require precertification or else a financial penalty applies. **Important**: Non-network providers are paid according to the allowed charge, as defined in the Definitions chapter, and could result in balance billing to you. If you reside outside the PPO service area (called out of area), non-network providers are payable at 80% instead of at the usual 70% coinsurance level.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Explanations and Limitations</th>
<th>EPO Plan (In-Network PPO Provider's Only)</th>
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</thead>
<tbody>
<tr>
<td>Chiropractic Services</td>
<td>• See the Non-Surgical Treatment of the Spine row in this Schedule of Medical Benefits.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Convalescent Care</td>
<td>• See the Skilled Nursing Facility row in this Schedule of Medical Benefits.</td>
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</tr>
</tbody>
</table>
| Corrective Appliances: Prosthetic and Orthotic Devices (Other Than Dental) | • Coverage is provided for medically necessary prosthetic and orthotic devices, including foot orthotics and colostomy/ostomy supplies, including:  
  » Rental when appropriate (but only up to the allowed purchase price of the device).  
  » Repair, adjustment or servicing of the device as is medically necessary.  
  » Replacement of the device is payable if there is a change in the covered person's physical condition making the current device inoperable or unsatisfactory in order to perform normal daily activities (as certified by the patient's physician), or if the device cannot be satisfactorily repaired.  
  • Corrective appliances, including foot orthotics, are covered only when ordered by a physician.  
  • Foot orthotics (orthopedic or supportive appliances for the feet): One pair of foot orthotics is payable for adults, to a maximum of $400 per pair per calendar year. Two pairs of foot orthotics are payable for children under age 19 years, to a maximum of $400 per pair per calendar year. This foot orthotic maximum does not include the cost of casting.  
  • Prosthetics (EPO and PPO plans): Prosthetics over $5,000 must be precertified. Prosthetics do not include self-help devices such as feeding utensils, reaching tools, and devices to assist in dressing and undressing.  
  • See the SRP Medical PPO Option’s Corrective Appliances Exclusions and Limitations in this section of this Handbook.  
  • See the "prosthetic appliance" and "orthotic appliance" in the Definitions section of this Handbook.  
  • See also the Wig row of this Schedule of Medical Benefits.  
  • See also the Hearing Benefits row in this Schedule of Medical Benefits. |
| Dialysis | • Covered only when ordered by a physician.  
  • Benefit payments may vary depending on the location in which the hemodialysis or peritoneal dialysis is performed or received by the patient.  
  • It is important that individuals with end-stage kidney/renal disease promptly apply for Medicare coverage, regardless of age. See also the Coordination of Benefits chapter that discusses what this Plan pays when you are also Medicare-eligible. |
| Dietitian Counseling | • Benefits are payable for nutritional counseling to assist individuals with their nutritional health and dietary needs. Services can be used for assistance with food choices when diagnosed with such diseases as obesity, high blood pressure, cardiac disease, diabetes, high cholesterol, allergies, kidney disease, etc.  
  • Services are payable only when performed by a registered dietitian or licensed or certified nutritionist.  
  • When prescribed by a physician or other health care practitioner, the services of a registered dietitian or licensed or certified nutritionist are payable to a maximum of three visits per person per calendar year, up to a lifetime maximum of $500 per person per condition.  
  • See the Nutrition row and Weight Loss row in this Schedule of Medical Benefits for additional information. |

### Breakdown of Coverage

- **100%**
- **90%** after deductible met
- **80%** after deductible met
- **70%** after deductible met
- **No deductible**
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<tbody>
<tr>
<td>Disease Education</td>
<td>In-Network PPO Provider</td>
<td>Non-Network PPO Provider</td>
<td>Non-Network PPO Provider</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
</tr>
</tbody>
</table>

- Covered only when ordered by a physician.
- Expenses reimbursed to a maximum of $500 per person per disease per lifetime and not subject to the deductible.
- Full reimbursement up to the Plan benefit will be made if the individual attends 80% or more of the classes. No reimbursement will be made if the individual attends less than 80% of the classes.
## SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted. Certain services require preauthorization or else a financial penalty applies. IMPORTANT: Non-network providers are paid according to the allowed charge, as defined in the Definitions chapter, and could result in balance billing to you. If you reside outside the PPO service area (called out of area), non-network providers are payable at 80% instead of the usual 70% coinsurance level.

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<th>Benefit Description</th>
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<tbody>
<tr>
<td><strong>Drugs (Outpatient Prescription Medicines)</strong></td>
<td></td>
</tr>
<tr>
<td>• Coverage is provided only for those pharmaceuticals (drugs and medicines) approved by the U.S. Food and Drug Administration (FDA) that require a prescription and are FDA approved for the condition, dose, route, duration and frequency, if prescribed by a physician or other health care practitioner authorized by law to prescribe them.</td>
<td>In-network retail pharmacy (up to a 30-day supply): Tier 1: $10 copay Tier 2: $25 copay Tier 3: $50 copay</td>
</tr>
<tr>
<td>• Coverage is provided for prenatal vitamins, prescription contraceptives such as birth control pills/patch, diaphragms, insulin and diabetic supplies (note that glucose meters are payable under Drug and Medical Equipment in this Schedule of Benefits), and self-administered injectables such as EpiPen and Glucagon. Vitamin A (e.g., Retin-A) skin products are payable up to age 25.</td>
<td>In-network retail pharmacy (up to a 30-day supply): Tier 1: $10 copay Tier 2: $25 copay Tier 3: $50 copay</td>
</tr>
<tr>
<td>• Contact the Prescription Drug Program (phone number is listed on the Quick Reference Chart in the front of this document) for:</td>
<td>Specialty pharmacy: $50</td>
</tr>
<tr>
<td>» The list of drugs on the Preferred Drug formulary tier.</td>
<td>Specialty pharmacy: $50</td>
</tr>
<tr>
<td>» Information on drugs needing preapproval by the clinical staff of the Prescription Drug Program.</td>
<td>Specialty pharmacy: $50</td>
</tr>
<tr>
<td>» Information on which drugs have a limit to the quantity payable by this Plan.</td>
<td>See the Direct Member Reimbursement provision to the left</td>
</tr>
<tr>
<td>• Specialty drugs are available on an outpatient basis only when ordered through and managed by the Prescription Drug Program. Specialty drugs are generally considered high-cost injectable, infusion, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique health concerns, and include items such as injectables for multiple sclerosis, rheumatoid arthritis or hepatitis. These drugs may need pre-certification, often require special handling, are dose-sensitive and are generally available only in a 30-day quantity.</td>
<td>See the Direct Member Reimbursement provision to the left</td>
</tr>
<tr>
<td>Prescription drug coverage offered under this Plan is creditable with Medicare Part D drug benefits.</td>
<td>See the Direct Member Reimbursement provision to the left</td>
</tr>
</tbody>
</table>

### The Prescription Drug Program: Benefits for prescription drugs are provided through the Plan’s Prescription Drug Program, whose name is listed on the Quick Reference Chart in the front of this section of the Handbook.

- **Retail drugs:** To obtain up to a 30-day supply of medications for the copay noted to the right, present your ID card to any in-network retail pharmacy. You can find the location of in-network retail pharmacies by contacting the Prescription Drug Program, whose name is listed on the Quick Reference Chart in the front of this section of the Handbook.

  - Have your doctor write the prescription for a 90-day supply with the appropriate refills.
  - Mail your prescription, copay and the mail-order form to the mail-order service of the Prescription Drug Program, whose name is listed on the Quick Reference Chart in the front of this section of the Handbook. Mail-order forms may be obtained from the Prescription Drug Program or SRP Benefits Services. Allow up to 14 days to receive your order.

  - Direct member reimbursement (DMR) for use of a non-network retail pharmacy: If you fill a prescription at a non-network pharmacy location, you will need to pay for the drug at the time of purchase and later send your drug receipt to the Prescription Drug Program using the DMR process as listed on the Quick Reference Chart in the front of this section of the Handbook. DMR forms may be obtained from the Prescription Drug Program or SRP Benefits Services. For eligible prescriptions, you will be reimbursed the cost of the drug minus the appropriate copay.

  - Copayments for outpatient prescription drugs are not applied to meet the Medical PPO deductible or out-of-pocket maximum.

  - New FDA-approved drugs will be covered by the Plan unless the class of drug is excluded under the Plan.

  - See drugs, medicines and nutrition exclusions in the Exclusions and Limitations: SRP Medical PPO Option in this section of the Handbook for more details. The following drugs/products are not payable: dental products, over-the-counter (OTC) medications, fertility/infertility drugs, growth hormones, and hair removal or hair growth products.

  - Note that if the cost of the drug is less than the copay/coinsurance, you pay just the drug cost.

  - Weight loss drugs are payable at 50% up to $1,000/year.

  - Up to nine diabetic supplies for a $50 copay through the mail order.

### Coverage and Benefits

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<tr>
<td>In-Network PPO Provider Only</td>
<td>In-Network PPO Provider</td>
<td>Non-Network</td>
</tr>
<tr>
<td><strong>Weight loss drugs:</strong></td>
<td><strong>Weight loss drugs:</strong></td>
<td><strong>Weight loss drugs:</strong></td>
</tr>
<tr>
<td>50% up to $1,000 per year</td>
<td>50% up to $1,000 per year</td>
<td>50% up to $1,000 per year</td>
</tr>
<tr>
<td><strong>Weight loss drugs:</strong></td>
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</table>
| Durable Medical Equipment (DME) | • Coverage is provided for medically necessary DME, including:  
  » Rental (but only up to the allowed purchase price of the DME).  
  » Repair, adjustment or servicing of medically necessary DME is payable.  
  » Replacement of medically necessary DME is payable if there is a change in the covered person’s physical condition or if the equipment cannot be satisfactorily repaired at a lesser expense.  
  • Coverage is provided for medically necessary oxygen, along with the medically necessary equipment and supplies required for its administration.  
  • Blood glucose meters for diabetics.  
  • DME over $5,000 requires precertification. For details, see the Precertification: The Utilization Review (UR) Program in this section of the Handbook.  
  • DME is covered only when its use is medically necessary and it is ordered by a physician or health care practitioner.  
  • Anti-embolism stockings (useful in preventing thrombophlebitis of the legs and for treating varicose veins): Up to four anti-embolism stockings (two pairs) are payable per person per calendar year.  
  • See Exclusions and Limitations: SRP Medical PPO Option related to corrective appliance and DME.  
  • To help determine what DME is covered, see the definition of “durable medical equipment” in the Definitions section of this Handbook. | 100% | 90% after deductible met | 90% after deductible met | 90% after deductible met | 90% after deductible met | 90% after deductible met | 90% after deductible met | 90% after deductible met | 90% after deductible met |
| Emergency Room Facility, Urgent Care Facility | • Hospital emergency room (ER) facility for a medical emergency.  
  • Urgent care facility (includes all covered charges billed by facility).  
  • Ancillary charges (such as lab or X-ray) performed during the ER or urgent care visit.  
  • See also Ambulance Services in this Schedule of Medical Benefits. | Emergency room: You pay a $100 copay per visit, then the Plan pays balance at 100%; copay waived if admitted. | 90% after deductible met | 90% after deductible met | 90% after deductible met | 90% after deductible met | 90% after deductible met | 90% after deductible met | 90% after deductible met | 90% after deductible met |
### SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information. All benefits are subject to the deductible except where noted. Certain services require pre-certification or else a financial penalty applies. **IMPORTANT** Non-network providers are paid according to the allowed charge, as defined in the Definitions chapter, and could result in balance billing to you. If you reside outside the PPO service area (called out of area), non-network providers are payable at 80% instead of at the usual 70% coinsurance level.

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<tbody>
<tr>
<td><strong>Family Planning, Fertility, Reproductive and Sexual Dysfunction Services</strong></td>
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<tr>
<td>• Prescription contraceptives such as oral birth control pills/patches, injectables (e.g., Depo-Provera, Lunelle), diaphragms, intrauterine devices (IUDs), cervical caps, contraceptive rings and implantable birth control devices/services (e.g., implanton). Certain contraceptives are payable under the Drugs row in this Schedule of Medical Benefits.</td>
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<td>• Medication for the treatment of sexual dysfunction (erectile dysfunction) is payable under the Drugs benefit in this Schedule of Medical Benefits.</td>
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<tr>
<td><strong>Genetic Testing and Counseling</strong></td>
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<tr>
<td>• Amniocentesis, chorionic villus sampling (CVS) and alphafetoprotein (AFP) analysis in pregnant women as ordered by the physician.</td>
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<tr>
<td>• Genetic counseling provided before and/or after the tests listed above.</td>
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<tr>
<td>• See Exclusions and Limitations: SRP Medical PPO Option related to genetic testing and counseling, other than those indicated here as covered, and prophylactic surgery or treatment.</td>
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<tbody>
<tr>
<td>Hearing Aid Benefits</td>
<td>• Hearing aid:</td>
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<tr>
<td></td>
<td>» Payable up to $1,000 per ear. Implantable hearing aids are not subject to this limitation.</td>
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<td></td>
<td>» Covered hearing aid items may be reimbursed only once every three calendar years while enrolled in an SRP-sponsored Medical Plan option.</td>
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<tr>
<td></td>
<td>» Retirees and their dependents and PERA employees and their dependents are not eligible for this hearing aid benefit.</td>
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<td></td>
<td>If coverage terminates, hearing aid benefits will only be payable if the hearing aid was prescribed and ordered before coverage terminated and was delivered within 30 days after coverage ended.</td>
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<tr>
<td></td>
<td>• Implantable hearing aid (e.g., cochlear implant): For individuals 1 year of age and older with severe to profound pre- or post-lingual hearing loss who have shown limited benefit from hearing aids.</td>
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<tr>
<td></td>
<td>» Surgical implant or internal components are payable.</td>
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<tr>
<td></td>
<td>» External components are paid as durable medical equipment.</td>
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<tr>
<td></td>
<td>» Must be medically necessary and preauthorized by the Utilization Review Company and must meet the following criteria: bilateral severe to profound hearing loss of at least 70 decibels or greater.</td>
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<tr>
<td></td>
<td>The following services, supplies and expenses are not covered: an audiology (hearing) examination, replacement of a hearing aid (for any reason) more than once every three calendar years from the date of purchase of the most recent hearing aid, batteries or other equipment not obtained at the time of purchase of the hearing aid, and repairs, servicing and alterations to a hearing aid.</td>
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**Hearing Aid Benefits**
- This benefit is available to regular full-time, three-quartertime and halftime employees as well as provisional employees and their dependents who are enrolled in a Medical Plan option sponsored by SRP. Retirees and their dependents and PERA employees and their dependents are not eligible for this hearing aid benefit.
- This benefit consists of medically necessary hearing aid devices.
- Hearing aid must be prescribed by a qualified audiologist. Audiologist is payable like a specialist under the Physician and Other Health Care Practitioner Services row in this Schedule of Medical Benefits.
- You must also present evidence to the Claims Administrator that a physician certifies that the covered person has a hearing loss that may be improved by use of a hearing aid device.
- The hearing aid benefit includes the following: ear molds, initial batteries, cords and necessary ancillary equipment for the hearing aid, hearing aid warranty and a 30-day follow-up consultation for hearing aid.
- **80% of reasonable and customary charges; not subject to deductible.**

**Implantable hearing aid (e.g., cochlear implant):**
- For individuals 1 year of age and older with severe to profound pre- or post-lingual hearing loss who have shown limited benefit from hearing aids.
- **Surgical implant or internal components are payable.**
- **External components are paid as durable medical equipment.**
- **Must be medically necessary and preauthorized by the Utilization Review Company and must meet the following criteria: bilateral severe to profound hearing loss of at least 70 decibels or greater.**

**Not Covered:**
- Audiology (hearing) examination
- Replacement of a hearing aid (for any reason) more than once every three calendar years from the date of purchase of the most recent hearing aid
- Batteries or other equipment not obtained at the time of purchase of the hearing aid
- Repairs, servicing and alterations to a hearing aid

**90% after deductible met**
- Out of area: 80% after deductible met

**90% after deductible met**
- Out of area: 80% after deductible met

| 100% | 90% after deductible met | Non-network: 70% after deductible met | Out of area: 80% after deductible met | Non-network: 70% after deductible met | Out of area: 80% after deductible met |
SCHEDULE OF MEDICAL BENEFITS

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| **Home Health Care and Home Infusion Services** | - Home health care and home infusion therapy services to the extent that such services and supplies are medically necessary. Covered charges are the actual costs charged by a home health or infusion therapy agency for:  
  » Part-time or intermittent nursing care by or under the direct supervision of a registered nurse;  
  » Part-time or intermittent home care by a home health aide;  
  » Physical, occupational or speech therapy and medical social services as ordered by a physician;  
  » Drugs and medicines (requiring a physician’s prescription) and other supplies prescribed by the attending physician; and  
  » Laboratory services (if unable to use an outpatient laboratory specimen drawing location).  
  - Home health care and home infusion services are covered only when ordered by a physician.  
  - Home hospice coverage is payable under Hospice Services in this Schedule of Medical Benefits.  
  - Home physical therapy services coverage is payable under Rehabilitation Services in this Schedule of Medical Benefits.  
  - Covered medications that are available via retail or mail-order pharmacy are to be paid under Drugs (Outpatient Prescription Medicines) benefit in this Schedule of Medical Benefits.  
  - Home health aide services are payable only when the patient is also receiving medically necessary skilled home care services.  
  - See Exclusions and Limitations: SRP Medical PPO Option related to home health care in this section of the Handbook. | 100% 100% 90% after deductible met Non-network: 70% after deductible met Non-network: 70% after deductible met Non-network: 70% after deductible met Non-network: 70% after deductible met | Non-network: 70% after deductible met Non-network: 70% after deductible met Non-network: 70% after deductible met Non-network: 70% after deductible met |
| **Hospice Services** | - Inpatient hospice facility or home hospice services as provided by a qualified hospice organization.  
  - Hospice is a program of palliative and supportive health care services providing physical, psychological, social, and spiritual care for terminally ill persons assessed to have a life expectancy of six months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home hospice services) or in a homelike setting (inpatient hospice), with emphasis on keeping the patient as comfortable and free from pain as possible and providing emotional support to the patient and his or her family.  
  - Covered when ordered by a physician.  
  - Covered hospice charges apply to covered individuals who in the opinion of the attending physician have no reasonable prospect of cure and are expected to live no longer than six months.  
  - Hospice care consists of inpatient hospice or home hospice care, nursing care, counseling, and other supportive services and supplies provided to meet the physical, psychological, spiritual and social needs of the dying individual. Drugs/medications requiring a physician’s prescription are payable through this hospice benefit and through the Drugs benefit as described in this Schedule of Medical Benefits.  
  - Hospice services are payable to a maximum of 365 days per lifetime, with a maximum daily allowance of $500 per day.  
  - Bereavement counseling is payable under the SRP Behavioral Health Program. | 100% 90% after deductible met 90% after deductible met 90% after deductible met Non-network: 70% after deductible met Non-network: 70% after deductible met Non-network: 70% after deductible met Non-network: 70% after deductible met | Non-network: 70% after deductible met Non-network: 70% after deductible met Non-network: 70% after deductible met Non-network: 70% after deductible met |
| **Laboratory Services (Outpatient)** | - Technical and professional fees.  
  - Inpatient laboratory services are covered under the Hospital Services section of this Schedule of Medical Benefits.  
  - Covered only when ordered by a physician or health care practitioner. | 100% 90% after deductible met Non-network: 70% after deductible met Non-network: 70% after deductible met Non-network: 70% after deductible met Non-network: 70% after deductible met | Non-network: 70% after deductible met Non-network: 70% after deductible met Non-network: 70% after deductible met Non-network: 70% after deductible met |
## SCHEDULE OF MEDICAL BENEFITS

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<tr>
<td>Maternity Services</td>
<td>• Hospital length of stay for childbirth: This Plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a health care practitioner to obtain authorization from the Utilization Review Company for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending health care practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).</td>
<td>100% after a $25 copay for the initial office visit</td>
<td>Non-network: 70% after deductible met</td>
<td>Non-network: 70% after deductible met</td>
</tr>
<tr>
<td></td>
<td>• See also Special Enrollment in this section of the Handbook for coverage of newborn dependent children.</td>
<td>Hospital and birthing center facility: Refer to the inpatient hospital row in this Schedule</td>
<td>90% after deductible met</td>
<td>90% after deductible met</td>
</tr>
<tr>
<td></td>
<td>• See Exclusions and Limitations, SRP Medical PPO Option as related to maternity services in this section of the Handbook.</td>
<td>Non-network: 70% after deductible met</td>
<td>Out of area: 80% after deductible met</td>
<td>Non-network: 70% after deductible met</td>
</tr>
<tr>
<td></td>
<td>• See also Exclusions and Limitations, SRP Medical PPO Option as related to maternity services in this section of the Handbook.</td>
<td>Out of area: 80% after deductible met</td>
<td>90% after deductible met</td>
<td>90% after deductible met</td>
</tr>
<tr>
<td></td>
<td>• Termination of pregnancy is covered only when the attending physician certifies that the individual's health would be endangered if the fetus were carried to term, for complications from an abortion, or that the child will be born with significant congenital deformities or defects.</td>
<td>90% after deductible met</td>
<td>90% after deductible met</td>
<td>90% after deductible met</td>
</tr>
<tr>
<td>Nondurable Supplies</td>
<td>• Coverage is provided for medically necessary nondurable supplies dispensed and used by a physician or health care practitioner in conjunction with treatment of the covered individual.</td>
<td>100%</td>
<td>90% after deductible met</td>
<td>90% after deductible met</td>
</tr>
<tr>
<td></td>
<td>• Coverage is provided for up to a 31-day supply of home/personal use.</td>
<td></td>
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<tr>
<td></td>
<td>• Sterile surgical supplies used immediately after surgery.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>• Supplies needed to operate or use covered durable medical equipment (DME) or corrective appliances.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Diabetic supplies (e.g., insulin syringes, test strips, lancets, alcohol swabs) are covered under Drugs in this Schedule of Medical Benefits.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Blood glucose meters are covered as DME.</td>
<td></td>
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<td></td>
</tr>
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### Benefit Description

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<tr>
<td><strong>Non-Surgical Treatment of the Spine Services</strong></td>
<td>Payable to a maximum of $1,500 per person per calendar year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Treatment or services due to neuromusculoskeletal disorders by use of physical manipulations and related services (including an initial visit and X-rays) as administered by a physician or chiropractor.</td>
<td>100% after a $15 copay for PCP, including chiropractor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Massage therapy is payable under this maximum when services are under the direction of a physician or chiropractor.</td>
<td>90% after deductible met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Massage therapy is payable when such services are under the direction of a physician or chiropractor.</td>
<td>100% after a $25 copay for specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nutritional Guidance</strong></td>
<td>Conditions that must be met for payment of nutritional supplements are as follows:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Submission of a physician's written certification that the consequence of the patient's not taking the supplement is either premature loss of life or irreversible major damage to the patient's health;</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The supplement is not used by the other members of the family unless condition 1 above also applies to them; and</td>
<td>90% after deductible met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The supplement is used primarily for reasons other than the patient's comfort.</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oral and Craniofacial Services</strong></td>
<td>Oral or craniofacial surgery is limited to cutting procedures to remove tumors, cysts, or abscesses, or for acute injury, and for reconstructive but not cosmetic purposes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oral and/or craniofacial surgery.</td>
<td>Oral, craniofacial services: 90% after deductible met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Accidental injury to teeth/jaw.</td>
<td>Oral, craniofacial services: Non-network: 70% after deductible met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oral and Craniofacial Services</strong></td>
<td>Oral, craniofacial services: Out of area: 80% after deductible met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Treatment of accidental injuries to the teeth: This Medical Plan will pay for treatment of certain accidental injuries to the teeth and jaw when, in the opinion of the Plan Administrator or its designee, all of the following conditions are met:</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• The accidental injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting);</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and</td>
<td>Accidental injury to teeth: 100%, no deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The dental treatment will return the person's teeth to their pre-injury level of health and function. The dental treatment provider is encouraged to seek pre-treatment approval from the Plan Administrator for dental work. (Under this Plan, approved dental treatment is payable under the Medical Plan without regard to whether there is also associated Dental Plan coverage.) See also the definition of &quot;injury to teeth&quot; in the Definitions section of this Handbook.</td>
<td>100%, no deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• No coverage for treatment of temporomandibular joint syndrome.</td>
<td>100%, no deductible</td>
<td></td>
<td></td>
<td></td>
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# SCHEDULE OF MEDICAL BENEFITS

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<tr>
<td><strong>Outpatient (Ambulatory) Surgery Facility</strong></td>
<td>Covered only when ordered by a physician. Under certain circumstances, the Medical Plan will pay for outpatient facility fees and anesthesia associated with medically necessary dental services if the Claims Administrator determines that outpatient surgery facility care is medically necessary to safeguard the health of the patient during performance of dental services. No payment is extended toward the dentist or any assistant dental provider fees under this Medical Plan. Physician fees are payable under the Physician Services section of this Schedule of Medical Benefits.</td>
<td>100% 90% after deductible met</td>
<td>Non-network: 70% after deductible met Out of area: 80% after deductible met</td>
<td>Non-network: 70% after deductible met</td>
</tr>
<tr>
<td><strong>Preadmission Testing (Outpatient)</strong></td>
<td>Covered only when ordered by a physician or health care practitioner. Laboratory tests, X-rays and other medically necessary tests performed on an outpatient basis prior to a scheduled hospital admission or outpatient surgery.</td>
<td>100% 90% after deductible met</td>
<td>Non-network: 70% after deductible met Out of area: 80% after deductible met</td>
<td>Non-network: 70% after deductible met</td>
</tr>
<tr>
<td><strong>Radiology (X-ray), Nuclear Medicine and Radiation Therapy Services (Outpatient)</strong></td>
<td>Covered only when ordered by a physician or health care practitioner. Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.</td>
<td>100% 90% after deductible met</td>
<td>Non-network: 70% after deductible met Out of area: 80% after deductible met</td>
<td>Non-network: 70% after deductible met</td>
</tr>
<tr>
<td><strong>Reconstructive Services and Breast Reconstruction After Mastectomy</strong></td>
<td>Reconstrctive surgery is payable only if such procedures or treatment are intended to improve bodily function and/or to correct deformity resulting from disease, infection, trauma or congenital anomaly that causes a functional defect or results from a prior covered therapeutic procedure. See the Exclusions and Limitations: SRP Medical PPO-Option as related to cosmetic services (including reconstructive surgery). Most cosmetic and dental (including orthognathic) services are excluded from coverage.</td>
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### SCHEDULE OF MEDICAL BENEFITS

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<tr>
<td><strong>Rehabilitation Services: Cardiac and Pulmonary</strong></td>
<td>• Cardiac or pulmonary rehabilitation programs must be medically necessary and ordered by a physician.</td>
<td>Cardiac rehab: 100% after a $15 copay per visit</td>
<td>90% after deductible met</td>
<td>90% after deductible met</td>
</tr>
<tr>
<td></td>
<td>• Cardiac rehabilitation is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.).</td>
<td>Non-network: 70% after deductible met</td>
<td>Out of area: 80% after deductible met</td>
<td>Non-network: 70% after deductible met</td>
</tr>
<tr>
<td></td>
<td>• Pulmonary rehabilitation is available to those individuals with a chronic respiratory disorder (e.g., emphysema, COPD) who are able to actively participate in a pulmonary rehabilitation program that is likely to improve their respiratory condition, as determined by the Plan Administrator or its designee.</td>
<td>Out of area: 80% after deductible met</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitation Services (Physical, Occupational and Speech Therapy)</strong></td>
<td>• Outpatient: Maximum 60 visits per person per year.</td>
<td>100% after a $15 copay per visit</td>
<td>90% after deductible met</td>
<td>90% after deductible met</td>
</tr>
<tr>
<td></td>
<td>• Inpatient: Maximum 60 days per person per illness or injury.</td>
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<tr>
<td></td>
<td>• Rehabilitation services are covered only when ordered by a physician. A treatment plan may be requested. Treatment beyond the original treatment plan may require review of the prognosis report for payment.</td>
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<tr>
<td></td>
<td>• See Exclusions and Limitations: SRP Medical PPO Option, as related to rehabilitation therapies.</td>
<td></td>
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<tr>
<td></td>
<td>• Maintenance rehabilitation and coma stimulation services are not covered.</td>
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</tr>
<tr>
<td></td>
<td>• Speech therapy:</td>
<td></td>
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<tr>
<td></td>
<td>» Speech therapy is covered if the services are provided by a licensed or duly qualified speech therapist for functional purposes, including but not limited to a speech impediment, stuttering, lisping, inability to pronounce certain letters, tongue thrusting, stammering, conditions of psychoneurotic origin or childhood developmental speech delays and disorders, is excluded from coverage.</td>
<td></td>
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<tr>
<td></td>
<td>» Speech therapy for developmental delays is not covered unless associated with the diagnosis of autism. Speech therapy for restorative is covered.</td>
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</tr>
<tr>
<td></td>
<td>» Biofeedback is payable if provided by a covered provider as defined under the Medical PPO for treatment of chronic pain, headaches, anxiety, muscle spasms or stress. If biofeedback is for a behavioral health disorder, the appropriate behavioral health benefits will apply.</td>
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### Second and Third Physician Opinions

See the Physician row in the Schedule of Medical Benefits.
**SCHEDULE OF MEDICAL BENEFITS**

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<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>• SNF coverage is payable to the benefit maximum so long as the attending physician continues treatment and certifies that continuation of such confinement is necessary for treatment of the injury or sickness requiring such confinement.</td>
<td>100%</td>
<td>90% after deductible met</td>
<td>90% after deductible met</td>
</tr>
<tr>
<td></td>
<td>Non-network: 70% after deductible met</td>
<td>Out of area: 80% after deductible met</td>
<td>Non-network: 70% after deductible met</td>
<td>Out of area: 80% after deductible met</td>
</tr>
</tbody>
</table>

- Extended care/SNF.
- SNF services are payable when medically necessary to a maximum of 365 days for the same or a related injury or illness when the attending physician determines that 24-hour nursing care is essential for recuperation from an injury or illness.
- SNF services include room and board and other ancillary services provided during the SNF admission.

- See the Non-Surgical Treatment of the Spine Services row in this Schedule.

**Spinal Manipulation**

- See the Non-Surgical Treatment of the Spine Services row in this Schedule.

**Teeth: Treatment for Accidental Injury**

- See the Oral and Craniofacial Services row in this Schedule.

**Tobacco/Smoking Cessation Support**

- See the Wellness row in this Schedule.

**Transplants (Organ and Tissue)**

- Coverage is provided for eligible services directly related to non-experimental transplants of human organs or tissue including only the following: bone marrow, cornea, heart, heart/lung, lung, kidney, liver, pancreas or skin, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies.
- Organ or tissue procurement fees. Donor charges are covered if recipient is covered under the Plan and donor has no other coverage.

- Transplantation services require precertification. See Precertification, the Utilization Review (UR) Program in this section of the Handbook.
- See Exclusions and Limitations: SRP Medical PPO Option as it relates to experimental and investigational services and transplants.

- Physician services payable according to the Physician Services row of the Schedule.
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<td><strong>Vision Services</strong></td>
<td>• For additional vision benefits, see the SRP Vision Plan in this section of the Handbook.</td>
</tr>
<tr>
<td>- One pair of contact lenses or eyeglasses is payable under this Medical Plan only if required to assist eye refraction after a surgery to remove the lens of the eye.</td>
<td></td>
</tr>
<tr>
<td>- Kerato-refractive astigmatism treatment or surgery that changes the shape of the cornea, such as radial keratotomy and keratoplasty surgery, is payable only if corrected vision in the operated eye is worse than 20/70 and vision can only be corrected to 20/70 or better by such surgery.</td>
<td></td>
</tr>
<tr>
<td><strong>Weight Loss Assistance</strong></td>
<td>• A weight loss program is reimbursed up to $100 per lifetime, not to include the cost for food.</td>
</tr>
<tr>
<td>- See also the Dietitian and Nutritional Guidance rows in this Schedule of Medical Benefits.</td>
<td></td>
</tr>
<tr>
<td>- Weight loss medication is payable at 50% up to $1,000 per year. Refer to the Drugs row in this Schedule of Medical Benefits.</td>
<td></td>
</tr>
<tr>
<td><strong>Wellness (Preventive) Program Well-Child Examinations and Immunizations</strong></td>
<td>• EPO Plan:</td>
</tr>
<tr>
<td>- Wellbaby/well-child care, including childhood immunizations.</td>
<td></td>
</tr>
<tr>
<td>- Adult wellness services, including routine physical examinations.</td>
<td></td>
</tr>
<tr>
<td>- Tobacco cessation (stop-smoking) assistance.</td>
<td></td>
</tr>
<tr>
<td>- Copay applies to office visit only, facility charges paid at 100%.</td>
<td></td>
</tr>
<tr>
<td>- Child wellness (under age 18 years) includes routine physical exams, X-rays, labs and childhood immunizations.</td>
<td></td>
</tr>
<tr>
<td>- Adult wellness (age 18 and older) includes physical exams, X-rays, labs, OB/GYN exams, all immunizations, colon exams, prostate/testicular exams, mammograms (age 40+), annual Pap smears (age 18+), PSA tests (age 50+) and colonoscopies (age 50+). These services performed under these age ranges are covered any other illness.</td>
<td></td>
</tr>
<tr>
<td>- PPO Plans:</td>
<td></td>
</tr>
<tr>
<td>- Child wellness (birth through 2 years old) includes but is not limited to routine physical exams, wellbaby exams, X-rays, labs and childhood immunizations. Benefits are payable to a maximum of $2,000 per child per calendar year.</td>
<td></td>
</tr>
<tr>
<td>- Adult wellness (age 3 years and older) includes but is not limited to physical exams, X-rays, labs and all immunizations. Benefits are payable to a maximum of $500 per calendar year. This maximum does not apply to mammograms (age 40+), annual Pap smears (age 18+), PSA tests (age 50+), and colonoscopies (age 50+).</td>
<td></td>
</tr>
<tr>
<td>- If your wellness/preventive care expenses exceed the annual calendar year maximum noted above, you are responsible for the charges in excess of the annual limit. Expenses that exceed the annual limit do not apply to the annual deductible or out-of-pocket maximum.</td>
<td></td>
</tr>
<tr>
<td>- Stop-smoking medication is reimbursed at 50% up to $300 per year. Stop-smoking program costs are reimbursed at 100% up to a $500 lifetime maximum.</td>
<td></td>
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<td>Wig/Hairpiece</td>
<td>* Payable to a maximum of $300 per person per lifetime, not subject to deductible.</td>
<td>100%</td>
<td>100%, no deductible</td>
<td>100%, no deductible</td>
</tr>
</tbody>
</table>

- A single wig or hairpiece is payable when hair loss is a result of a medical condition such as chemotherapy for cancer or as a result of a burn.
Exclusions and Limitations: SRP Medical PPO or EPO Option

The following is a list of services and supplies or expenses not covered by the SRP Medical PPO or EPO option. The Plan Administrator, and other plan fiduciaries and individuals to whom responsibility for the administration of the SRP Medical PPO or EPO Option has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. These exclusions are sorted into general exclusions that apply to all services and specific medical service exclusions that apply to certain specified services.

General Exclusions

1. Costs of reports, bills, etc.: Expenses for preparing medical reports, bills, disability/sick leave forms or claim forms; mailing, shipping or handling expenses; and charges for broken/missed appointments, charges for telephone calls, e-mailing charges, prescription refill charges, charges for disabled person license plates/automotive forms, interest charges, late fees, mileage costs, provider administration fees, concierge/retainer agreement/membership fees, special education and associated costs in conjunction with sign language education for a patient or family members, and/or photocopying fees (unless photocopy fees are related to medical records requested by the Medical PPO or EPO).

2. Educational services: Expenses for educational services, supplies or equipment, including but not limited to computers, software, printers, books, tutoring, visual aids, auditory aids, speech aids, programs to assist with auditory perception or listening/learning skills, and programs/services to remedy or enhance concentration, memory, motivation, behavior, developmental delay or self-esteem, etc., even if they are required because of an injury, illness or disability of a covered individual.

3. Employer-provided services: Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by SRP, or if benefits are otherwise provided under this Medical PPO or EPO or any other plan that SRP contributes to or otherwise sponsors.

4. Expenses exceeding maximum Medical PPO or EPO benefits: Expenses that exceed any Medical PPO or EPO benefit limitation, limited overall benefit maximum, annual maximum Medical PPO or EPO benefit, or overall ("lifetime") maximum Medical PPO or EPO benefit as described in Plan Design for the SRP Medical PPO or EPO Option in this section of the Handbook.

5. Expenses exceeding allowed charges: Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the allowed charge as defined in Definitions in this section of the Handbook.

6. Expenses incurred before or after coverage: Expenses for services rendered or supplies provided before the patient became covered under the Medical Plan or Dental Program; or after the date the patient’s coverage ends, except under those conditions described in COBRA Continuation Coverage in this section of the Handbook.

7. Experimental and/or investigational services: Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be experimental and/or investigational as defined in Definitions in this section of the Handbook.

8. Government-provided services: Any treatment or service that is compensated for or furnished by the U.S. government or any agency thereof except as required under Medicaid provisions or federal law or unless charges for treatment or service are imposed against the individual. For example, if an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs hospital or other military medical facility on account of a military-service-related illness or injury, benefits are not payable by the Plan.

Need more help? See the Quick Reference Chart in the front of this section.
9. **Failure to comply with medically appropriate treatment:** Expenses incurred by any covered individual who fails to comply with medically appropriate treatment, as determined by the Plan Administrator or its designee.

10. **Illegal act:** Expenses incurred by any covered individual for injuries resulting from or sustained as a result of commission, or attempted commission by the covered individual, of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the covered individual, unless such injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor. The Plan Administrator’s discretionary determination that this exclusion applies shall not be affected by any subsequent official action or determination with respect to prosecution of the covered individual (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.

11. **Leaving a hospital contrary to medical advice:** Hospital or other health care facility expenses if you leave the facility against the medical advice of the attending physician within 72 hours after admission.

12. **Medical students, interns or residents:** Expenses for the services of a medical student, intern or resident.

13. **Medically unnecessary services:** Services or supplies determined by the Plan Administrator or its designee not to be medically necessary as defined in Definitions in this section of the Handbook.

14. **Modifications of homes or vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a covered individual, including, without limitation, construction or modification of ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, handrails, emergency alert system, etc.

15. **No-cost services:** Expenses for services rendered or supplies provided for which a covered individual is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Medical PPO or EPO.

16. **No physician prescription:** Any treatment or service not recommended or prescribed by a physician or, where permitted under the Medical PPO or EPO, a health care practitioner, including a behavioral health practitioner, midwife, nurse practitioner, physician assistant, chiropractor, dentist or podiatrist. No coverage for certified surgical assistants.

17. **Personal comfort:** Expenses related to personal comfort services or items, including but not limited to guest meals, television, radio, VCR/DVD/CD or other similar devices, telephone, beautician/barber services, personal care kits, birth announcements and newborn photographs.

18. **Relatives providing services:** Expenses for services provided by any physician or other health care practitioner who is the parent, spouse, sibling (by birth or marriage), stepchild or child of the patient or covered employee.

19. **Services provided outside the United States:** Expenses for medical services or supplies rendered or provided outside the United States, except for treatment of an unexpected medical condition as determined by the Plan Administrator or its designee or for a medical emergency.

20. **Standby physicians or health care practitioners:** Expenses for any physician or other health care provider who did not directly provide or supervise medical services to the patient, even if the physician or health care practitioner was available to do so on a standby basis.

21. **Telephone calls:** Any and all telephone calls between a physician or other health care provider and any patient, other health care provider, Utilization Review Company, or any representative of the Medical PPO or EPO for any purpose whatsoever, including, without
limitation, communication with any representative of the Medical PPO or EPO or its Utilization Review Company for any purpose related to the care or treatment of a covered individual, consultation with any health care provider regarding medical management or care of a patient; coordinating medical management of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient’s care; discussing test results; initiating therapy or a plan of care that can be handled by telephone; providing advice to a new or established patient; providing counseling to anxious or distraught patients or family members.

22. **Internet/virtual office visit:** Expenses related to an online Internet consultation with a physician or other health care practitioner, also called a virtual office visit/consultation, physician-patient Web service or physician-patient e-mail service, including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online Internet provider.

23. **Travel contrary to medical advice:** Expenses incurred by any covered individual during travel if a physician or other health care provider has specifically advised against such travel because of the health condition of the covered individual.

24. **Travel expenses:** Expenses for and related to travel (non-emergency transportation, lodging, meals and related expenses) of a physician, health care practitioner, covered individual or family members.

25. **Workers’ Compensation:** Any treatment or service due to sickness that is covered by a Workers’ Compensation Act or other similar legislation, or due to an injury arising out of or in the course of any employment for wage or profit.

26. **War or similar event:** Any treatment or service resulting from war or any act of war declared or undeclared.

27. Expenses for **residential behavioral health care services.**

28. Expenses for **hypnosis or hypnotherapy/biofeedback.**

29. Expenses for **tests to determine the presence of or degree of a person’s attention deficit disorder, dyslexia or learning disorder.**

30. **Behavioral health care services:** Expenses for behavioral health care services related to adoption counseling; court-ordered behavioral health care services; custody counseling; developmental disabilities; dyslexia; learning disorders; family planning counseling; genetic testing and counseling; mental retardation; pregnancy counseling; transsexual counseling; and vocational disabilities.

31. **Expenses for which a third party is responsible:** Expenses for services or supplies for which a third party is required to pay are not covered. See the provisions relating to third-party liability in the Coordination of Benefits chapter in this Handbook for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.

32. **Expenses for applied behavioral analysis (ABA) therapy.** (ABA is the design, implementation, and evaluation of environmental modifications to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior.)

33. Expenses for **certified surgical assistants.**
Specific Medical Service Exclusions

Alternative/Complementary Health Care Services Exclusions

1. Expenses for acupuncture and/or acupressure, except acupuncture is payable only as a means to administer anesthesia. See the physician row on the Schedule of Medical Benefits.

2. Expenses for chelation therapy, except as may be medically necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.

3. Expenses for prayer, religious healing or spiritual healing (except services provided by a Christian Science practitioner or a medicine man as noted under Physician and Other Health Care Practitioner Services in the Schedule of Medical Benefits in this section of the Handbook).

4. Expenses for naturopathic, naprapathic and/or homeopathic services or treatments/supplies.

Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions

1. Expenses for any items that are not corrective appliances, orthotic devices, prosthetic appliances or durable medical equipment as defined in Definitions in this section of the Handbook, including but not limited to air purifiers, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, mattresses, waterbeds and air conditioners.

2. Expenses for replacement of lost, missing or stolen, duplicate or personalized corrective appliances, orthotic devices, prosthetic appliances or durable medical equipment.

3. Expenses for corrective appliances and durable medical equipment to the extent they exceed the cost of standard models of such appliances or equipment, unless as determined by the Plan Administrator or its designee, the standard model is unable to meet the medical needs of the patient.

4. Expenses for occupational therapy (orthotic) supplies and devices needed to assist a person in performing activities of daily living (ADLs), including but not limited to self-help devices such as feeding utensils, reaching tools, and devices to assist in dressing and undressing.

5. Expenses for nondurable supplies, except as payable under Nondurable Supplies in the Schedule of Medical Benefits in this section of the Handbook.

Cosmetic Services Exclusions

1. Surgery or medical treatment to improve or preserve physical appearance but not physical function. Cosmetic surgery or treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical or surgical treatment intended to restore or improve physical appearance or restore self-esteem as determined by the Plan Administrator or its designee. The Medical PPO and EPO do cover medically necessary reconstructive services. To determine the extent of this coverage, see Reconstructive Services in the Schedule of Medical Benefits in this section of the Handbook. Medical PPO or EPO participants should use the Medical PPO’s or EPO’s precertification procedure to determine if a proposed surgery or service will be considered cosmetic surgery or medically necessary reconstructive services. Refer to Precertification: The Utilization Review (UR) Program in this section of the Handbook.
Custodial Care Exclusions

1. Expenses for custodial care as defined in Definitions in this section of the Handbook, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, personal care, or sitter/companion service, except when custodial care is provided as part of a covered hospice program or when the services of home health aides are payable under home health care services in the Schedule of Medical Benefits in this section of the Handbook.

2. Services required to be performed by physicians, nurses or other skilled health care providers are not considered to be custodial care services and are covered if they are determined by the Plan Administrator or its designee to be medically necessary. However, any services that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary.

Dental Services Exclusions

1. Expenses for dental prosthetics such as dentures or bridges, or dental services or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, illness or injury affecting the mouth or another part of the body.

2. Expenses for dental services may be covered under the Medical PPO or EPO if they are incurred for the repair or replacement of accidental injury to teeth or restoration of the jaw if damaged by an external object in an accident. For the purposes of this coverage by the Medical PPO or EPO, an accident does not include any injury caused by biting or chewing. See Oral and Craniofacial Services in the Schedule of Medical Benefits in this section of the Handbook to determine if services are covered.

3. Expenses for the treatment of temporomandibular joint (TMJ) dysfunction or syndrome, as defined in Definitions in this section of the Handbook.

4. Expenses for orthognathic services/surgery for treatment of prognathism, retrognathism and TMJ syndrome, and other cosmetic reasons.

5. Expenses for oral surgery to remove teeth, including wisdom teeth, gingivectomies, treatment of dental abscesses and root canal (endodontic) therapy. For payable oral surgery services, see Oral and Craniofacial Services in the Schedule of Medical Benefits in this section of the Handbook.

Drugs, Medicines and Nutrition Exclusions

1. Pharmaceuticals requiring a prescription that have not been approved by the U.S. Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed (i.e., are used “off-label”); or are experimental and/or investigational as defined in Definitions in this section of the Handbook.

2. Non-prescription (or non-legend or over-the-counter) drugs or medicines, except insulin.

3. Foods and nutritional supplements, including but not limited to home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), except when medically necessary as provided during hospitalization, for prenatal vitamins or minerals requiring a prescription, or for nutritional supplements as listed in Nutritional Guidance in the Schedule of Medical Benefits in this section of the Handbook.

4. Naturopathic, naprapathic or homeopathic services and substances.

5. Drugs, medicines or devices for:
   - Fertility or infertility
   - Dental products such as fluoride preparations and products for periodontal disease

Need more help? See the Quick Reference Chart in the front of this section.
• Growth hormone
• Hair removal or hair growth products (e.g., Propecia, Rogaine, Minoxidil, Vaniqa)
• Vitamin A derivatives (retinoids) for dermatologic use (e.g., Retin A) for individuals over the age of 25

6. Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal or state law.

7. Take-home drugs or medicines provided by a hospital, emergency room, ambulatory surgical facility/center or other health care facility.

8. Vaccinations, immunizations, inoculations or preventative injections, except those provided under wellness for children and/or adults (including out-of-country immunizations); and those required for treatment of an injury or exposure to disease or infection (such as antirabies, tetanus, anti-venom or immunoglobulin).

9. Drugs requiring a prescription by state law but not by federal law.

**Durable Medical Equipment Exclusions**

(See Exclusions and Limitations: SRP Medical PPO or EPO Option in this section of the Handbook as they relate to corrective appliances, durable medical equipment and nondurable supplies.)

**Fertility and Infertility Services Exclusions**

Expenses related to treatment of infertility involving prescription drugs. Note that the Plan has a limitation on the treatment of infertility that applies to in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate expenses, donor egg/semen or other related fees, cryostorage of egg or sperm, adoption, ovarian transplant, infertility donor expenses and reversal of sterilization procedures. See Fertility Benefits in the Schedule of Medical Benefits in this section of the Handbook.

**Foot/Hand Care Exclusions**

1. Expenses for routine foot care (including but not limited to trimming of toenails, removal of corns and calluses, and hygienic/preventive care with assessment of pulses, skin condition and sensation) or hand care, including manicure and skin conditioning, unless the Plan Administrator or its designee determines such care to be medically necessary. Exception: Note that routine foot care from a podiatrist is payable for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.

**Genetic Testing and Counseling Exclusions**

1. **Genetic testing:** Expenses for genetic tests, including obtaining a specimen and laboratory analysis to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, including pre-parental genetic testing that is intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents.

   Note that certain prenatal genetic testing and associated counseling for amniocentesis, chorionic villus sampling (CVS), fetoscopy and alphafetoprotein (AFP) analysis in pregnant women are payable as listed in Genetic Testing and Counseling in the Schedule of Medical Benefits in this section of the Handbook.

2. **Genetic counseling:** Expenses for genetic counseling, unless related to a covered genetic testing benefit.

   See also the exclusion related to Prophylactic Surgery or Treatment in this section of the Handbook.
Hair Exclusions
1. Expenses for hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine and Vaniqa; or for hair replacement devices, including but not limited to wigs, toupees and hairpieces or hair analysis. **Note:** A single wig or hairpiece is covered as listed in Wig/Hairpiece in the Schedule of Medical Benefits in this section of the Handbook.

Home Health Care Exclusions
1. Expenses for any home health care services other than part-time, intermittent skilled nursing services and supplies, except when the services of home health aides are payable under Home Health Care and Home Infusion Services in the Schedule of Medical Benefits in this section of the Handbook.
2. Expenses under a home health care program for services that are provided by someone who ordinarily lives in the patient’s home or is a parent, spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a physician.
3. Expenses for a homemaker, custodial care, child care, adult care or personal care attendant, except as provided under the SRP Medical PPO’s or EPO’s hospice coverage, and when custodial care is provided by home health aides that are payable under Home Health Care and Home Infusion Services in the Schedule of Medical Benefits in this section of the Handbook.

Maternity/Family Planning Exclusions
1. Expenses for elective termination of pregnancy (abortion) unless the attending physician certifies that the health of the woman would be endangered if the fetus were carried to term, or the child will be born with significant congenital deformity or defect, or for medical complications arising from an abortion.
2. Expenses related to cryostorage of umbilical cord blood or other tissue or organs.

Nondurable Supplies
(See Exclusions and Limitations: SRP Medical PPO or EPO Option related to corrective appliances, durable medical equipment and nondurable supplies.)

Nursing Care Exclusions
1. Expenses for services of private-duty nurses.

Prophylactic Surgery or Treatment Exclusions
1. Expenses for all medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery as defined in Definitions in this section of the Handbook, when the services, procedures, prescription of drugs or prophylactic surgery is prescribed or performed for the purpose of:
   - Avoiding the possibility or risk of an illness, disease, physical or mental disorder, or condition based on family history and/or genetic test results; or
   - Treating the consequences of chromosomal abnormalities or genetically transmitted characteristics when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, except when the services or procedures are based on the results of amniocentesis, chorionic villus sampling (CVS) or alphafetoprotein (AFP) analysis.
PPO and EPO participants should use the PPO’s and EPO’s precertification procedure to determine if proposed surgery is covered or excluded as prophylactic surgery. Refer to Precertification: The Utilization Review (UR) Program in this section of the Handbook.

Rehabilitation Therapy Exclusions (Inpatient or Outpatient)

1. Expenses for educational, job training, vocational rehabilitation and/or special education for sign language.
2. Expenses for Rolfing (deep massage).
3. Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose or in the judgment of the Plan Administrator or its designee, or is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including but not limited to coma stimulation programs and services.
4. Expenses for maintenance rehabilitation as defined in Definitions in this section of the Handbook.
5. Expenses for speech therapy for functional purposes, including but not limited to a speech impediment, stuttering, lisping, inability to pronounce certain letters, tongue thrusting, stammering, conditions of psychoneurotic origin or developmental speech delay.

Smoking Cessation or Tobacco Withdrawal Exclusions

1. Expenses for over-the-counter tobacco/smoking cessation products, such as non-prescription nicotine gum or patches.

Sexual Dysfunction Services Exclusions

1. Expenses for medical supplies and/or medical or surgical treatment of sexual dysfunction or inadequacy, and any complications thereof.
2. Expenses for medical, surgical or prescription drug treatment related to transsexual (sex change) procedures, or the preparation for such procedures, such as psychological counseling or hormone therapy, or any complications resulting from such services or procedures.

Transplant (Organ and Tissue) Exclusions

1. Expenses for human organ and/or tissue transplants that are experimental and/or investigational, including but not limited to donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, postoperative services and drugs or medicines, and all complications thereof, except those transplant services as described under Transplants in the Schedule of Medical Benefits in this section of the Handbook.
2. Expenses related to non-human (xenografted) organ and/or tissue transplants or implants, except heart valves.
3. Expenses for insertion and maintenance of an artificial heart or other organ or related device, including complications thereof, except heart valves and kidney dialysis.
4. Expenses incurred by the person who donates the organ or tissue, unless the person who receives the donated organ or tissue is the person covered by the Medical PPO or EPO.
Vision Care Exclusions

1. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures, including but not limited to radial keratotomy (RK) and automated lamellar keratoplasty (ALK), or laser-assisted in-situ keratomileusis (LASIK), or orthokeratology lenses for reshaping the cornea of the eye to improve vision, except when such services are payable as listed under Vision Services in the Schedule of Medical Benefits in this section of the Handbook.

2. Expenses for diagnosis and treatment of refractive errors, including vision screening, eye examinations, purchase, fitting and repair of eyeglasses or lenses, and associated supplies, except one pair of eyeglasses or contact lenses provided as a prosthetic device following surgery to remove the lens of the eye. See also SRP Vision Plan in this section of the Handbook.

3. Vision therapy (orthoptics) and supplies.

Weight Management and Physical Fitness Exclusions

1. Expenses for gastric restrictive, gastric stapling, gastric banding, intestinal bypass and reversal procedures, and similar weight management procedures, and complications thereof. No coverage for the treatment or procedure for excessive weight or the complications thereof regardless of whether such treatment or procedure is determined to be medically necessary, except for the special Weight Loss Assistance benefit described in the Schedule of Medical Benefits in this section of the Handbook.

2. Expenses for medical or surgical treatment of severe underweight, including but not limited to high-calorie and/or high-protein food supplements or other food or nutritional supplements, except in conjunction with medically necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25% under normal body weight for the patient’s age, sex, height and body frame based on weight tables generally used by physicians to determine normal body weight.

3. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including bicycles and exercise equipment.

Coordination of Benefits

You or your covered dependents may be entitled to benefits under the SRP Medical PPO or EPO Option and may also be entitled to recover all or part of your medical care expenses from some other source. In many of those cases, either the Medical PPO or EPO or the other source (the primary plan or program) pays benefits or provides services first, and the other (the secondary plan or program) pays some or all of the difference between the total cost of those services and payment by the primary plan or program. In other cases, only one plan pays benefits. This can occur if you or a covered dependent is also covered by:

- Another group health care plan;
- Medicare;
- Other government program, such as Medicaid, Tricare/CHAMPUS or a program of the U.S. Department of Veterans Affairs, or any coverage provided by a federal, state or local government or agency; or
- Workers’ Compensation.

This section describes the rules that determine which plan pays first (is primary) and which pays second (is secondary), or when one of the plans is responsible for benefits and the other is not. The Medical PPO and EPO operate under rules that prevent them from paying benefits which, together with the benefits from another source you possess (as described above), would allow you...
to recover more than 100% of expenses you incur. In many instances, you may recover less than 100% of those expenses from the duplicate sources of coverage or recovery.

In some instances, the Medical PPO or EPO will not provide coverage if you can recover from some other resource. In other instances, such as with Workers’ Compensation, the Medical PPO or EPO will advance its benefits, but only subject to its right to recover them from a third party.

**When and How Coordination of Benefits (COB) Applies**

For the purposes of this COB provision, the word “plan” refers to any group medical policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical care services incurred by the covered individual or that provides medical care services to the covered individual. A “group plan” provides its benefits or services to employees, retirees or members of a group who are eligible for and have elected coverage. The Medical PPO or EPO do not coordinate with individual plan policies or auto insurance.

Many families that have more than one family member working outside the home are covered by more than one medical plan. If this is the case with your family, you must let the Medical PPO or EPO Claims Administrator know about all your coverage when you submit a claim.

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

**Which Plan Pays First: Order of Benefit Determination Rules**

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform order of benefit determination rules in a specific sequence. The Medical PPO or EPO use the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules always pays its benefits first.**

When two group plans cover the same person, the following order of benefit determination rules establishes which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

**Rule 1: Non-Dependent/Dependent**

A. The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first, and the plan that covers the same person as a dependent pays second.

B. There is one exception to this rule. If the person is also a Medicare beneficiary and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee), then the order of benefits is reversed, so that the plan covering the person as a dependent pays first and the plan covering the person other than as a dependent (that is, as a retired employee) pays second.
Rule 2: Dependent Child Covered Under More Than One Plan

A. The plan that covers the parent whose birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose birthday falls later in the calendar year pays second, if:
   • The parents are married;
   • The parents are not separated (whether or not they ever have been married); or
   • A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

B. If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first, and the plan that has covered the other parent for the shorter period of time pays second.

C. The word “birthday” refers only to the month and day in a calendar year, not the year in which the person was born.

D. If the specific terms of a court decree state that one parent is responsible for the child’s medical care expenses or medical care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child’s medical care services or expenses, but that parent’s current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any plan year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

E. If the parents are not married or are separated (whether or not they ever were married) or divorced, and there is no court decree allocating responsibility for the child’s medical care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:
   • The plan of the custodial parent pays first;
   • The plan of the spouse of the custodial parent pays second;
   • The plan of the non-custodial parent pays third; and
   • The plan of the spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

A. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee’s dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee’s dependent, pays second.

B. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.
Rule 4: Continuation Coverage
A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person’s dependent) pays first, and the plan providing continuation coverage to that same person pays second.
B. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
C. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage
A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first, and the plan that covered the person for the shorter period of time pays second.
B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.
C. The start of a new plan does not include a change:
   • In the amount or scope of a plan’s benefits;
   • In the entity that pays, provides or administers the plan; or
   • From one type of plan to another (such as from a single-employer plan to a multiple-employer plan).
D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

How Much This Plan Pays When It Is Secondary
When the Medical PPO or EPO pays second, it will pay the same benefits that it would have paid had it paid first, less whatever payments were actually made by the plan (or plans) that paid first. This is also referred to as non-duplication or a carve-out COB plan design.

When the Medical PPO or EPO pays second, it will never pay more in benefits than it would have paid for each claim, as it is submitted, had it been the plan that paid first. This has the effect of maintaining the Medical PPO’s or EPO’s deductibles, coinsurance and exclusions. As a result, when the Medical PPO or EPO pays second, you may not receive the equivalent of 100% of the total cost of the covered health care services.

This Plan does not administer a benefit reserve calculation in its coordination of benefits.
Administration of COB

To administer COB, the Medical PPO or EPO reserves the right to:

- Exchange information with other plans involved in paying claims;
- Require that you or your medical care provider furnish any necessary information;
- Reimburse any plan that made payments the Medical PPO or EPO should have made; or
- Recover any overpayment from your hospital, physician, other health care provider, other
  insurance company, you or your dependent.

If the Medical PPO or EPO should have paid benefits that were paid by any other plan, the
Medical PPO or EPO may pay the party that made the other payments in the amount this Plan
Administrator or its designee determines to be proper under this provision. Any amounts paid
will be considered to be benefits under the Medical PPO or EPO, and the Medical PPO or EPO will
be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a claim under each plan that covers the
person for the expenses that were incurred. However, any person who claims benefits under the
Medical PPO or EPO must provide all the information the plan needs to apply COB.

The Medical PPO and EPO follow the customary COB rule that the medical program coordinates
with only other medical plans or programs, and not with any Dental Plan or program.

If the Medical PPO or EPO is primary, and if the coordinating secondary plan is an HMO, EPO or other
plan that provides benefits in the form of services, the Medical PPO or EPO will consider the reasonable
cash value of each service to be both the allowable expense and the benefits paid by the primary plan.
The reasonable cash value of such a service may be determined based on the allowed charges.

If the Medical PPO or EPO is secondary, and if the coordinating primary plan does not cover
medical care services because they were obtained out-of-network, benefits for services covered
by the Medical PPO or EPO will be payable by the Medical PPO or EPO subject to the rules
applicable to COB, but only to the extent they would have been payable if the Medical PPO or
EPO were the primary plan.

If the Medical PPO or EPO is secondary, and if the coordinating plan is also secondary because
it provides by its terms that it is always secondary or excess to any other coverage, or because
it does not use the same order of benefit determination rules as the Medical PPO or EPO, the
Medical PPO or EPO will not relinquish its secondary position. If the Medical PPO or EPO
advances an amount equal to the benefits it would have paid had it been the primary plan, the
Medical PPO or EPO will pursue its rights, and the plan participant must execute any documents
required or requested by the Medical PPO or EPO to recover the amount advanced from the other
payer, such as with Workers’ Compensation.

Coordination with Medicare

Entitlement to Medicare coverage: Generally, anyone age 65 or older is entitled to Medicare
coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is
also entitled to Medicare coverage after a waiting period.

Medicare participants may retain or cancel coverage under the Medical PPO or EPO: If you, your
covered spouse or dependent child becomes covered by Medicare, whether because of end-stage
renal disease (ESRD), disability or age, you may either retain or cancel your coverage under the
Medical PPO or EPO within 31 days of date Medicare is effective. See also Changing Elections in
this section of the Handbook.
Coverage under Medicare and the Medical PPO or EPO: If you and/or any of your dependents are covered by both the Medical PPO or EPO and by Medicare, as long as you remain actively employed, the Medical PPO or EPO pays first and Medicare pays second.

If you are covered by Medicare and you cancel your employee coverage under the Medical PPO or EPO, coverage of your spouse and/or your dependent child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. See COBRA Continuation Coverage in this section of the Handbook for further information.

If any of your dependents are covered by Medicare and you cancel that dependent’s coverage under the Medical PPO or EPO, that dependent will not be entitled to COBRA Continuation Coverage.

The choice of retaining or canceling coverage under the Medical PPO or EPO of a Medicare participant is yours and yours alone. Neither the Medical PPO or EPO nor your employer will provide any consideration, incentive or benefits to encourage you to cancel coverage under the Medical PPO or EPO.

Coverage under Medicare and the Medical PPO or EPO when you are totally disabled: If you become totally disabled and entitled to Medicare because of your disability, you will no longer be considered to remain actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and if you are still covered by the Medical PPO or EPO, the Medical PPO or EPO pays second.

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

When the plan participant is covered by this Plan and also by Medicare Parts A and B: When the plan participant is covered by Medicare Parts A and B and the Medical PPO or EPO is secondary to Medicare, the Medical PPO or EPO pays the same benefits provided for active employees less any amounts paid by Medicare. Benefits payable by the Medical PPO or EPO are based on the fees allowed by Medicare and not on the billed charges of the health care provider.

When the plan participant is covered by this Plan and also by Medicare Advantage Program (formerly called Medicare + Choice [Part C]): This plan provides benefits that supplement the benefits you receive from Medicare. If a plan participant is covered by a Medicare Advantage Program and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services in-network when the Medicare Advantage program requires it, the Medical PPO or EPO will reimburse all applicable copayments and will pay the same benefits provided for active employees less any amounts paid by the Medicare Advantage program.

However, if the plan participant doesn’t comply with the rules of the Medicare Advantage program, including, without limitation, approved referral, preauthorization or case management requirements, the Medical PPO or EPO will coordinate payment as if the participant is covered by Medicare Parts A and B.

When the plan participant is covered by this Plan and eligible but not yet covered by Medicare: If the plan participant is eligible for, but is not enrolled in Medicare, the Medical PPO or EPO pays
the same benefits provided for active employees less the amounts that would have been paid by Medicare had the plan participant been covered by Medicare Parts A and B and not on the billed charges of the health care provider.

**When the plan participant is covered by this Plan and also enters into a Medicare private contract:**
Under the law, a Medicare participant is entitled to enter into a Medicare private contract with certain health care practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care practitioner.

If a Medicare participant enters into such a contract, the Medical PPO and EPO plans will pay benefits for health care services and/or supplies the Medicare participant receives pursuant to it, but those benefits will be subject to all of the Medical PPO’s/EPO’s terms and provisions, including those relating to exclusions, medical necessity, allowed charges and utilization review.

**IMPORTANT NOTE FOR MEDICARE-ELIGIBLE RETIREEES AND THEIR MEDICARE-ELIGIBLE DEPENDENTS**
Benefits that are paid for by this Plan for Medicare-eligible retirees and their Medicare-eligible dependents are reduced by the amounts payable under Medicare Parts A (Hospital) and B (Professional Services). This reduction will apply even if the Medicare-eligible individual is NOT enrolled in Medicare Parts A and B; therefore, if you are Medicare-eligible, you should consider enrolling in Medicare Parts A and B in order to receive the maximum amount of benefits under this Plan.

**Summary Chart on COB with Medicare:** If you are covered by Medicare and also have other group health plan coverage, the COB rules are set by the Centers for Medicare & Medicaid Services (CMS). These COB rules are outlined below.

<table>
<thead>
<tr>
<th>IF YOU:</th>
<th>CONDITION</th>
<th>PAYS FIRST</th>
<th>PAYS SECOND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are age 65 and older and covered by a group health plan because you are working or are covered by a group health plan of a working spouse of any age</td>
<td>The employer has less than 20 employees</td>
<td>Medicare</td>
<td>Group health plan</td>
</tr>
<tr>
<td></td>
<td>The employer has 20 or more employees</td>
<td>Group health plan</td>
<td>Medicare</td>
</tr>
<tr>
<td>Have an employer group health plan after your retire and are age 65</td>
<td>Entitled for Medicare</td>
<td>Medicare</td>
<td>Group health plan (e.g., a retiree plan coverage)</td>
</tr>
<tr>
<td>Are disabled and covered by a large group health plan from your work because of active employment or from a family member who is working</td>
<td>The employer has less than 100 employees</td>
<td>Medicare</td>
<td>Group health plan</td>
</tr>
<tr>
<td></td>
<td>The Employer has 100 or more Employees</td>
<td>Medicare</td>
<td>Large group health plan</td>
</tr>
</tbody>
</table>
# Summary of the Coordination of Benefits Between Medicare and the Group Health Plan

<table>
<thead>
<tr>
<th>If You:</th>
<th>Condition</th>
<th>Pays First</th>
<th>Pays Second</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have end-stage renal disease (ESRD is permanent kidney failure) and group health plan coverage (including a retirement plan)</td>
<td>First 30 months of eligibility or entitlement to Medicare</td>
<td>Group health plan</td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td>After 30 months</td>
<td>Medicare</td>
<td>Group health plan</td>
</tr>
<tr>
<td>Are covered under Workers’ Compensation because of a job-related injury or illness</td>
<td>Entitled for Medicare</td>
<td>Workers’ Compensation for Workers’ Compensation-related services</td>
<td>Medicare</td>
</tr>
<tr>
<td>Have black lung disease and are covered under the Federal Black Lung Program</td>
<td>Entitled to Medicare and the Federal Black Lung Program</td>
<td>Federal Black Lung Program for services related to black lung</td>
<td>Medicare</td>
</tr>
<tr>
<td>Have been in an accident where no-fault or liability insurance is involved</td>
<td>Entitled for Medicare</td>
<td>No-fault or liability insurance, for the accident-related services</td>
<td>Medicare</td>
</tr>
<tr>
<td>Are a veteran and have veterans’ Benefits</td>
<td>Entitled to Medicare and Veterans’ Benefits</td>
<td>Medicare pays for Medicare-covered services; Veterans’ Affairs pays for VA-authorized services. Generally, Medicare and VA cannot pay for the same service.</td>
<td>Usually does not apply</td>
</tr>
<tr>
<td>Are covered under TRICARE</td>
<td>Entitled to Medicare and TRICARE</td>
<td>Medicare pays for Medicare-covered services. TRICARE pays for services from a military hospital or any other federal provider.</td>
<td>TRICARE may pay second</td>
</tr>
<tr>
<td>Are age 65 or over OR are disabled and covered by both Medicare and COBRA</td>
<td>Entitled for Medicare</td>
<td>Medicare</td>
<td>COBRA</td>
</tr>
<tr>
<td>Have end-stage renal disease (ESRD) and COBRA</td>
<td>First 30 months of eligibility or entitlement to Medicare</td>
<td>COBRA</td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td>After 30 months</td>
<td>Medicare</td>
<td>COBRA</td>
</tr>
</tbody>
</table>

See also [www.medicare.gov/Publications/Pubs/pdf/02179.pdf](http://www.medicare.gov/Publications/Pubs/pdf/02179.pdf) or 1-800-Medicare for more information.

## Coordination with Other Government Programs

**Medicaid:** If a covered individual is covered by both this Plan and the Medical PPO or EPO and Medicaid/CHIP, the Medical PPO or EPO pays first and Medicaid/CHIP pays second.
Tricare/CHAMPUS: If a covered dependent is covered by both the Medical PPO or EPO and the Tricare/Civilian Health and Medical Program of the Uniformed Service (CHAMPUS), the program that provides health care services to dependents of active armed services personnel, the Medical PPO or EPO pays first and Tricare/CHAMPUS pays second. For an employee called to active duty for more than 30 days and who is covered by both this Plan and Tricare, Tricare is primary and the Medical PPO or EPO is secondary.

Veterans Affairs/Military Medical Facility Services: If a covered individual receives services in a U.S. Department of Veterans Affairs hospital or other military medical facility on account of a military-service-related illness or injury, benefits are not payable by the Medical PPO or EPO. If a covered individual receives services in a U.S. Department of Veterans Affairs hospital or other military medical facility on account of any other condition that is not a military-service-related illness or injury, benefits are payable by the Medical PPO or EPO to the extent those services are medically necessary and the charges are allowed charges.

Indian Health Services (IHS): If an individual is covered by both this Plan and Indian Health Services, this Plan pays first and Indian Health Services pays second.

Other coverage provided by state or federal law: If you are covered by both the Medical PPO or EPO and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and the Medical PPO or EPO pays second.

Workers’ Compensation: The Medical PPO and EPO do not provide benefits if the expenses are covered by Workers’ Compensation or occupational disease law. If SRP contests the application of Workers’ Compensation law for the illness or injury for which expenses are incurred, the Medical PPO or EPO will advance benefits, subject to its right to recover those payments if and when it is determined that they are covered under a Workers’ Compensation or occupational disease law. However, before such payment will be made, you and/or your covered dependent must execute a reimbursement agreement acceptable to the Plan Administrator or its designee.

THIRD-PARTY LIABILITY

A. Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party pays or is liable to pay due to any recovery, whether by settlement, judgment or otherwise. (See the exclusion regarding expenses for which a third party is responsible in the Exclusions chapter.) The Plan may, however, advance payment on account of Plan Benefits (hereafter called an “Advance”), subject to its right to be reimbursed to the full extent of any Advance payment from the covered employee and/or a representative, guardian, conservator, or trustee of the covered employee and/or dependent(s) if and when there is any recovery from any third party. In the event the Plan does make an Advance, the covered employee or covered dependent, with respect to whom the Advance is made, shall be deemed to have been notified of, and agreed to comply with, the terms of paragraphs A-G of this section.

The Plan’s right of reimbursement will apply:

1. Even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical or dental expenses for which the Advance was made;
2. Even if the recovery is not sufficient to make the ill or injured employee and/or dependent(s) whole pursuant to state law or otherwise (sometimes referred to as the “make-whole” rule);
3. Without any reduction for legal or other expenses incurred by the employee and/or dependent(s) in connection with the recovery against the third party or that third party’s
insurer pursuant to state law or otherwise (sometimes referred to as the “common fund” rule);

4. Regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the “collateral source” rule);

5. Even if recovery was reduced due to the negligence of the covered employee or covered dependent (sometimes referred to as “contributory negligence”) or any other common law defense; and

6. With respect to payments to be made, or made, by (a) the responsible party, its insurer or any other source on behalf of such party, (b) any first-party insurance through medical payment coverage, personal injury protection or no-fault coverage, (c) any policy of insurance from any insurance company or guarantor of a third party, (d) Workers’ Compensation or other liability insurance company, or (e) any other source, including but not limited to crime fraud victim restitution funds, any medical, disability or other benefit payments, or school insurance coverage.

B. Reimbursement and/or Subrogation Agreement

The covered employee and/or any covered dependent(s) on whose behalf the Advance is made shall, if requested by the Plan Administrator or its designee, sign and deliver a reimbursement and/or subrogation agreement (hereafter called the “Agreement”) in a form provided by or on behalf of the Plan. If the ill or injured dependent is a minor or is not competent to execute an Agreement, that person’s parent (in the case of a minor dependent child), spouse or legal representative (in the case of an incompetent adult) shall execute an Agreement upon request by the Plan Administrator or its designee.

If an Agreement is not requested by the Plan Administrator, or is requested but is not executed, the Plan may either refuse to make any Advance or may make an Advance in reliance on the covered employee’s or covered dependent’s deemed agreement under paragraph A above to comply with the provisions of paragraphs A-G of this section.

C. Cooperation with the Plan by All Covered Individuals

By accepting an Advance, regardless of whether or not an Agreement has been executed, the covered employee and/or covered dependent(s) each agree:

1. To reimburse the Plan for all amounts paid or payable to the covered employee and/or covered dependent(s) or that third party’s insurer for the entire amount Advanced;

2. That the Plan has the first right of reimbursement from any judgment or settlement;

3. To do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan’s reimbursement and/or subrogation rights;

4. To not assign the right of recovery to any third party without the specific consent of the Plan;

5. To notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party alleged to be responsible for the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party’s insurer based on those acts;

6. To inform the Plan Administrator or its designee of all material developments with respect to all claims, actions or proceedings they have against the third party;

7. To maintain any payment from a first or third party in a constructive trust for the benefit of the Plan;

8. To include the name of the Plan as a co-payee on any settlement payment checks or drafts; and

9. To take all additional actions as are requested by the Plan Administrator, or its designee, in order to allow the Plan Administrator, or its designee, to recover all or part of the Advance.
D. Subrogation

1. By accepting an Advance, the covered employee and/or covered dependent(s) jointly agree that the Plan will be subrogated to the covered employee and/or covered dependent’s right of recovery from a third party or that third party’s insurer for the entire amount Advanced, regardless of any state or common law rule to the contrary, including, without limitation, a so-called collateral source rule (that would have the effect of prohibiting the Plan from recovering any amount). This means that in any legal action against a third party who may have been responsible for the injury or illness that resulted in the Advance, the Plan may be substituted in place of the covered employee and/or covered dependent(s), but only to the extent of the amount of the Advance. The Plan is subrogated in any and all actions against third parties for the portion of all recoveries that the Plan is entitled.

2. Under its subrogation rights, the Plan may, at its discretion:
   a. Start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the covered employee and/or covered dependent(s), but in doing so, the Plan will not represent or provide legal representation for the covered employee and/or covered dependent(s) with respect to their damages that exceed any Advance; or
   b. Intervene in any claim, legal action or administrative proceeding started by the covered employee or covered dependent(s) against any third party or third party’s insurer concerning the injury or illness that resulted in the Advance.

3. Notwithstanding subparagraphs (D)(1) and (2) above, the covered employee or covered dependent, with respect to which an Advance has been made, shall have the initial right to file a recovery claim and if they fail to do so, the Plan may, at its option, file a claim in the name of such covered employee or covered dependent.

E. Application to Any Fund

1. The Plan’s right to reimbursement and subrogation shall apply to any fund, account or other asset created:
   a. Pursuant to the judgment of any court awarding damages against any third party in favor of the ill or injured employee and/or dependent(s) payable by any third party on account of an illness or injury alleged to have been caused by that third party; or
   b. As a result of any settlement paid by any third party on account of any claim by or on behalf of the ill or injured employee and/or dependent(s).

F. Lien and Segregation of Recovery

By accepting the Advance, the covered employee and/or covered dependent agrees to the following:

1. The Plan will automatically have an equitable lien, to the extent of the Advance, upon any recovery, whether by settlement, judgment or otherwise, by the covered employee and/or covered dependent. The Plan’s lien extends to any recovery from the third party, the third party’s insurer, and the third party’s guarantor and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health insurance, or other policy. The Plan’s lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.

2. The Plan holds in a constructive trust that portion of the recovery that is the extent of the Advance. The covered employee, covered dependent and those acting on their behalf, shall place and maintain such portion of any recovery in a separate segregated account until the reimbursement obligation to the Plan is satisfied. The location of the account and the account number must be provided to the Plan.

3. Should the covered employee, covered dependent or those acting on their behalf fail to maintain this segregated account or comply with any of the Plan’s reimbursement
requirements, they stipulate to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Plan receives all amounts that must be reimbursed.

G. Remedies Available to the Plan

In addition to the remedies discussed above, if the covered employee or covered dependent does not reimburse the Plan as required by paragraphs A-G of this section, the Plan may, at its sole discretion:

1. Offset any future Plan benefits that may become payable on behalf of the covered employee and/or his/her covered dependent(s) by the amount of any Advance made with respect to such employee or dependents and with respect to which the Plan has not yet been reimbursed; or
2. Obtain a judgment against the covered employee and/or covered dependent(s) for the amount Advanced and not reimbursed, and garnish or attach the wages or earnings of the covered employee and/or covered dependent(s).

Claim Filing and Appeals Information

This following discussion provides detailed procedures for filing claims for certain group health benefits under the SRP Health Care Program and the SRP Medical Reimbursement Tax Saver Plan and the Dependent Care Assistance Tax Saver Plan (both referred to as Plan) and for appealing adverse benefit determinations in connection with those claims in compliance with 29 CFR section 2560.503-1 of the Code of Federal Regulations. Benefit claims under the Plan covered by these procedures are:

- Medical benefit claims (including prescription drug claims, behavioral health claims and hearing aid claims) filed under the SRP Medical PPO or EPO Option
- Dental benefit claims filed under the SRP Dental Program
- Vision benefit claims filed under the SRP Vision Plan
- Medical Reimbursement Tax Saver Account claims
- Dependent Care Assistance Tax Saver Account claims

Vision Plan claims, Medical Reimbursement Tax Saver Account claims and Dependent Care Assistance Tax Saver Account claims are always post-service claims.

Note: There are various contracted Claims Administrators for these benefits. Refer to the Quick Reference Chart to find the appropriate Claims Administrator for the claims covered by these procedures. Throughout this chapter when the term “Claims Administrator” is used, it refers to the appropriate Claims Administrator for the claim in question.

For claims administration under the EDS Dental Plan, contact EDS Member/Customer Services at the telephone number listed on the Quick Reference Chart in the front of this section of the Handbook.

The Plan takes steps to ensure that Plan provisions are applied consistently with respect to you and other similarly situated plan participants. The claims procedure outlined in this Handbook will afford you a full, fair and fast review of the claims to which it applies.

How Benefits Are Paid

Plan Benefits covered by these procedures are considered for payment upon the receipt of a written claim, on a form provided by the Plan Administrator, and written proof of claim, but sometimes additional information or records may be required.
Generally, Plan benefits payable on account of expenses for a hospital or health care facility will be paid directly to the institution providing the services. Plan benefits payable on account of expenses for surgery will usually be paid directly to the surgeon or anesthesiologist providing the services.

However, if, at the time you submit your claim, you furnish evidence acceptable to the Claims Administrator that you or your covered dependent paid some or all of those charges, Plan benefits will be paid to you up to the amount allowed by the Plan for those services. When deductibles, coinsurance or copayments apply, you are responsible for paying your share of the charges.

If services are provided through a contracted network of providers, like a PPO or EPO, the contracted provider may submit the proof of claim directly to the Claims Administrator or may complete the necessary claim form and return it to you for submission to the Claims Administrator. However, you will be responsible for the payment to the PPO or EPO health care provider of any applicable deductible, copayment or coinsurance.

The Plan may, at its sole discretion, pay benefits directly to any provider who provided the services or supplies on which the claim is based, or it may pay those Plan benefits to you.

Qualified Medical Child Support Orders (QMCSOs)

A Qualified Medical Child Support Order (QMCSO) may require the Plan to pay Plan benefits on account of eligible expenses incurred by or on behalf of the dependent child(ren) covered by the Plan either to the provider who rendered the services or to the custodial parent of the dependent child(ren). If the Plan Administrator or its designee determines that it has received a QMCSO, it will pay Plan benefits with respect to eligible expenses incurred by or on behalf of the dependent child(ren) as required by the QMCSO.

When You Must Repay Plan Benefits

If it is found that the Plan benefits paid by the Plan are too much because the Plan erroneously paid benefits to which you were not entitled under the terms and provisions of the Plan, then the Plan will be entitled to a refund from you or your health care provider of the difference between the amount of Plan benefits actually paid by the Plan for those expenses and the amount of Plan benefits that should have been paid by the Plan for those expenses based on the actual facts.

**TIME LIMIT FOR FILING CLAIMS**

Claims (other than Vision Plan claims, Medical Reimbursement Tax Saver Account [TSA] claims and Dependent Care Assistance TSA claims) should be filed within **90 calendar days after the date of service.** In no event will claims be considered for payment later than **24 months** after the date of service.

Vision Plan claims must be submitted within **180 days** after the date of service.

Claims for the Medical Reimbursement TSA out-of-pocket expenses and Dependent Care Assistance TSA claims incurred during the plan year (calendar year) must be submitted no later than **March 31** of the following year.

1. **Additional information needed:** There may be times, after filing or appealing an adverse determination on a claim, that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after these stated time frames.
2. **Independent medical examination**: While a claim is pending, the Plan has the right at its own expense to require the examination of the individual whose injury or illness is the basis of a claim when and as often as determined by the Plan Administrator or its designee to be reasonably required.

3. **Statements**: All statements made by the Employer, the Claims Administrator, the Plan Administrator or its designees, in the absence of fraud, will be considered representations and not warranties.

4. **Days defined**: For the purpose of the claims and appeal procedures outlined in this Handbook, “days” refers to calendar days, not business days.

5. **Adverse benefit determination defined**: For the purpose of the claim and appeal procedures described in this Handbook, an adverse benefit determination is defined as:
   - A denial, reduction or termination of, or a failure to provide or make payment in whole or in part, for a benefit, including a denial, reduction, termination or failure to make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in this Plan; and
   - A denial, reduction or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

**When You Must Get Plan Approval in Advance of Obtaining Health Care**

Some Plan benefits are payable without a financial penalty only if the Plan approves payment before you receive the services. This prior approval is referred to as precertification, preauthorization or pre-service review.

Precertification is required for scheduled (elective) hospital admissions, long-term acute care hospital admissions, and major organ/tissue transplants. You are not required to obtain approval in advance for emergency care or hospital admission for delivery of a baby.

Preauthorization is required for elective inpatient behavioral health admissions. See Precertification in this section of the Handbook for details.

**Consequences of Failure to Properly Submit a Claim**

Except as otherwise provided in the next paragraph, if you or your authorized representative (as defined later in this Handbook) fail to follow the Plan’s procedures for filing a claim, you or your representative will be notified of the failure and the proper procedures to be followed. For a pre-service claim, this notice will be provided as soon as possible but no later than five days after the failure. For an urgent care claim, this notice will be provided orally as soon as possible but no later than 24 hours after the failure followed by written (or electronic as applicable) notification no later than three days after the oral notification.

The Plan’s obligation to notify you of the failure to follow the Plan’s procedures for filing a claim only arises if the failure is a communication by you or your authorized representative that:

- Is received by the organizational unit (Benefits Services or appropriate Claims Administrator) that is customarily responsible for handling benefit matters;
- Names a specific individual (along with their Plan ID number, Social Security number or health insurance claim number);
- Names a specific medical condition or symptom; and
- Names a specific treatment, service or product for which approval is requested.
Important Definitions Related to Claim Filing and Appeals

Claim

For the purposes of benefits covered by these procedures, a claim is a request for a Plan benefit made by an individual covered under the Plan (commonly called the “claimant” but hereafter referred to as “you”) or that individual’s authorized representative in accordance with the Plan’s reasonable claims procedures, described in Claim Filing and Appeals Information in this section of the Handbook.

There are four types of claims covered by these procedures: pre-service, urgent, concurrent and post-service. The type of claim is determined as of the time the claim or review of denial of the claim is being processed. For example, an urgent care claim turns into a post-service claim once services are rendered. If services are rendered between the date a claim is denied and the date an appeal is filed, then the appeal process for post-service claims would be used, even though the urgent care claims procedure was used to initially process the claim.

The following are not claims:

• A request for Plan benefits that is NOT made in accordance with the Plan’s benefit claims filing procedures described in this Handbook
• A request for Plan benefits that is made by someone other than you or your authorized representative
• A request for Plan benefits that is made by a person who will not identify himself/herself (anonymous)
• A casual inquiry about benefits, such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service
• A request for prior approval of Plan benefits where prior approval is not required by the Plan
• An eligibility inquiry that does not request Plan benefits; however, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and you will be notified of the decision and allowed to file an appeal
• A submission of a prescription with a subsequent adverse benefit determination at the point of sale at a retail pharmacy or from a mail-order service
• A request for services and claims for a work-related injury/illness, unless the Workers’ Compensation program has provided a written confirmation that the injury/illness is not compensable as a work-related claim

If you have a concern or question that is not a type covered by these procedures (e.g., a question relating to eligibility that is not a claim for benefits), call or write Benefits Services at the phone number or address listed on the Quick Reference Chart in the front of this section of the Handbook.

Pre-service claim: A pre-service claim is a request for benefits under this Plan (commonly called precertification or preauthorization) where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care. The Plan Administrator may determine, in its sole discretion, to pay benefits for the services needing precertification that were obtained without prior approval if you were unable to obtain prior approval because:

• Circumstances existed that made obtaining such prior approval impossible; or
• Application of the pre-service (precertification) procedure could have seriously jeopardized the patient’s life or health.

Urgent care claim: An urgent care claim is a claim (request) for medical care or treatment where applying the time periods for making non-urgent care (pre-service) determinations:
• Could seriously jeopardize the life or health of an individual or the ability of that individual to regain maximum function; or
• In the opinion of a physician with knowledge of the individual’s medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, or is a claim involving urgent care.

Urgent care claims are a subset of pre-service claims.

**Concurrent care claim:** A concurrent care claim refers to a Plan decision to reduce or terminate a preapproved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a preapproved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.

**Post-service claim:** A post-service claim is a claim for benefits under the Plan that is not a pre-service claim. Post-service claims are claims that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim and an electronic bill submitted for payment after services have been provided are examples of post-service claims.

### Authorized Representative

The Plan recognizes an authorized representative as the person who can act on behalf of an individual to file a claim under the Plan (because of the individual’s death, disability or other reason acceptable to the Plan Administrator) and to appeal an adverse benefit determination. Subject to the written statement requirement discussed below, the following individuals may be recognized as an authorized representative:

• Health care provider
• Legal spouse
• Dependent child age 18 or over
• Parents or adult siblings age 18 or over
• Grandparent
• Court-ordered representative, such as an individual with durable power of attorney or legal guardian
• Other adult age 18 or over

To designate an authorized representative, you must complete an authorized representative form and submit it to Benefits Services. On the form, you will provide the designated representative’s name, address and telephone number. If unable to complete and submit the form, the Plan will require written proof that the proposed authorized representative is one of the individuals listed above.

Once it receives an authorized representative form from you, the Plan will route all future claims and appeals-related correspondence to the authorized representative and not you. The Plan will honor the designated authorized representative until it is revoked, or as otherwise mandated by a court order, before requiring you to submit a new authorized representative form. You may revoke a designated authorized representative at any time by submitting a completed form available from Benefits Services.

If the claim is an urgent care claim as defined above, the Plan will consider a health care professional with knowledge of your medical condition to be the authorized representative bypassing the need for completion of the Plan’s authorized representative form.

Need more help? See the **Quick Reference Chart** in the front of this section.
The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of the individual.

Health Care Professional
The term “health care professional” means a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

How to File a Post-Service Claim for Benefits Under This Plan
If your claim is a post-service claim (as defined earlier), you or your authorized representative must file the claim in accordance with the Plan’s post-service claims procedures described below.

Vision Plan claims, Medical Reimbursement Tax Saver Account claims and Dependent Care Assistance Tax Saver Account claims are always post-service claims.

1. A post-service claim must be made in writing. The Plan accepts a claim from a health care provider if submitted in a timely fashion. A post-service claim must contain all of the following information:
   • A description of the services or supplies provided
   • Details of the charges for those services or supplies
   • Date(s) the services or supplies were provided.
   • Patient’s name (along with patient’s Plan ID number, Social Security number [SSN] or health insurance claim number [HICN]).
   • Employee’s name and identification number (e.g., Plan ID number, SSN or HICN)
   • Provider’s name and address
For Vision Plan claims, the patient’s date of birth and relationship to the employee also are required.

Additional information required for medical, dental and SRP Behavioral Health Program claims includes:
   • Diagnosis
   • Patient’s date of birth
   • Provider’s signature, telephone number, professional degree or license, and federal tax identification number

Accident claims: Note that for claims related to an accident, the Plan will process the first $2,500 of eligible expenses before asking for details about the accident claim.

2. Proof of dependent eligibility: When submitting a post-service claim on behalf of a newborn dependent child, you must provide the appropriate Plan Administrator with written confirmation of the child’s eligibility for coverage (e.g., copy of certified birth certificate for newborn). When submitting a post-service claim on behalf of a dependent child over the age of 19, you must provide the Plan Administrator with written confirmation of eligibility. When submitting a claim on behalf of a new spouse, you must provide proof of marital status to the Plan Administrator.

3. Duplicate coverage: If another Plan is the primary payer, you must provide the appropriate Claims Administrator with a copy of the form called an Explanation of Benefits (EOB) from the other plan along with the claim you submit to this Plan so that accurate coordination of benefits can be performed. See Coordination of Benefits in this section of this Handbook.

Need more help? See the Quick Reference Chart in the front of this section.
4. Claims Administrators will not accept a balance due statement, cash register receipts, canceled checks or credit card receipts as proof of claim.

5. Please review your bill to be sure it is appropriate and correct. Report any discrepancies in billing to the appropriate Claims Administrator. This can reduce costs to you and the Plan.

6. A post-service claim must be sent to the appropriate Claims Administrator, whose mailing address is listed on the Quick Reference Chart in the front of this section of the Handbook.

7. The Claims Administrator will notify you of the Plan’s benefit determination within a reasonable period of time but not later than 30 calendar days after the Claims Administrator receives the post-service claim.
   - The Claims Administrator may extend the 30-calendar-day period one time for up to 15 additional calendar days if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan. The Claims Administrator will notify you of the extension and the date by which the Plan expects to make a decision, prior to the expiration of the initial 30-day period using a written Notice of Extension.
   - If a period of time is extended due to failure to submit information required to process the claim, the Notice of Extension will specifically describe the required information and you will be given 45 calendar days after receipt of the Notice to provide the specified information. If the Plan cannot process a claim without the required information, the time period for the Plan to process the claim will be tolled from the date on which the Notice of Extension is sent until the date on which the Claims Administrator receives your response.

8. Plan benefits will automatically be assigned and the portion of the post-service claim for which the Plan is responsible will be paid to the provider of service unless the provider clearly marks on the bills that they have been paid by the covered person. For contracted providers (e.g., PPO or EPO providers), the Claims Administrator will pay the portion of the post-service claim for which the Plan is responsible according to the contractual agreement in place with the contracted provider.

9. **Explanation of Benefits (EOB):** If the Claims Administrator approves the post-service claim, you will be sent a form called an Explanation of Benefits (EOB). The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your deductible, whether your out-of-pocket maximum has been reached, whether coverage for services was denied and why, amounts you need to pay to the provider, etc. If you have questions about the EOB or do not agree with the determinations made, contact the Claims Administrator.

10. **If the post-service claim is denied in whole or in part,** a notice of the denial will be provided to you in writing (or electronically as applicable) on the EOB. The notice of denial will:
   - Give the specific reason(s) for the denial;
   - Reference the specific Plan provision(s) on which the denial is based;
   - Describe any additional information needed to perfect the claim and an explanation of why such additional information is necessary;
   - Provide an explanation of the Plan’s appeal procedure along with time limits;
   - Contain a statement that you have the right to bring a civil action under ERISA Section 502(a) if your claim is denied on appeal;
   - If the denial is based on an internal rule, guideline, protocol or other similar criterion, the denial will contain a statement that such rule, guideline, protocol or criterion was relied upon and that it will be provided free of charge to you upon request; and
   - If the denial is based on medical necessity, experimental treatment or similar exclusion or limit, the denial will contain a statement that an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided free of charge to you upon request.

Need more help? See the **Quick Reference Chart** in the front of this section.
11. If you disagree with a denial of a post-service claim, you or your authorized representative may appeal the decision by filing an appeal in accordance with the Plan’s appeal procedure for denial of post-service claims. You have 180 calendar days after receipt of the denial to file an appeal. The Plan will not accept appeals filed after this 180-calendar-day period.

Appeal of a Denial of a Post-Service Claim

This Plan maintains a two-level appeal procedure for appeals of post-service claims.

1. Appeals must be made in writing to the appropriate Claims Administrator for the first level of appeal review and to the Plan Administrator for the second level of appeal review. Their mailing addresses are listed on the Quick Reference Chart in the front of this section of the Handbook.

2. At each appeal review level, you will be provided with:
   - Upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to the claim for benefits (whether a document, record or other information is relevant will be determined solely by the reviewer in accordance with applicable regulations);
   - The opportunity to submit to the reviewer written comments, documents, records and other information relating to the claim for benefits;
   - A full and fair review that takes into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted or considered in the initial benefit determination; and
   - A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

3. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:
   - Consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
   - Be neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
   - Provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

4. Under this Plan’s two-level appeal procedure, the Plan subcontracts the first level of appeal review to the Claims Administrator, who will make the first-level determination on the post-service claim appeal within a reasonable period of time but not later than 30 calendar days after receipt of the appeal.
   - There is no extension permitted to the Plan in the first or second level of the appeal review procedure.
   - You will be sent a written notice of the appeal determination as discussed below.
   - If still dissatisfied with the first-level appeal determination, you will have a reasonable period of time (180 calendar days under this Plan) after receipt of the first-level appeal determination to request a second-level appeal review by writing to the Plan Administrator.
5. A written (or electronic as applicable) notice of the appeal determination will be provided to you (at each level of the appeal review procedure). If the post-service claim is denied on appeal, the notice of appeal determination will include:

- The specific reason(s) for the adverse appeal review decision;
- Reference to the specific Plan provision(s) on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of documents, records and other information relevant to the claim (whether a document, record or other information is relevant will be determined solely by the reviewer in accordance with applicable regulations);
- A statement that you have the right to bring a civil action under ERISA Section 502(a) following the appeal;
- If the denial is based on an internal rule, guideline, protocol or other similar criterion, the denial will contain a statement that such rule, guideline, protocol or criterion was relied upon and that it will be provided free of charge to you upon request;
- If the denial is based on medical necessity, experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the denial applying the terms of the Plan to your medical circumstances will be provided free of charge to you upon request; and
- The notice of first-level appeal determination will describe the procedure to proceed to a second-level appeal review with time frames if dissatisfied with the determination.

6. This concludes the post-service claim appeal procedure under this Plan. The Plan does not offer a voluntary post-service claim appeal procedure.

How to File an Urgent Care Claim for Benefits Under This Plan

Urgent care claims are a subset of pre-service claims. If your claim is an urgent care claim (as defined earlier), you or your authorized representative must file the claim in accordance with the Plan’s urgent care claims procedure described below.

1. An urgent care claim must be made by means of an oral or written request to the Utilization Review Company or SRP Behavioral Health Program whose telephone number and mailing address are listed on the Quick Reference Chart in the front of this section of the Handbook. Services under the SRP Medical PPO or EPO and the SRP Behavioral Health Program that require precertification are described in the SRP Health Care Program in this section of the Handbook.

2. If a health care professional with knowledge of an individual’s medical condition determines that a claim involves urgent care (as described earlier in this Handbook), the Plan will consider the health care professional to be the individual’s authorized representative (bypassing the need for completion of the Plan’s authorized representative form).

3. The Utilization Review Company or Behavioral Health Program will notify you of the Plan’s benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the urgent care claim, unless you fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan. If the urgent care claim is also a concurrent care claim, the Utilization Review Company or Behavioral Health Program will notify you of the Plan’s
benefit determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim as long as your claim is filed with the Plan at least 24 hours before the expiration of the prescribed course of treatment. If you provide insufficient information to decide the urgent care claim:

- The Utilization Review Company or Behavioral Health Program will notify you as soon as possible, but not later than 24 hours after receipt of the urgent care claim, of the specific information necessary to complete the urgent care claim. You will be given a reasonable amount of time, but not less than 48 hours, to provide the specified information.
- You will be notified of the Plan’s benefit determination on the urgent care claim as soon as possible, but not later than 48 hours after the earlier of the receipt of the specified information or the end of the period of reasonable time allowed to you in which to provide the information.

4. If the urgent care claim is approved, you will be notified orally followed by written (or electronic as applicable) notification.

5. If the urgent care claim is denied, in whole or in part, you will be notified orally followed by written (or electronic as applicable) notification no later than three days after the oral notification. The notice of denial will:

- Give the specific reason(s) for the denial;
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional information needed to perfect the claim and an explanation of why such additional information is necessary;
- Provide an explanation of the Plan’s appeal procedure along with time limits;
- Contain a statement that you have the right to bring civil action under ERISA Section 502(a) if your claim is denied on the appeal;
- If the denial is based on an internal rule, guideline, protocol or other similar criterion, the denial will contain a statement that such rule, guideline, protocol or criterion was relied upon and that it will be provided free of charge to you upon request;
- If the denial is based on medical necessity, experimental treatment or similar exclusion or limit, the denial will contain a statement that an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided free of charge to you upon request; and
- Contain a description of the expedited appeal review procedure for urgent care claims.

6. If you disagree with a denial of an urgent care claim, you or your authorized representative may appeal the decision by filing an expedited appeal in accordance with the Plan’s expedited appeal procedure for denial of urgent care claims. You have 180 calendar days after receipt of the denial to file an appeal. The Plan will not accept appeals filed after this 180-calendar-day period.
**Expedited Appeal of a Denial of an Urgent Care Claim**

The Plan maintains a one-level mandatory appeal procedure for expedited appeals of urgent care claims, which is described in this section. It also maintains a voluntary appeals procedure for voluntary appeals of expedited urgent care claims, which is described in the next section. The mandatory appeals procedure is “mandatory” in the sense that it must be completed before proceeding to the voluntary appeal and it must be completed before bringing a civil action against the Plan in connection with the denied claim. Unless you want to preserve your right to bring a civil action against the Plan, you are not required to appeal a denied urgent care claim.

1. An expedited mandatory appeal must be made orally or in writing to the Utilization Review Company or Behavioral Health Program at the telephone number or mailing address listed on the Quick Reference Chart in the front of this section of the Handbook.

2. You will be provided with:
   - Upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to the claim for benefits (whether a document, record or other information is relevant will be determined solely by the reviewer in accordance with applicable regulations);
   - The opportunity to submit to the reviewer written comments, documents, records and other information relating to the claim for benefits;
   - A full and fair review that takes into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted or considered in the initial benefit determination;
   - A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.

3. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:
   - Consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
   - Be neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
   - Provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

4. The Plan subcontracts the mandatory appeal review to the Utilization Review Company or Behavioral Health Program, which will make the mandatory appeal determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal. There is no extension permitted to the Plan in the mandatory appeal procedure.

5. A notice of the mandatory appeal determination for an urgent care claim will be provided to you orally followed by written (or electronic as applicable) notification. If the urgent care claim is denied on appeal, the notice of appeal determination will include:
   - The specific reason(s) for the adverse appeal review decision;
• Reference to the specific Plan provision(s) on which the denial is based;
• A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of documents, records and other information relevant to the claim (whether a document, record or other information is relevant will be determined solely by the reviewer in accordance with applicable regulations.);
• A statement that you have the right to bring a civil action under ERISA Section 502(a) following the appeal;
• If the denial is based on an internal rule, guideline, protocol or other similar criterion, the denial will contain a statement that such rule, guideline, protocol or criterion was relied upon and that it will be provided free of charge to you upon request; and
• If the denial is based on medical necessity, experimental treatment or similar exclusion or limit, the denial will contain a statement that an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided free of charge to you upon request.

The notice of mandatory appeal determination will describe the procedure to proceed to a voluntary appeal review and time frames if dissatisfied with the determination.

6. This concludes the mandatory urgent care claim expedited appeal procedure under the Plan.

**Voluntary Additional Appeal of a Denial of an Urgent Care Claim**

If dissatisfied with the mandatory appeal determination, you or your authorized representative may appeal the determination by filing an appeal in accordance with the Plan’s procedure for voluntary appeal of a denial of an urgent care claim. You have 180 calendar days after receipt of the mandatory appeal determination to file a voluntary appeal. The Plan will not accept voluntary appeals filed after this 180-calendar-day period.

The Plan’s voluntary appeal procedure for urgent care claims is available only after you have completed the mandatory appeal procedure for urgent care claims outlined in the preceding section. If you elect not to have a denied urgent care claim reviewed according to the voluntary appeal procedure of this Plan, the Plan will not maintain that you have failed to exhaust the administrative remedies (claim appeal process) of this Plan because you did not elect to submit your denied urgent care claim to this voluntary appeal procedure. This section provides the full description of the voluntary appeal procedure under this Plan to allow you to make an informed decision about whether to submit your denied urgent care claim to this voluntary appeal procedure.

1. The Plan agrees that any statute of limitations or other defense based on timeliness is tolled (suspended) during the time that your voluntary appeal is pending.
2. Your decision whether to proceed with this voluntary appeal procedure will not have any effect on your right to any other benefit under this Plan.
3. You have the right to representation if you so choose during this voluntary appeal procedure.
4. There is no cost to you for having your denied claim reviewed under this voluntary appeal procedure unless you obtain representation and the person providing the representation charges you.
5. In the voluntary appeal procedure under this Plan, decisions will be made by a designee of the Plan Administrator of this self-funded group health Plan who is the Benefits Manager and an employee of the Plan sponsor, SRP.
6. There is no arbitration provision in this Plan.
7. You are not precluded from challenging the claim denial under ERISA Section 502(a) or other applicable law.
8. The voluntary appeal process is as follows:

- Voluntary appeals must be made in writing to the Plan Administrator at the address listed on the **Quick Reference Chart** in the front of this section of the Handbook.

You will be provided with:

- Upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to the claim for benefits (whether a document, record or other information is relevant will be determined solely by the reviewer in accordance with applicable regulations);
- The opportunity to submit to the reviewer written comments, documents, records and other information relating to the claim for benefits;
- A full and fair review that takes into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted or considered in the initial benefit determination; and
- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.

In deciding a voluntary appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the Benefits Manager will:

- Consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Be neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
- Provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

The Benefits Manager will make the determination on the voluntary urgent care claim appeal within a reasonable period of time appropriate to the circumstances but not more than 30 calendar days after receipt of the appeal. The 30-calendar-day period may be extended one time for up to 15 additional calendar days if the Benefits Manager determines that an extension is necessary due to matters beyond the control of the Plan. You will be notified of the extension and the date by which the Benefits Manager expects to make a decision prior to the expiration of the initial 30-day period using a **Notice of Extension**.

A written (or electronic as applicable) notice of the voluntary appeal determination will be provided to you. If the urgent care claim is denied on voluntary appeal, the notice of voluntary appeal determination will include:

- The specific reason(s) for the adverse appeal review decision;
- Reference to the specific Plan provision(s) on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of documents, records and other information relevant to the claim (whether a document, record or other information is relevant will be determined solely by the reviewer in accordance with applicable regulations);
» If the denial is based on an internal rule, guideline, protocol or other similar criterion, the denial will contain a statement that such rule, guideline, protocol or criterion was relied upon and that it will be provided free of charge to you upon request; and
» If the denial was based on medical necessity, experimental treatment or similar exclusion or limit, the denial will contain a statement that an explanation of the scientific or clinical judgment of the denial, applying the terms of the Plan to your medical circumstances, will be provided free of charge to you upon request; and
» A statement that you have the right to bring a civil action under ERISA Section 502(a).

9. This concludes the voluntary appeal procedure for urgent care claims under this Plan.

How to File a Concurrent Care Claim for Benefits Under This Plan

If your claim is a concurrent care claim (as defined earlier), you or your authorized representative must file the claim in accordance with the Plan’s concurrent care claims procedure as follows.

Concurrent Care Cut Short by the Plan

1. Adverse benefit determination: If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the course of treatment (other than by Plan amendment or termination) before the end of the previously approved period of time or approved number of treatment is an adverse benefit determination. In such event, the Plan will notify you of the adverse benefit determination sufficiently in advance of the reduction or termination to allow you to complete the appeal procedure before the treatment ends or is reduced. The notice of adverse benefit determination will:
   • Give the specific reason(s) for the adverse benefit determination;
   • Reference the specific Plan provision(s) on which the adverse benefit determination is based;
   • Describe any additional information needed to perfect the claim and an explanation of why such additional information is necessary;
   • Provide an explanation of the Plan’s appeal procedure along with time limits;
   • Contain a statement that you have the right to bring civil action under ERISA Section 502(a) if your claim is denied on the appeal;
   • If the adverse benefit determination is based on an internal rule, guideline, protocol or other similar criterion, the adverse benefit determination will contain a statement that such rule, guideline, protocol or criterion was relied upon and that it will be provided free of charge to you upon request;
   • If the adverse benefit determination is based on medical necessity, experimental treatment or similar exclusion or limit, the adverse benefit determination will contain a statement that an explanation of the scientific or clinical judgment for the adverse benefit determination, applying the terms of the Plan to your medical circumstances, will be provided free of charge to you upon request; and
   • Contain a description of the appeal review procedure.

2. Appeal: If you disagree with an adverse benefit determination on concurrent care that is reduced or terminated, you or your authorized representative may appeal the decision by filing an expedited appeal in accordance with the Plan’s expedited appeal procedure for denial of urgent care claims (described earlier in this Handbook). You will be given a reasonable period of time after receipt of the adverse benefit determination to file an expedited appeal.
Concurrent Care You Want to Extend

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, you or your authorized representative may request an extension of the course of treatment beyond the period of time or number of treatments in accordance with the Plan’s concurrent care claims procedure described below.

If the concurrent care claim is:

- An urgent care claim, the claim and any appeal must be made by using the claim and appeal procedures for urgent care claims discussed earlier in this Handbook. The Utilization Review Company or Behavioral Health Program will notify you of the Plan’s benefit determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim as long as your claim is filed with the Plan at least 24 hours before the expiration of the prescribed course of treatment.
- A post-service claim, the claim and any appeals must be made by using the claim appeal procedures for post-service claims discussed earlier in this Handbook.
- A pre-service claim, the claim and any appeal must be made by using the claim and appeal procedures for pre-service claims discussed later in this Handbook.

How to File a Pre-Service Claim for Benefits Under This Plan

If your claim is a pre-service claim (as defined earlier), you or your authorized representative must file the claim in accordance with the Plan’s pre-service claims procedures described below.

1. A pre-service claim must be made by means of an oral or written request to the Utilization Review Company or Behavioral Health Program whose telephone number and mailing address are listed on the Quick Reference Chart in the front of this section of the Handbook. Services under the Medical PPO or EPO and SRP Behavioral Health Program that require precertification are described in Precertification: The Utilization Review Program (UR) in this section of the Handbook.

2. The Utilization Review Company or Behavioral Health Program will notify you of the Plan’s benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 calendar days after the Plan receives the pre-service claim. The Utilization Review Company or Behavioral Health Program may extend the 15-calendar-day period one time for up to 15 additional calendar days if the Utilization Review Company or Behavioral Health Program determines that an extension is necessary due to matters beyond the control of the Plan. The Utilization Review Company or Behavioral Health Program will notify you of the extension and of the date by which the Plan expects to make a decision prior to the expiration of the initial 15-day period using a written Notice of Extension.

If a period of time is extended due to failure to submit information required to process the claim, the Notice of Extension will specifically describe the required information and you will be given 45 calendar days after receipt of the Notice to provide the specified information. If the Plan cannot process a claim without the required information, the time period for the Plan to process the claim will be tolled from the date on which the Notice of Extension is sent until the date on which the Utilization Review Company or Behavioral Health Program receives your response.

3. If the pre-service claim is approved, you will be notified orally followed by written (or electronic as applicable) notification on a form called an Explanation of Benefits (EOB). The provider of service or you (when applicable) will be paid the portion of the claim for which the Plan is responsible.

Need more help? See the Quick Reference Chart in the front of this section.
4. **If the pre-service claim is denied, in whole or in part,** you will be notified orally followed by written (or electronic, as applicable) notification on the Explanation of Benefits (EOB). The notice of denial will:

   - Give the specific reason(s) for the denial;
   - Reference the specific Plan provision(s) on which the denial is based;
   - Describe any additional information needed to perfect the claim and an explanation of why such additional information is necessary;
   - Provide an explanation of the Plan’s appeal procedure along with time limits;
   - Contain a statement that you have the right to bring a civil action under ERISA Section 502(a) if your claim is denied on appeal;
   - If the denial was based on an internal rule, guideline, protocol or other similar criterion, the denial will contain a statement that such rule, guideline, protocol or criterion was relied upon and that it will be provided free of charge to you upon request; and
   - If the denial is based on medical necessity, experimental treatment or similar exclusion or limit, the denial will contain a statement that an explanation of the scientific or clinical judgment for the denial applying the terms of the Plan to your medical circumstances will be provided free of charge to you upon request.

5. **If you disagree with a denial of a pre-service claim,** you or your authorized representative may appeal the decision by filing an appeal in accordance with the Plan’s appeal procedure for denial of a pre-service claim. You have 180 calendar days after receipt of a denial to file an appeal. The Plan will not accept appeals filed after this 180-calendar-day period.

**Appeal of a Denial of a Pre-Service Claim**

This Plan maintains a one-level mandatory appeals procedure for appeals of pre-service claims, which is described in this section. It also maintains a voluntary appeals procedure for voluntary appeals of pre-service claims, which is described in the next section. The mandatory appeals procedure is “mandatory” in the sense that it must be completed before proceeding to the voluntary appeal and it must be completed before bringing a civil action against the Plan in connection with the denied claim. Unless you want to preserve your right to bring a civil action against the Plan, you are not required to appeal a denied pre-service claim.

1. A mandatory appeal must be made in writing to the Utilization Review Company or Behavioral Health Program at the address listed on the Quick Reference Chart in the front of this section of the Handbook.

2. You will be provided with:

   - Upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to the claim for benefits (whether a document, record or other information is relevant will be determined solely by the reviewer in accordance with applicable regulations);
   - The opportunity to submit to the reviewer written comments, documents, records and other information relating to the claim for benefits;
   - A full and fair review that takes into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted or considered in the initial benefit determination; and
   - A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal.
nor the subordinate of such individual.

3. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:
   • Consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
   • Be neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
   • Provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

4. The Plan subcontracts the mandatory appeal review to the Utilization Review Company or Behavioral Health Program, which will make the mandatory appeal determination on the pre-service claim appeal within a reasonable period of time appropriate to the circumstances, but not later than 30 calendar days after receipt of the appeal.
   • There is no extension permitted to the Plan in the mandatory appeal procedure.

5. A written (or electronic as applicable) notice of the mandatory appeal determination will be provided to you. If the pre-service claim is denied on mandatory appeal, the notice of mandatory appeal determination will include:
   • The specific reason(s) for the adverse appeal review decision;
   • Reference to the specific Plan provision(s) on which the denial is based;
   • A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of documents, records and other information relevant to the claim (whether a document, record or other information is relevant will be determined solely by the reviewer in accordance with applicable regulations);
   • A statement that you have the right to bring a civil action under ERISA Section 502(a) following the appeal;
   • If the denial is based on an internal rule, guideline, protocol or other similar criterion, the denial will contain a statement that such rule, guideline, protocol or criterion was relied upon and that it will be provided free of charge to you upon request; and
   • If the denial was based on a medical necessity, experimental treatment or similar exclusion or limit, the denial will contain a statement that an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided free of charge to you upon request.
   • The notice of mandatory appeal determination will describe the procedure to proceed to a voluntary appeal review and time frames if dissatisfied with the determination.

6. This concludes the mandatory pre-service claim appeal procedure under the Plan.
**Voluntary Additional Appeal of a Denial of a Pre-Service Claim**

If dissatisfied with the mandatory appeal determination, you or your authorized representative may appeal the determination by filing an appeal in accordance with the Plan’s procedure for voluntary appeal of a denial of a pre-service claim discussed in this section. You have 180 calendar days after receipt of the mandatory appeal determination to file a voluntary appeal. The Plan will not accept voluntary appeals filed after this 180-calendar-day period.

The Plan’s voluntary appeal procedure for pre-service claims is available only after you have completed the mandatory appeal procedure for pre-service claims outlined in the preceding section. If you elect not to have a denied pre-service claim reviewed according to the voluntary appeal procedure of this Plan, the Plan will not maintain that you have failed to exhaust the administrative remedies (claim appeal process) of this Plan because you did not elect to submit your denied pre-service claim to this voluntary appeal procedure. This section provides the full description of the voluntary appeal procedure under this Plan to allow you to make an informed decision about whether to submit your denied pre-service claim to this voluntary appeal procedure.

1. The Plan agrees that any statute of limitations or other defense based on timeliness is tolled (suspended) during the time that your voluntary appeal is pending.
2. Your decision whether to proceed with this voluntary appeal procedure will not have any effect on your right to any other benefit under this Plan.
3. You have the right to representation if you so choose during this voluntary appeal procedure.
4. There is no cost to you for having your denied claim reviewed under this voluntary appeal procedure unless you obtain representation and the person providing the representation charges you.
5. In the voluntary appeal procedure under this Plan, decisions will be made by a designee of the Plan Administrator of this self-funded group health plan who is the Benefits Manager and an employee of the Plan sponsor, SRP.
6. There is no arbitration provision in this Plan.
7. You are not precluded from challenging the claim denial under ERISA Section 502(a) or other applicable law.
8. The voluntary appeal process is as follows:
   - Voluntary appeals must be made in writing to the Plan Administrator at the address listed on the Quick Reference Chart in the front of this section of the Handbook.
   - You will be provided with:
     - Upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to the claim for benefits (whether a document, record or other information is relevant will be determined solely by the reviewer in accordance with applicable regulations);
     - The opportunity to submit to the reviewer written comments, documents, records and other information relating to the claim for benefits;
     - A full and fair review that takes into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted or considered in the initial benefit determination;
     - A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual;
In deciding a voluntary appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the Benefits Manager will:

- Consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Be neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
- Provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

The Benefits Manager will make the determination on the voluntary pre-service claim appeal within a reasonable period of time appropriate to the circumstances but not later than 30 calendar days after receipt of the appeal. The 30-calendar-day period may be extended one time for up to 15 additional calendar days if the Benefits Manager determines that an extension is necessary due to matters beyond the control of the Plan. You will be notified of the extension and the date by which the Benefits Manager expects to make a decision prior to the expiration of the initial 30-day period using a Notice of Extension.

A written (or electronic, as applicable) notice of the voluntary appeal determination will be provided to you. If the pre-service claim is denied on voluntary appeal, the notice of voluntary appeal determination will include:

- The specific reason(s) for the adverse appeal review decision;
- Reference to the specific Plan provision(s) on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of documents, records and other information relevant to the claim (whether a document, record or other information is relevant will be determined solely by the reviewer in accordance with applicable regulations);
- If the denial is based on an internal rule, guideline, protocol or other similar criterion, the denial will contain a statement that such rule, guideline, protocol or criterion was relied upon and that it will be provided free of charge to you upon request;
- If the denial was based on a medical necessity, experimental treatment or similar exclusion or limit, the denial will contain a statement that an explanation of the scientific or clinical judgment of the denial, applying the terms of the Plan to your medical circumstances, will be provided free of charge to you upon request; and
- A statement that you have the right to bring civil action under ERISA Section 502(a).

9. This concludes the voluntary appeal procedure for pre-service claims under this Plan.
### OVERVIEW OF TIMEFRAMES FOR CLAIMS AND APPEALS

<table>
<thead>
<tr>
<th></th>
<th>Urgent</th>
<th>Concurrent</th>
<th>Pre-service</th>
<th>Post-service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan must make</strong></td>
<td></td>
<td>Before the benefit is reduced or treatment terminated</td>
<td>15 days</td>
<td>30 days</td>
</tr>
<tr>
<td><strong>Initial Claim Benefit</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Determination</strong></td>
<td>72 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Extension permitted during initial benefit determination?</strong></td>
<td>No</td>
<td>No</td>
<td>15 days</td>
<td>15 days</td>
</tr>
<tr>
<td><strong>Appeal Review must be submitted to the Plan within:</strong></td>
<td>180 days</td>
<td>180 days</td>
<td>180 days</td>
<td>180 days</td>
</tr>
<tr>
<td><strong>Plan must make</strong></td>
<td></td>
<td>Before the benefit is reduced or treatment terminated</td>
<td>30 days for a one level appeal</td>
<td>30 days for each level of a 2 level appeal</td>
</tr>
<tr>
<td><strong>Appeal Claim Benefit</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Determination</strong></td>
<td>72 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Extension permitted during appeal review?</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Voluntary Appeal?</strong></td>
<td>Yes</td>
<td>Yes - if urgent or preservice claim</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### Limitation on When a Lawsuit May Be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan’s claims and appeal procedures) for every issue deemed relevant by the claimant, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. No lawsuit to obtain benefits may be started more than three years after the end of the year in which health care services were provided.

### Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to administer the Plan, to construe and apply all Plan provisions, and to resolve any ambiguities in the application or terms of the Plan, including the discretionary authority to determine all questions of fact relating to eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be conclusive, final and binding upon all participants in the Plan and upon all individuals claiming any rights under the Plan, including beneficiaries unless it can be shown that the interpretation or determination was arbitrary and capricious.

### Facility of Payment

If the Plan Administrator or its designee determines that you cannot submit a claim or you cannot prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the plan’s obligations to the extent of that payment. The Plan, Plan Administrator, Claims Administrator and any other designee of the Plan Administrator will not be required to see to the application of the money so paid.
SRP Vision Plan

The SRP Vision Plan is part of the self-insured health plans maintained separately by the District and the Association.

Eligibility

Regular full-time, three-quarter-time and half-time employees of SRP along with PERA employees and their eligible dependents may participate in the SRP Vision Plan. Provisional employees and their dependents and retirees and their dependents are not eligible for SRP Vision Plan benefits.

Vision services are designed to protect your visual wellness and are offered through in-network providers or from non-network providers. Covered expenses (as shown on the Schedule of SRP Vision Benefits in this section of the Handbook, refer to the allowed charge up to the maximum allowed as payable under this Vision Plan. You may have to pay extra if you choose cosmetic or elective eyewear options.

- **Network vision providers**: Network providers (ophthalmologist, optometrist or optician) have a contract to provide discounted fees and services at wholesale cost to you for services covered under the SRP Vision Plan. By using the services of an in-network provider, both you and the SRP Vision Plan pay less (see the in-network column of the Schedule of SRP Vision Benefits). A current list of network vision providers is available free of charge when you call the SRP Vision Plan listed on the Quick Reference Chart in the front of this section of the Handbook. To receive services, simply call an in-network vision provider and identify yourself as a member of the SRP Vision Plan.

- **Non-network providers**: Services may be received from any licensed optometrist, ophthalmologist and/or optician; however, the SRP Vision Plan will pay the non-network provider benefits level as noted in the Schedule of Vision Benefits. The itemized bill reflecting the non-network provider’s fees must be submitted to the SRP Vision Plan’s Claims Department for reimbursement within 180 days of the date of service. Non-network provider services are billed at retail (without a discount), and vision services will cost you more from a non-network vision provider than if those same services were obtained from an in-network vision provider.

Vision Terms Defined

- **Vision exam**: A professional examination and an eye refraction, including an assessment of your health history particularly as it is relevant to your vision; an external exam of the eyes for pathological abnormalities of the eyes, including but not limited to pupil, lens and lashes/eyelids; and an internal exam, including but not limited to an assessment of the lens and retina along with tonometry (measurement of the fluid pressure in the eye to help detect signs of glaucoma), visual field testing (checks peripheral visual capabilities), biomicroscopy (retina examination) and inspection of the retina with an ophthalmoscope, visual acuity (the ability to see clearly at all distances) and refraction (testing the eyes’ ability to focus light rays on the retina from a distance and close up).

- **Ophthalmologist**: A physician licensed to practice ophthalmology, including surgery and prescription of drugs.

- **Optician**: A person licensed to dispense ophthalmic materials (manufacture and sell eyeglasses and/or contact lenses).

- **Optometrist**: A person licensed to practice optometry.
Schedule of Vision Benefits

The chart opposite lists the vision care benefits available under the SRP Vision Plan.

Filing a Claim/Appealing a Denied Vision Plan Claim

See Claim Filing and Appeals Information in this section of the Handbook.

Exclusions and Limitations of the SRP Vision Plan

The SRP Vision Plan is designed to cover visual needs rather than cosmetic materials. When a covered person selects any of the following extras, the SRP Vision Plan will pay the cost of the allowed vision service/supply and the covered person will pay the additional cost for the extras, such as:

1. Oversized lenses (except with prior authorization by the SRP Vision Plan), progressive multifocal lenses, blended lenses, coated lenses, high-index lenses, aspheric lenses, laminated lenses, photochromic/gradient lenses, plano (non-prescription/no power) lenses or orthokeratology lenses for reshaping the cornea of the eye to improve vision.
2. Vision services and supplies that cost more than the SRP Vision Plan’s allowance or are obtained/received more frequently than allowed as noted in the Schedule of Vision Benefits.
3. Lenses and frames furnished under this program that are lost or broken will not be replaced except at the normal intervals when services are otherwise available as described in the Schedule of Vision Benefits.
4. Glasses secured when there is no prescription charge, or two pairs of lenses or glasses in lieu of bifocals.

The following is a list of services and supplies or expenses not covered by the SRP Vision Plan.
1. Orthoptics (vision training to improve visual perception and coordination between the two eyes), subnormal vision aids and any associated supplemental testing
2. Medical or surgical treatment of the eyes, including but not limited to refractive keratoplasty (RK)
3. Services or materials provided as a result of any Workers’ Compensation law or similar occupational health legislation, or obtained through or required by any government agency or program, whether federal, state or any subdivision thereof
4. Services or supplies received for an illness that is a result of war, whether declared or undeclared
5. Vision exams/checkups or screenings requested by the participant’s employer as a condition of employment, for school or government
6. Treatment received from a medical department maintained by an employer, a mutual benefit association, a labor union, a trustee or a similar type group
7. Experimental and/or investigational treatment or procedure
8. Any service or material provided by any other vision care plan or group benefit plan containing benefits for vision care
9. Benefits incurred beyond the termination date of the SRP Vision Plan, unless COBRA coverage is in place
### SCHEDULE OF VISION BENEFITS

See also **Exclusions: SRP Vision Plan** and **Definitions** in this section of the Handbook.

<table>
<thead>
<tr>
<th>Covered Vision Benefits</th>
<th>Explanations and Limitations</th>
<th>In-Network Provider</th>
<th>Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision Examination</strong></td>
<td>• One comprehensive vision exam of the visual function, including prescribing of corrective eyeglasses, where indicated, is payable once each calendar year. • You pay an additional fee if you also want an exam for contact lenses.</td>
<td>100% after you pay a $15 copay per exam</td>
<td>100%, not to exceed $50 per exam</td>
</tr>
<tr>
<td><strong>Frames for Eyeglasses</strong></td>
<td>• One frame is payable once each calendar year. • You pay the difference in cost between frames you select and the cost allowed under the SRP Vision Plan. • Benefits for safety glasses are also available.</td>
<td>Frames under the standard in-network frame allowance: 100% up to a maximum allowance of $150</td>
<td>100% not to exceed $75</td>
</tr>
<tr>
<td><strong>Lenses for Eyeglasses</strong></td>
<td>• A pair of single-vision, bifocal, trifocal or lenticular lenses as required, including solid tint, polycarbonate and progressive lenses, is payable once each calendar year.</td>
<td>100% for standard single-vision, bifocal, trifocal or lenticular lenses in glass or plastic</td>
<td>Single vision: 100%, up to $40. Bifocals: 100%, up to $60. Trifocals: 100%, up to $80</td>
</tr>
<tr>
<td><strong>Corrective Surgery</strong></td>
<td>• PRK (photorefractive keratectomy) • LASIK (laser-assisted in-situ keratomileusis) • Custom LASIK (Wavefront LASIK):</td>
<td>$250 per eye contributed to the discounted pricing</td>
<td>$225 per eye, no discounted pricing</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td>• Elective contact lenses • Medically necessary (as determined by the Vision Plan Claims Administrator) contact lenses are payable only for the following reasons: (a) Following cataract surgery; (b) To correct extreme visual acuity problems that cannot be corrected with normal eyeglasses; or (c) Anisometropia (condition of unequal refractive state for the two eyes) or keratoconus (developmental or dystrophic deformity of the cornea causing it to become cone-shaped)</td>
<td>Cosmetic lenses (elective/ not medically necessary): 100%, up to $100 per pair or $50 per lens in lieu of lenses and frames during each 12 months</td>
<td>Cosmetic lenses (medically necessary): 100% to a maximum allowance of $350</td>
</tr>
</tbody>
</table>

Need more help? See the [Quick Reference Chart](#) in the front of this section.
<table>
<thead>
<tr>
<th>Covered Vision Benefits</th>
<th>Explanations and Limitations</th>
<th>In-Network Provider</th>
<th>Non-Network Provider</th>
</tr>
</thead>
</table>
| Safety Eyewear/Safety Glasses Benefit   | • This safety eyewear benefit is available for SRP employees only and not for dependents.  
• Lenses and frames provided under this benefit are certified as safe for the work environment by meeting the necessary requirements set forth by the American National Standards Institute.  
• The Vision Plan guarantees benefits only with services obtained from an in-network provider.  
• To order safety eyewear:  
  a. Obtain a Vision Plan Safety Eyewear Authorization form from the Vision Plan Claims Administrator (whose name and contact information is listed on the Quick Reference Chart in this document), listing the in-network eye doctor you would like to visit.  
  b. Have the Safety Eyewear Authorization form signed by your supervisor.  
  c. Fax the Safety Eyewear Authorization form to the Vision Plan Claims Administrator.  
  d. Confirmation of eligibility will be provided to the in-network provider.  
• Lenses are payable every calendar year and include single-vision, lined bifocal and lined trifocal lenses.  
• Lens options include coverage for polycarbonate, progressive, solid tints and color coating.  
• Frames are payable every calendar year. The in-network vision provider can show you the approved frames. Titmus-branded frames are covered in full.                                                                 | Safety glasses :  
$25 copay per pair | No coverage |
SRP Dental Program

The SRP Dental Program is a voluntary benefit that is part of the self-insured health plans maintained separately by the District and the Association.

Eligibility

Regular full-time, three-quarter-time and half-time employees of SRP along with PERA employees are eligible to participate in this SRP Dental Program. Your eligible dependents are also eligible to participate in this SRP Dental Program. Retirees and provisional employees are not eligible for SRP Dental Program benefits.

Dental Providers

When you elect to participate in the SRP Dental Program, you may choose any licensed dental care provider for your care. Dental care providers payable by the SRP Dental Program include a dentist or dental hygienist who is legally licensed and who is a dentist or performs services under the direction of a licensed dentist; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient. This SRP Dental Program contracts with a network of dental providers that offer you a discount off their billed charges. For a list of contracted dental providers, contact the SRP Dental Program provider network listed on the Quick Reference Chart in the front of this section of the Handbook.

• Network participating dental providers: If you receive dental services or supplies from a dental care provider that is a member of the SRP Dental Program’s contracted dental network, you will be responsible for paying less money out of your pocket. Dental care providers who are members of this dental network have agreed to extend a discount for their services and to accept the amount the SRP Dental Program pays for covered services, plus any additional coinsurance you are responsible for paying, as payment in full. To verify if a dental provider participates in the network, contact the dental network, whose name and phone number are listed on the Quick Reference Chart in the front of this section of the Handbook.

• Non-network dental providers: Out-of-network (non-network, non-participating) dental care providers have no agreements with the SRP Dental Program and are generally free to set their own charges for the services or supplies they provide. The SRP Dental Program will reimburse the SRP Dental Program participant for the allowed charge for any medically necessary services or supplies, subject to the SRP Dental Program’s deductible, coinsurance, exclusions and limitations. Non-network dental care providers may bill you for any balance that may be due in addition to the amount payable by the SRP Dental Program, also called balance billing. You can avoid balance billing by using in-network participating dental providers.

SRP Dental Program Definitions

The following terms pertaining to the SRP Dental Program are defined in Definitions in this section of the Handbook. These definitions will help you understand the covered and excluded services that pertain to the SRP Dental Program. These definitions do not and should not be interpreted to extend coverage under your Medical and/or Dental Plan option.

- Accidental injury to teeth
- Allowed charge
- Appliance (dental)
- Bitewing X-rays
- Bridge
- Bridgework (dental)

Need more help? See the Quick Reference Chart in the front of this section.
Covered Dental Expenses

You are covered for expenses you incur for most, but not all, dental services and supplies provided by a dental care provider, as defined in Definitions in this section of this Handbook, that are determined by the Plan Administrator or its designee to be “medically necessary,” but only to the extent that:

- The Plan Administrator or its designee determines that the services are the most cost-effective ones that meet acceptable standards of dental practice and would produce a satisfactory result; and
- The charges for them are allowed charges and not otherwise excluded charges. (See Definitions in this section of the Handbook.)

Non-Eligible Dental Expenses

The SRP Dental Program will not reimburse you for any expenses that are not eligible dental expenses. That means you must pay the full cost for all expenses that are not covered by the SRP Dental Program, as well as any charges for eligible dental expenses that exceed the amount determined by the SRP Dental Program to be an allowed charge.
Dental Plan Deductible

Each calendar year, you are responsible for paying all your eligible dental expenses until you satisfy the annual Dental Plan deductible. Then, the Dental Program begins to pay benefits. There are two types of deductibles: individual and family. The deductible applies to orthodontia and basic/major services.

- The individual deductible is the maximum amount one covered person has to pay each calendar year before SRP Dental Program benefits begin. The SRP Dental Program’s individual deductible is $50.
- The family deductible is the maximum amount that a family of two or more has to pay each calendar year before plan benefits begin. The SRP Dental Program’s family deductible is $100.
- Note that eligible dental expenses incurred for preventive services are not subject to a deductible.

Coinsurance for Dental Services

Once you’ve met your annual deductible, the SRP Dental Program pays a percentage of the eligible dental expenses, and you are responsible for paying the rest. The applicable percentage paid by the SRP Dental Program is shown in the Schedule of Dental Benefits. The part you pay is called the coinsurance.

Annual Maximum Dental Program Benefits

The SRP Dental Program’s calendar year annual maximum Dental Plan benefit payable for any individual covered under the SRP Dental Program is $2,500. This maximum does not include your deductible, any amounts over the allowed charge or orthodontia expenses. Preventive services are not subject to the annual maximum SRP Dental Program benefit.

Overall Lifetime Orthodontia Maximum Dental Program Benefits

The overall lifetime maximum SRP Dental Program benefit payable for orthodontia services for any individual covered under the SRP Dental Program is $2,500. Any orthodontia treatment is subject to the overall lifetime maximum plan benefit in effect when the initial treatment began.

Once you are covered under this Plan, services related to orthodontia will have an initial payment made upon insertion of the appliance or upon initial banding. The initial banding date is considered the date of service for orthodontic services. The second payment will be made one year after the insertion or banding if the patient has current eligibility. Benefits will cease when the overall lifetime orthodontia maximum SRP Dental Program benefits have been reached or when your dental benefits end or when you stop orthodontia treatment before the treatment plan is completed.

Note: This Plan will not extend payment for orthodontia services when the orthodontia banding (the process of cementing orthodontic bands to the teeth) occurred prior to the effective date of coverage under this Plan.

Payment of Dental Benefits

When Charges for Dental Services and Supplies Are Incurred

Dental services and supplies are considered to have been incurred on the date the services are performed or on the date the supplies are furnished. However, this rule does not apply to the following services because they must be performed over a period of time.
• **Fixed partial dentures, bridgework, crowns, inlays and onlays:** All services related to installation of fixed partial dentures, bridgework, crowns, inlays and onlays are considered to have been incurred on the date the tooth (or teeth) are prepared for the installation.

• **Removable partial or complete dentures:** All services related to the preparation of removable partial or completed dentures are considered to have been incurred on the date the dentures are delivered to you, not the date an impression for the dentures is taken.

• **Root canal treatment (endodontics):** All services related to root canal treatment (endodontics) are considered to have been incurred on the date the tooth is opened for the treatment.

**Extension of Dental Coverage**

Dental benefits may be extended beyond the date your dental coverage terminates for certain services that began prior to your dental coverage termination date. Only the following services are eligible: root canal therapy, crowns, bridges, inlays, onlays, and full or partial dentures.

Benefits will be extended beyond your dental coverage termination date for the lesser of:

• Three months (90 days); or
• The period of time covered by a dental treatment plan, providing the condition existed on your coverage termination date and you or your covered dependents were in a period of dental treatment at the time.

The dental work (pulp chamber opened and explored, teeth prepped, impressions made) must have been started prior to the termination date of your dental coverage. If the work is completed 90 days or more after the termination of dental coverage, no benefits are payable by the SRP Dental Program.

**Pretreatment Estimates**

Whenever you expect that your dental expenses for a course of treatment will be more than $500, you may use the pretreatment estimate procedure to help you and your dentist understand what and how benefits may be payable under the SRP Dental Program before you begin treatment.

To request a pretreatment estimate, you and your dentist should complete the regular dental claim form, available from the Claims Administrator for dental services, whose name is listed on the Quick Reference Chart in the front of this section of the Handbook, indicating the type of work to be performed with the estimated cost (valid for one year). Once it is received, the Claims Administrator will review the form and then send you and your dentist within 15 days a statement showing what the SRP Dental Program will pay based on the coded estimate submitted.

**Prescription Drugs Needed for Dental Purpose**

Necessary prescription drugs prescribed for a dental purpose, such as antibiotics or pain medications, should be obtained using the prescription drug benefit of your Medical Plan option. Note that some medications prescribed for a dental purpose may not be payable, such as fluoride or periodontal mouthwashes, etc. For more information about prescription drug coverage for employees enrolled in the SRP Medical PPO or EPO Option, see the discussion of exclusions as related to prescription drugs in Medical Exclusions in this section of the Handbook.
Coordination of Benefits

You or your covered dependents may be entitled to benefits under the SRP Dental Program and may also be entitled to recover all or part of your dental care expenses from some other source. In many of those cases, either the SRP Dental Program or the other source (the primary plan or program) pays benefits or provides services first, and the other (the secondary plan or program) pays some or all of the difference between the total cost of those services and payment by the primary plan or program. In other cases, only one plan pays benefits. This can occur if you or a covered dependent is also covered by:

- Another group dental care plan; or
- Workers’ Compensation.

This section describes the rules that determine which plan pays first (is primary) and which pays second (is secondary), or when one of the plans is responsible for benefits and the other is not. The SRP Dental Program operates under rules that prevent it from paying benefits that, together with the benefits from another source you possess (as described above), would allow you to recover more than 100% of expenses you incur. In many instances, you may recover less than 100% of those expenses from the duplicate sources of coverage or recovery.

In some instances, the SRP Dental Program will not provide coverage if you can recover from some other resource. In other instances, such as with Workers’ Compensation, the SRP Dental Program will advance its benefits, but only subject to its right to recover them from a third party.

When and How Coordination of Benefits (COB) Applies

For the purposes of this COB provision, the word “plan” refers to any group dental policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of dental care services incurred by the covered individual or that provides health care services to the covered individual. A “group plan” provides its benefits or services to employees, retirees or members of a group who are eligible for and have elected coverage. The SRP Dental Program does not coordinate with individual plan policies or auto insurance.

Many families that have more than one family member working outside the home are covered by more than one Dental Plan. If this is the case with your family, you must let the SRP Dental Program Claims Administrator know about all your coverage when you submit a claim.

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

Which Plan Pays First: Order of Benefit Determination Rules

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform order of benefit determination rules in a specific sequence. The SRP Dental Program uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules always pays its benefits first.**

When two group plans cover the same person, the following order of benefit determination rules establishes which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:
Rule 1: Non-Dependent/Dependent
A. The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first, and the plan that covers the same person as a dependent pays second.

Rule 2: Dependent Child Covered Under More Than One Plan
A. The plan that covers the parent whose birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose birthday falls later in the calendar year pays second, if:
   • The parents are married;
   • The parents are not separated (whether or not they ever have been married); or
   • A court decree awards joint custody without specifying that one parent has the responsibility to provide dental care coverage for the child.
B. If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first, and the plan that has covered the other parent for the shorter period of time pays second.
C. The word “birthday” refers only to the month and day in a calendar year, not the year in which the person was born.
D. If the specific terms of a court decree state that one parent is responsible for the child’s dental care expenses or dental care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child’s dental care services or expenses, but that parent’s current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any plan year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.
E. If the parents are not married or are separated (whether or not they ever were married) or are divorced, and there is no court decree allocating responsibility for the child’s dental care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:
   • The plan of the custodial parent pays first;
   • The plan of the spouse of the custodial parent pays second;
   • The plan of the non-custodial parent pays third; and
   • The plan of the spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee
A. The plan that covers a person either as an active employee (that is, an employee who is neither laid off nor retired), or as that active employee’s dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee’s dependent, pays second.
B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
C. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.
Rule 4: Continuation Coverage
A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person’s dependent) pays first, and the plan providing continuation coverage to that same person pays second.
B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
C. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage
A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first, and the plan that covered the person for the shorter period of time pays second.
B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.
C. The start of a new plan does not include a change:
   • In the amount or scope of a plan’s benefits;
   • In the entity that pays, provides or administers the plan; or
   • From one type of plan to another (such as from a single-employer plan to a multiple-employer plan).
D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

How Much This Plan Pays When It Is Secondary
When the SRP Dental Program pays second, it will pay the same benefits that it would have paid had it paid first, less whatever payments were actually made by the plan (or plans) that paid first. This is also referred to as non-duplication or a carve-out COB plan design.

When the SRP Dental Program pays second, it will never pay more in benefits than it would have paid for each claim, as it is submitted, had it been the plan that paid first. This has the effect of maintaining the SRP Dental Program’s deductibles, coinsurance and exclusions. As a result, when the SRP Dental Program pays second, you may not receive the equivalent of 100% of the total cost of the covered dental care services.

This plan does not administer a benefit reserve calculation in its COB.

Administration of COB
To administer COB, the SRP Dental Program reserves the right to:
• Exchange information with other plans involved in paying claims;
• Require that you or your dental care provider furnish any necessary information;
• Reimburse any plan that made payments the SRP Dental Program should have made; or
• Recover any overpayment from your dentist, other insurance company, you or your dependent.

If the SRP Dental Program should have paid benefits that were paid by any other plan, the SRP Dental Program may pay the party that made the other payments in the amount this Plan Administrator for the SRP Dental Program or its designee determines to be proper under this provision. Any amounts paid will be considered to be benefits under the SRP Dental Program, and the SRP Dental Program will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under the SRP Dental Program must provide all the information the plan needs to apply COB.

The SRP Dental Program follows the customary COB rule that the Dental Program coordinates with only other dental plans or programs, and not with any medical plan or program.

If the SRP Dental Program is primary, and if the coordinating secondary plan provides benefits in the form of services, the SRP Dental Program will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the allowed charges.

If the SRP Dental Program is secondary, and if the coordinating primary plan does not cover dental care services because they were obtained out-of-network, benefits for services covered by the SRP Dental Program will be payable by the SRP Dental Program subject to the rules applicable to COB, but only to the extent they would have been payable if the SRP Dental Program were the primary plan.

If the SRP Dental Program is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as the SRP Dental Program, the SRP Dental Program will not relinquish its secondary position. If the SRP Dental Program advances an amount equal to the benefits it would have paid had it been the primary plan, the SRP Dental Program will pursue its rights, and the SRP Dental Program participant must execute any documents required or requested by the SRP Dental Program to recover the amount advanced from the other payer, such as with Workers’ Compensation.

Coordination with Other Government Programs

Other coverage provided by state or federal law: If you are covered by both the SRP Dental Program and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and the SRP Dental Program pays second.

Workers’ Compensation: The SRP Dental Program does not provide benefits if the expenses are covered by Workers’ Compensation or occupational disease law. If SRP contests the application of Workers’ Compensation law for the illness or injury for which expenses are incurred, the SRP Dental Program will advance benefits, subject to its right to recover those payments if and when it is determined that they are covered under a Workers’ Compensation or occupational disease law. However, before such payment will be made, you and/or your covered dependent must execute a reimbursement agreement acceptable to the Plan Administrator or its designee.

Third-Party Liability: See also the Third-Party Liability provisions in this Handbook.
Filing a Claim/Appealing a Denied Dental Claim
See [Claims Filing and Appeals Information](#) in this section of the Handbook.

Schedule of Dental Benefits
The charts on the following pages list the dental benefits available under the SRP Dental Program.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Explanations and Limitations</th>
<th>In-Network, Participating Dental Providers</th>
<th>Non-Network, Non-Participating Dental Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive and Diagnostic Services</strong></td>
<td></td>
<td>100% of discounted fee, no deductible</td>
<td>100% of the lesser of billed charges or the Dental Network’s allowance to non-participating dental providers</td>
</tr>
<tr>
<td>• Routine oral examination</td>
<td>• Preventative services are not subject to the annual maximum SRP Dental Program benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prophylaxis (cleaning of the teeth)</td>
<td>• Routine oral examinations are limited to two times a year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bitewing X-rays</td>
<td>• Prophylaxis, scaling, cleaning and polishing are limited to three times a year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Full-mouth and panoramic X-rays</td>
<td>• Bitewing X-rays are limited to twice in a calendar year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diagnostic X-rays</td>
<td>• Full-mouth and panoramic X-rays are limited to once in a period of 36 consecutive months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Topical application of fluoride</td>
<td>• Fluoride is limited to not more than twice per year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Application of sealants on bicuspid and posterior teeth (molars)</td>
<td>• Application of sealants is limited to permanent bicuspids and molars, once in a period of 36 consecutive months, for children under the age of 19.</td>
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</tr>
</tbody>
</table>

| **Orthodontia Services** | | After deductible met, 50% of discounted fee to the lifetime orthodontia maximum | After deductible met, 50% of the lesser of billed charges or the Dental Network’s allowance to non-participating dental providers to the lifetime orthodontia maximum |
| • Necessary services related to an active course of orthodontia treatment, including diagnosis, evaluation and pre-care | • Orthodontia services are subject to the overall lifetime maximum orthodontia benefits ($2,500/lifetime) at the time of banding or appliance placement. | | |
| • The initial installation of orthodontia appliances for an active course of orthodontia treatment | • There is no coverage for repair or replacement of lost or broken orthodontia appliances. | | |
| • Adjustment of active orthodontia appliances | • Space maintainers for the premature loss of posterior primary teeth are limited to children under the age of 14. | | |
| • This orthodontia benefit if for non-surgical services provided to correct malocclusion (alignment of the teeth and or jaws) that significantly interferes with their function | • Note: This Plan will not extend payment for orthodontia services when the orthodontia banding (the process of cementing orthodontic bands to the teeth) occurred prior to the effective date of coverage under this Plan. | | |
| • Space maintainers only when part of an active orthodontia plan | | | |
### SRP DENTAL PROGRAM: SCHEDULE OF DENTAL BENEFITS

See exclusions and limitations and definitions in this section of the handbook for important information. This chart notes what the SRP dental program pays.

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<tbody>
<tr>
<td>Dental Implants</td>
<td>• Dental implants&lt;br&gt;• Replaces a single missing tooth bounded by teeth on each side</td>
<td>• Dental implant lifetime maximum is $1,000 per tooth. This implant limit applies to the Dental Plan calendar-year maximum.&lt;br&gt;• Implant performed in place of a three-unit bridge.&lt;br&gt;• Teeth on each side will clinically support the bridge.&lt;br&gt;• Predetermination is strongly recommended.</td>
<td>After deductible met, 70% of discounted fee to the dental implant lifetime limit is applied to the calendar-year maximum.</td>
</tr>
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</table>
### SRP DENTAL PROGRAM: SCHEDULE OF DENTAL BENEFITS

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<tr>
<td><strong>Basic and Major Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Non-routine oral examinations</td>
<td>• Basic and Major services are subject to the annual maximum SRP Dental Program benefit.</td>
<td>After deductible met, SRP Dental Program pays 70% of discounted fee</td>
<td></td>
</tr>
<tr>
<td>• Examination in connection with emergency palliative treatment or for consultation purposes</td>
<td>• Periodontal prophylaxis is limited to once every four months, not to exceed three times per year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Periodontal prophylaxis and treatment of periodontal and other diseases of the gums and supporting structures of the mouth, gingiva and alveolar bone, including periodontal scaling, root planning, periodontal occlusal guard and adjustment as necessary</td>
<td>• Periodontal scaling and root planning are limited to once per year per quadrant of the mouth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Injection of necessary antibiotic drugs by the attending dentist; amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration</td>
<td>• Periodontal occlusal guard is payable once every three years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oral surgery, including tooth extractions</td>
<td>• TMJ appliance is payable once every three years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Administration of general anesthesia and/or intravenous sedation (only in connection with covered oral or periodontal surgery)</td>
<td>• Oral surgery includes but is not limited to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Endodontic treatment, including root canal therapy</td>
<td>- Wisdom teeth extraction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Laboratory services, including cultures necessary for diagnosis and/or treatment of a specific dental condition</td>
<td>- Removal of impacted teeth or teeth covered partially or totally by bone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inlays, onlays and crowns, including repair or re-cementing of crowns, inlays or onlays; crowns placed over an implant; installation of fixed bridgework and dentures</td>
<td>- Simple tooth extraction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dentures, partial dentures and fixed bridgework; adjusting, relining or re-basing of removable dentures; replacement of an existing partial or full removable denture or fixed bridgework; addition of teeth to an existing partial or removable denture</td>
<td>• Replacement of bridgework or dentures is allowed only if the existing bridge or denture cannot be made serviceable and was installed at least five years prior to the replacement date.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diagnosis or treatment of TMJ dysfunction/syndrome limited to a TMJ appliance/guard</td>
<td>• Note that local anesthesia is not separately billed and is payable as part of a dental service that necessitates local anesthesia.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Occlusal guards for bruxism and harmful habits</td>
<td>• Space maintainers for the premature loss of posterior primary teeth are limited to children under the age of 14.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Treatment of Accidental Injury to Teeth

• If enrolled in the Medical PPO, see Teeth: Treatment for Accidental Injury in the Schedule of Medical Benefits in this section of the Handbook.
Exclusions and Limitations: SRP Dental Program

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

1. **Costs of reports, bills, etc.:** Expenses for preparing dental reports, bills, disability/sick leave forms or claim forms; mailing, shipping or handling expenses; and charges for broken appointments, charges for telephone calls, e-mailing charges, prescription refill charges, charge for disabled person license plates/automotive forms, interest charges, late fees, mileage costs, provider administration fees, concierge/retainer agreement/membership fees, and/or photocopying fees.

2. **Expenses exceeding maximum SRP Dental Program benefits:** Expenses that exceed any plan benefit limitation, annual maximum SRP Dental Program benefit or overall (“lifetime”) maximum SRP Dental Program benefit as defined in the SRP Dental Program section of the Handbook.

3. **Expenses exceeding allowed charges:** Any portion of the expenses for covered dental services or supplies that are determined by the Plan Administrator or its designee to exceed the allowed charge as defined in Definitions in this section of the Handbook.

4. **Expenses incurred before or after coverage:** Expenses for services rendered or supplies provided before the patient became covered under the Dental Program or after the date the patient’s coverage ends, except under those conditions described in the Extension of Dental Coverage in this section of the Handbook or under the COBRA provisions of the plan.

5. **Experimental and/or investigational services:** Expenses for any dental services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be experimental and/or investigational as defined in Definitions in this section of the Handbook.

6. **Government-provided services (Tricare/CHAMPUS, VA, etc.):** Any treatment or service that is compensated for or furnished by the United States government or any agency thereof except as required under Medicaid provisions or federal law or unless charges for treatment or service are imposed against the individual. For example, if an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military-service-related illness or injury, benefits are not payable by the Plan.

7. **Illegal act:** Expenses incurred by any covered individual for injuries resulting from or sustained as a result of commission, or attempted commission by the covered individual, of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the covered individual, unless such injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor. The Plan Administrator’s discretionary determination that this exclusion applies shall not be affected by any subsequent official action or determination with respect to prosecution of the covered individual (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.

8. **Medically unnecessary services:** Services or supplies determined by the Plan Administrator or its designee not to be medically necessary as defined in Definitions in this section of the Handbook.

9. **Non-dentist:** Expenses for services rendered or supplies provided that are not recommended or prescribed by a dentist.
10. **Occupational illness, injury or conditions subject to Workers’ Compensation:** Any treatment or service due to sickness that is covered by the Workers’ Compensation Act or other similar legislation, or due to injury arising out of or in the course of any employment for wage or profit.

11. **Relatives providing services:** Expenses for services provided by a dentist or dental hygienist or other dental care practitioner who is the parent, spouse, sibling (by birth or marriage), or child of the patient or covered employee.

12. **War or similar event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion or invasion, except as required by law.

13. **Analgesia, sedation, hypnosis, etc.:** Expenses for analgesia, sedation, hypnosis and/or related services provided for apprehension or anxiety.

14. **Appliances/occlusal guards:** Expenses for any dental appliances and supplies, including but not limited to items to increase vertical dimension or restore occlusion, precision or semi-precision attachments, bite registrations, and splinting or dental services that do not have uniform professional endorsement, except those appliance and occlusal guards listed as payable under basic and major services in the Schedule of Dental Benefits in this section of the Handbook.

15. **Cosmetic services:** Expenses for dental surgery or dental treatment for cosmetic purposes, as determined by the Plan Administrator or its designee, including but not limited to bleaching/whitening, veneers and facings. However, the following will be covered if they otherwise qualify as covered dental expenses and are not covered under your Medical Plan:

- Reconstructive dental surgery when that service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;
- Surgery or treatment to correct deformities caused by sickness;
- Surgery or treatment to correct birth defects outside the normal range of human variation;
- Reconstructive dental surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional disorder.

16. **Drugs and medicines:** Expenses for prescription drugs and medications that are covered under your SRP Medical Plan and for any other dental services or supplies if benefits are otherwise provided under your SRP Medical Plan; or under any other plan or program that SRP contributes to or otherwise sponsors; or through a medical or dental department, clinic or similar facility provided or maintained by SRP.

17. **Duplicate or replacement bridges, dentures or appliances:** Expenses for any duplicate or replacement of any lost, missing or stolen bridge, denture or orthodontic appliance other than replacements are described major services in the Schedule of Dental Benefits in this section of the Handbook.

18. **Duplication of dental services:** If a person covered by the SRP Dental Program transfers from the care of one dentist to the care of another dentist during the course of any treatment, or if more than one dentist renders services for the same dental procedure, the SRP Dental Program will not be liable for more than the amount that it would have been liable had but one dentist rendered all the services during each course of treatment, nor will the SRP Dental Program be liable for duplication of services.

19. **Gnathologic recordings for jaw movement and position:** Expenses for gnathologic recordings (measurement of force exerted in the closing of the jaws) as performed for jaw movement and position.

20. **Education services and home-use supplies:** Expenses for dental education, such as for plaque control, oral hygiene, or diet or home-use supplies, including but not limited to toothpaste, toothbrush, water-pick-type device, fluoride, mouthwash, dental floss, etc.
21. **Hospital expenses related to dental care:** Expenses for hospitalization related to dental surgery or care except as may be payable under your Medical Plan option.

22. **Gold restorations,** except porcelain fused to gold for crowns.

23. **Mouth guards:** Expenses for athletic mouth guards and associated devices.

24. **Myofunctional therapy:** Expenses for myofunctional therapy.

25. **Periodontal splinting:** Expenses for periodontal splinting (tying two or more teeth together when there is bone loss to gain additional stability).

26. **Personalized bridges, dentures, retainers or appliances:** Expenses for personalization or characterization of any dental prosthesis, including but not limited to any bridge, denture, retainer or appliance.

27. **Services not performed by a dentist or dental hygienist:** Expenses for dental services not performed by a dentist (except for services of a dental hygienist that are supervised and billed by a dentist and are for cleaning or scaling of teeth or for fluoride treatments).

**Employers Dental Services (EDS) Plan**

The Employers Dental Services (EDS) Plan is one of two dental benefit options offered to eligible SRP employees and their dependents. This EDS Dental Plan is similar in structure to a medical HMO. EDS is a fully insured, prepaid option for dental care. Under the EDS Dental Plan, you’ll note that some of the dental services are provided at no charge while other dental procedures require a copayment at the time of service.

This section outlines the insured prepaid Dental Plan benefits; however, where this section deviates from the certificate of coverage and summary of benefits produced by the insurance company, the insurance company documents will prevail. For a copy of insurance coverage documents, contact the EDS Customer Service Department listed on the Quick Reference Chart in the front of this section of the Handbook or visit the website at www.mydentalplan.net.

**Eligibility for Dental Coverage**

Regular full-time, three-quarter-time and half-time employees of SRP, along with PERA employees, are eligible to participate in this EDS Dental Plan. Your eligible dependents are also eligible to participate in this EDS Dental Plan. Retirees, provisional employees and employees in a benefits-ineligible position are not eligible for the EDS Dental Plan benefits.

For this prepaid EDS Dental Plan coverage, **you and any covered dependents must reside within the designated service area at the time of enrollment.**

**Dental Providers**

When you elect to participate in the EDS Dental Plan option, you **must** use the services of the licensed dental care providers who contract with the EDS Dental Plan. There is no benefit when using providers not contracted with the EDS Dental Plan, except in an emergency. Note that all members of your family must select and obtain services from the same EDS dental facility.

Dental care providers payable by this plan include a dentist who is legally licensed or a dental hygienist who performs services under the direction of a licensed dentist; and both of whom act within the scope of their licenses; and neither is the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.
EDS Dental Office Locations

You can obtain a complete, updated statewide listing of EDS contracted dental offices by contacting the EDS website or EDS Customer Service Department listed on the Quick Reference Chart in the front of this section of the Handbook. Covered dental services are only available at an EDS dental office. All EDS providers are monitored by EDS under a quality assurance/peer review program so that you may feel confident of receiving quality dental care.

Selecting a Dentist/Changing a Dentist/Referral to a Specialty Dental Provider

At the time you enroll in the EDS Dental Plan, you will select a dentist from the list of EDS contracted network dental providers. If you need to change your dentist, simply call the EDS Customer Service Department at its number listed on the Quick Reference Chart in the front of this section of the Handbook or visit the website at www.mydentalplan.net. Your change will be effective on the first of the month following your call to change providers. If you need a dental specialist, your regular family dentist will make a referral for you to an EDS-contracted dental specialist or you can self-refer. Questions about the referral process can be directed to the EDS customer service staff.

Your Dental ID Card

When you enroll in the EDS Dental Plan, you will be sent two ID cards for your family. Keep your ID card with you at all times and show it whenever you use a dental provider. The card is printed with important coverage information and phone numbers you will need. If you lose your card or need to correct information, contact the EDS Customer Service Department listed on the Quick Reference Chart in the front of this section of the Handbook or visit the website at www.mydentalplan.net.

Covered Dental Expenses

The EDS Dental Plan emphasizes early detection of dental problems through regular checkups and prompt treatment of dental problems at participating offices. Under this EDS Dental Plan, there are no deductibles, no claim forms and no annual maximum benefit limitations. EDS provides a complete Schedule of Dental Benefits listing dental services, including orthodontia and some TMJ services, along with a chart listing the amount payable by you and the EDS Dental Plan. If you have questions about your EDS Dental Plan, or need to obtain an Enrollment and Coverage booklet containing the Schedule of Dental Benefits, contact the EDS Customer Service Department or visit the website at www.mydentalplan.net.

An office visit fee will be charged at each dental appointment. All fees are payable to the EDS dental office at the time services are rendered. If you are unable to keep your appointment with the dentist, notify the dentist’s office at least 24 hours in advance of the cancellation or a missed appointment fee will be charged.

Dental Emergency Care

The EDS Dental Plan provides coverage for dental emergencies. Contact your usual EDS dentist first. If you are unable to reach your EDS dentist, you may seek care immediately from any licensed dentist. EDS will provide coverage for the temporary relief of pain, bleeding and acute infection to a maximum of $200, minus any member costs listed in the EDS Schedule of Dental Benefits. All follow-up care should be obtained from your usual EDS dentist.
You will need to pay for emergency dental services at the time care is provided, and later you may send the bill to the EDS Dental Plan address listed on the Quick Reference Chart in the front of this section of the Handbook for consideration for reimbursement.

**Prescription Discount Program**

Individuals enrolled in the EDS Dental Plan can receive discounts on medical or dental prescriptions at certain participating pharmacies located in Arizona. A list of participating pharmacies is provided in your EDS Schedule of Dental Benefits or by calling the EDS Customer Service Department.

To access the discount program, simply present your EDS ID card to the pharmacist at the participating pharmacy to receive a discount off the cost of the medication. This benefit is not valid in combination with other discount plans, HMO prescription cards or any other prescription cards.

**EDS Conversion Plan**

When your EDS Dental Plan coverage terminates, you have the option of converting to an EDS Conversion Plan within 31 days of your termination. Contact the EDS Customer Service Department for information.

**Exclusions and Limitations: What the EDS Dental Plan Does Not Cover**

The EDS Dental Plan does not provide coverage for any of the following services, except where required by law. For a complete list of exclusions, refer to your EDS Enrollment and Coverage Booklet.

1. Any services by a dentist, specialist or professional not under contract to EDS, except in an emergency.
2. Dental services that in the judgment of the dentist are not reasonable and necessary for the prevention, correction or improvement of a condition subject to treatment by the practice of dentistry.
3. Programs or treatments, including prosthetics, that were in progress before the date an individual became an EDS Dental Plan member.
4. Any dental services related to sickness or injury arising out of or in the course of any occupation or employment for remuneration or profit. Dental services for which the member is entitled to reimbursement or is in any way indemnified for such expenses through any public program, state, federal or local and paid for by the federal government, state government or county.
5. Any dental services not specifically described in the EDS Schedule of Benefits.
6. Any dental service, other than emergency dental services, that are related to accidents or accidental injury.
7. Any costs or expenses incurred in the event the member desires to be or is involuntarily hospitalized for any dental procedures or services, except in connection with dental emergencies.
8. Dispensing of drugs or any prescription drug charges incurred for oral disease, except as may be payable in the EDS Schedule of Dental Benefits.
9. Any dental services, other than emergency dental services, that are necessitated as a result of a self-inflicted condition.
10. Oral surgery or extractions solely for orthodontic purposes or requiring the setting of fractures or dislocations, except as may be specifically provided in the EDS Schedule of Dental Benefits.
11. Treatment of malignancies, cysts, neoplasms or congenital defects.

12. Conditions affecting the temporomandibular joint (TMJ), including dysfunction and/or malocclusion, except as may be specifically provided for in the EDS Schedule of Dental Benefits.

13. Any general anesthetic charges or services of an anesthetist or anesthesiologist.


15. Any dental services requiring or pertaining to cosmetic surgery for beautification, treatment of obesity, and appliances or restoration necessary to increase vertical dimension or to restore an occlusion or correct a congenital condition.

16. Any new service or procedure performed after the last day of the month during which an individual ceased to be eligible for participation under this EDS Dental Plan.

17. If a member continually fails to follow a prescribed course of treatment, the treating EDS dentist may refuse to continue that course of treatment at any time.

**Filing a Claim/Appealing a Denied Claim**

When you use an EDS provider, there will be no claims. However, claims for emergency dental services you incur should be filed with the EDS Dental Plan.

If you elect to be covered under the EDS Dental Plan, your claims and any appeal of denial of a claim will be processed by the EDS Dental Plan. The EDS Dental Plan will automatically send you information on its claims and appeals procedures. If you have any questions, contact the EDS Dental Plan Customer Service Department (see the Quick Reference Chart in the front of this section of the Handbook for phone numbers, or refer to the information on your ID card to find out the appropriate address of your the EDS Dental Plan Claims Department).
Definitions

The following are definitions of specific terms and words used in the SRP Health Care Program section of the Handbook that would be helpful in understanding covered or excluded health care services that pertain to the SRP Medical PPO or EPO Option, the SRP Dental Program and the SRP Vision Plan. These definitions do not and should not be interpreted to extend coverage under your Medical, Dental or Vision plans.

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**Accident:** A sudden, unexpected bodily injury caused by some unintentional, external chance event or circumstance.

**Accidental injury to teeth:** Damage to teeth or jaw by an external object in an accident. An accident does not include any injury caused by biting or chewing.

**Active rehabilitation:** See rehabilitation therapy.

**Activities of daily living:** Activities performed as part of a person’s daily routine of care, such as bathing, dressing, feeding/eating, toileting and/or moving/turning/ambulating.

**Adoption:** A legal proceeding that creates a parent-child relationship between persons not related by blood, resulting in the fact that the adopted child is entitled to all privileges belonging to a natural child of the adoptive parents. See the definition of dependent.

**Allowed charge/allowed amount/allowable charge:** The amount this Plan allows as payment for an eligible expense. The allowed charge amount is determined by the Plan Administrator or its designee to be the lowest of:

1. **With respect to a network provider** (PPO/EPO network health care or dental care provider/facility), the negotiated fee/rate set forth in the agreement between the participating network health care or dental care provider/facility and the PPO/EPO network or the Plan; or
2. **With respect to a non-network provider,** allowed charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible medically necessary services or supplies performed by non-network providers. The Plan’s allowed charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. See also the definition of balance billing in this chapter; or
3. For an in-network health care provider/facility whose network contract stipulates that it does not have to accept the network negotiated fee/rate for claims involving a third-party payer, including but not limited to auto insurance, Workers’ Compensation or other individual insurance, or where this Plan may be a secondary payer, the allowed charge amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as an in-network claim; or
4. The health care or dental care provider’s/facility’s actual billed charge.

The Plan will not always pay benefits equal to or based on the health care or dental care provider’s actual charge for eligible expenses, even after you have paid the applicable deductible and coinsurance. This is because the Plan covers only the allowed charge amount for eligible expenses.
Any amount in excess of the allowed charge amount does not count toward the Plan’s annual out-of-pocket maximums. Participants are responsible for amounts that exceed allowed charge amounts by this Plan.

In the case where the PPO/EPO allowed charge amount on an eligible claim exceeds the actual billed charges, the participant will pay his or her coinsurance on the lesser amount, the billed charges, and the Plan will pay its coinsurance on the PPO/EPO allowed charge amount; plus, the Plan will pay the participant’s additional coinsurance responsibility on the difference in the PPO/EPO allowed charge amount versus the actual billed charges.

**Ambulance:** A legally licensed company providing vehicles, trucks, boats, helicopters or airplanes certified for emergency patient transportation.

**Ambulatory surgical facility/center:** A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and that fully meets one of the following two tests:

1. It is licensed as an ambulatory surgical facility/center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements:
   » It is operated under the supervision of a licensed physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly-qualified physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one hospital in the area.
   » It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
   » It provides at least one operating room and at least one post-anesthesia recovery room.
   » It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.
   » It has immediate access to a blood bank or blood supplies.
   » It provides the full-time services of one or more registered graduate nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room.
   » It maintains an adequate medical record for each patient that contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, a medical history and laboratory tests and/or X-rays), an operative report and a discharge summary.

An ambulatory surgical facility/center that is part of a hospital, as defined in Definitions in this section of the Handbook, will be considered an ambulatory surgical facility/center for the purposes of this plan.

**Ancillary services:** Services provided by a hospital or other health care facility other than room and board, including but not limited to use of the operating room, recovery room, intensive care unit, etc., laboratory and X-ray services, drugs and medicines, and medical supplies provided during confinement.

**Appliance (dental):** A device to provide or restore function or provide a therapeutic (healing) effect.

   » **Fixed appliance:** A device that is cemented to the teeth or attached by adhesive materials.
   » **Prosthetic appliance:** A removable device that replaces a missing tooth or teeth.

**Appropriate:** See the definition of medically necessary.
Balance billing: A bill from a health care provider to a patient for the difference (or balance) between this Plan’s allowed charges and what the provider actually charged. Amounts associated with balance billing are not covered by this Plan, even if the Plan’s out-of-pocket maximum limits are reached. See also the provisions related to the Plan’s out-of-pocket expenses and the Plan’s definition of allowed charge. Note that amounts exceeding the allowed charge do not count toward the Plan’s out-of-pocket maximum and may result in balance billing to you. Typically, in-network providers do not balance bill except in situations of third-party liability claims. Out-of-network health care providers commonly engage in balance billing a plan participant for any balance that may be due in addition to the amount payable by the plan. Generally, you can avoid balance billing by using in-network providers.

Behavioral health disorder: A behavioral health disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Behavioral health disorder includes, among other things, autism, depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods, or is provided by behavioral health practitioners. Certain behavioral health disorders, conditions and diseases are specifically excluded from coverage as noted under Exclusions and Limitations: SRP Medical PPO or EPO Option in this section of the Handbook. See also the definition of substance abuse in Definitions in this section of the Handbook.

Behavioral health practitioners: A psychiatrist, psychologist, psychiatric nurse or a mental health or substance abuse counselor or social worker who has a master’s degree and who is legally licensed and/or legally authorized to practice or provide service, care or treatment of behavioral health disorders under the laws of the state or jurisdiction where the services are rendered; acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Behavioral health treatment: Behavioral health treatment includes outpatient visits and inpatient services (including room and board given by a behavioral health treatment facility or an area of a hospital that provides behavioral or mental health or substance abuse treatment) for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the illness that is identified under the DSM code is considered a behavioral health treatment for the purposes of this plan.

Behavioral health treatment facility: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of providing a program for diagnosis, evaluation and effective treatment of behavioral health disorders and that fully meets one of the following two tests:
1. It is licensed as a behavioral health treatment facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements: has at least one physician on staff or on call and provides skilled nursing care by licensed nurses under the direction of a full-time registered nurse (RN) and prepares and maintains a written plan of treatment for each patient based on the medical, psychological and social needs of the patient.
A behavioral health treatment facility that qualifies as a hospital, as defined in Definitions in this section of the Handbook, is covered by this plan as a hospital and not a behavioral health treatment facility. A residential treatment facility, transitional facility, group home, halfway house or temporary shelter is not a behavioral health treatment facility under this plan.

**Benefit, benefit payment, plan benefit:** The amount of money payable for a claim, based on the allowed charge for an in-network provider or the allowed charge for an out-of-network provider, after calculation of all deductibles, coinsurance and copayments, and after determination of the plan’s exclusions, limitations and maximums.

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

1. It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements:
   - It is operated and equipped in accordance with any applicable state law for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center.
   - It is equipped to perform routine diagnostic and laboratory examinations, including but not limited to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic X-rays, or has an arrangement to obtain those services.
   - It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
   - It provides at least two beds or two birthing rooms.
   - It is operated under the full-time supervision of a licensed physician, registered nurse (RN) or certified nurse midwife.
   - It has a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications.
   - It has trained personnel and necessary equipment to handle emergency situations.
   - It has immediate access to a blood bank or blood supplies.
   - It has the capacity to administer local anesthetic and to perform minor surgeries.
   - It maintains an adequate medical record for each patient that contains a prenatal history, a prenatal examination, any laboratory or diagnostic tests, and a postpartum summary.
   - It is expected to discharge or transfer patients within 48 hours following delivery.

A birth (or birthing) center that is part of a hospital, as defined in this section of the Handbook, will be considered to be a birth (or birthing) center for the purposes of this plan.

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

**Bridge, bridgework (dental):**

*Fixed:* A prosthesis that replaces one or more teeth and is cemented in place to existing abutment teeth. It consists of one or more pontics and one or more retainers (crowns or inlays). The patient cannot remove the prosthesis.

*Removable:* A prosthesis that replaces one or more teeth and that is held in place by clasps. The patient can remove the prosthesis.

Need more help? See the *Quick Reference Chart* in the front of this section.
Calendar year: The 12-month period beginning January 1 and ending December 31. The plan year is the calendar year. All deductibles, out-of-pocket maximums, copays and annual maximum plan benefits are determined during the calendar year.

Cardiac rehabilitation: Cardiac rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications in order to limit further cardiac damage and reduce the risk of death. Patients are to continue at home the exercise and educational techniques they learn in this program. Cardiac rehabilitation services are payable for patients who have had a heart attack (myocardial infarction) or open-heart surgery.

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

Certified surgical assistant: A person who does not hold a valid health care license as a registered nurse (RN), nurse practitioner (NP), physician assistant (PA), podiatrist (DPM), dentist, MD or DO, who assists the primary surgeon with a surgical procedure in the operating room and who bills, commonly as an assistant surgeon. Such individuals are not payable by this plan, including but not limited to designation as a certified surgical assistant (CSA), certified surgical technologist (CST), surgical technologist (ST), certified technical assistant (CTA) or certified operating room technician (CORT).

Chemical dependency: Means substance abuse. See the definition of substance abuse.

Child(ren): See the definition of dependent child(ren).

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

Christian Science practitioner: Christian Science, founded in 1866 by Mary Baker Eddy, is a system of religious teaching based on an interpretation of Scripture. It emphasizes full healing of disease by mental and spiritual means. Certain members of the Christian Science church are designated as Christian Science practitioners who counsel and assist church members in mental and spiritual means to overcome illness based on Christian Science teachings.

Claims Administrator: The person or company retained by the plan to administer the claim payment responsibilities and other administration or accounting services as specified by the plan.

COBRA: Temporary extension of health care coverage. See COBRA Continuation Coverage in this section.
of the Handbook.

**Coinsurance**: That portion of eligible expenses for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a fixed percentage of eligible expenses after the plan’s deductible has been met. In some instances, the covered individual may be responsible for paying a higher percentage of those expenses, and in other instances, no coinsurance applies.

**Company, the company**: Salt River Project, also referred to as SRP.

**Convalescent care facility**: See the definition of skilled nursing facility.

**Coordination of benefits (COB)**: The rules and procedures applicable to determination of how plan benefits are payable when a person is covered by two or more health care plans. See Coordination of Benefits in this section of the Handbook.

**Copayment, copay**: The fixed dollar amount you are responsible for paying when you incur an eligible expense for certain services, such as those provided under the prescription drug benefits of the SRP Medical PPO/EPO Option or in certain instances by in-network providers.

**Corrective appliances**: The general term for appliances or devices that support a weakened body part (orthotic) or replace a missing body part (prosthetic). To determine the category of any particular item, see the definitions of durable medical equipment, nondurable supplies, orthotic appliance (or device) and prosthetic appliance (or device).

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

**Cost-efficient**: See the definition of medically necessary for the definition of cost-efficient as it applies to services that are medically necessary.

**Course of treatment (dental)**: The planned program of one or more services or supplies, provided by one or more dentists to treat a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment begins when a dentist first renders a service to correct or treat the diagnosed dental condition.

**Covered dependent**: See eligible dependent.

**Covered employee**: See employee.

**Covered individual**: Any eligible employee or eligible retiree and that person’s eligible spouse and/or dependent child who has completed all required formalities for enrollment for coverage under the plan and is actually covered by the plan.

**Covered medical and/or dental expenses**: See the definition of eligible expenses.

**Crown**: The portion of a tooth covered by enamel. An artificial crown is a dental prosthesis used to return a tooth to proper occlusion, contact and contour, as used as a restoration or an abutment for a fixed prosthesis.
**Custodial care:** Care and services (including room and board needed to provide that care or services) given mainly for personal hygiene or to perform the activities of daily living. Custodial care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Some examples of custodial care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are custodial care regardless of where the care is given or who recommends, provides, or directs the care. Custodial care may be payable by this plan under certain circumstances, such as when custodial care is provided during a covered hospitalization, during a covered period of hospice care or by a home health aide as part of covered home health benefits. See the definitions of *home health care* and *hospice*.

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**Deductible:** The amount of eligible health care expenses you are responsible for paying before the plan begins to pay benefits. The amount of deductibles is discussed in the *SRP Medical PPO or EPO Option* and *SRP Dental Program* in this section of the Handbook. See the definitions of *individual deductible* and *family deductible*.

**Dental:** As used in this Handbook, dental refers to any services performed by or under the supervision of a dentist, or supplies, including dental prosthetics. Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant or the joint of the jaw (the temporomandibular joint); bite alignment, the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection. Dental services and supplies are *not covered* under the *SRP Medical PPO or EPO Option* unless the plan specifically indicates otherwise in the *Schedule of Medical Benefits* in this section of the Handbook.

**Dental care provider:** A dentist, or dental hygienist, or other health care practitioner or nurse, as those terms are specifically defined in *Definitions* in this section of the Handbook, who is legally licensed and is a dentist or performs services under the direction of a licensed dentist; acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

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

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

**Denture:** A device replacing missing teeth.
Dependent child: An eligible dependent child includes any of the following:

For the period January 1, 2010, through August 31, 2010, a dependent child is defined as an unmarried dependent child who is defined as any of the following children:

1. A natural child or a stepchild or a legally adopted child of you (the employee or retiree) or a child placed for adoption with the employee or retiree who:
   (i.) Lives with you (has the same principal place of abode) for more than half the year;
   (ii.) Does not provide more than half of his or her own support for the year and is not the qualifying child of any other person (qualifying child is defined in IRC Section 152[c]);
   (iii.) If the employee or retiree is the legal guardian of a child who is not a “relative,” as listed in IRC Section 152(d)(2)(A) through (G), the child must, for the entire year, have the same principal place of abode as the employee or retiree and be a member of the employee’s or retiree’s household (proof of the same principal place of abode may be requested by the Plan); and
   (iv.) The child has not had his or her 19th birthday. A child may continue eligibility beyond the 19th birthday until the child reaches his or her 26th birthday, provided the child is a full-time student enrolled in an accredited college, university, trade school or technical school for 12 credit hours or more, or the equivalent (the number of credit hours constituting “full-time” as defined by the school the dependent is attending). See SRP Student Status Verification Process in this section of the Handbook. Effective August 31, 2010, the Plan will no longer impose a requirement for children to maintain a student status in order to be eligible for coverage.

2. A legally adopted child or a child who has been placed with you for legal adoption, regardless of whether the adoption has become final, is treated as a child and will qualify as a dependent if the individual satisfies the provisions of paragraph (1). The phrase “placed with you for legal adoption” means the assumption and retention by you of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child’s placement with you ends upon the termination of such legal obligation. Proof of adoption may be requested.

3. A dependent child, regardless of age, who is physically or mentally unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. Proof of the disability must be submitted to the Plan Administrator or its designee, Benefits Services, within 31 days of the date the dependent reaches the age at which coverage normally ends. If coverage is extended, proof of disability will be required from time to time.

4. A child who is eligible for coverage under this plan by virtue of a Qualified Medical Child Support Order (QMCSO).

See the definitions of eligible dependent and Qualified Medical Child Support Order (QMCSO).

Effective September 1, 2010, a dependent child is any of the employee’s or retiree’s children under the age of 26 (whether married or unmarried), who is a:

• Son or daughter;
• Stepson or stepdaughter; or
• Legally adopted child or child placed for adoption with the employee or retiree (proof of adoption or placement for adoption may be requested).
• In addition to dependent children (as noted above), the following individuals are also considered to be dependent children under this Plan:
  • A dependent child age 26 or older who is unmarried and who is physically or mentally unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted
or can be expected to last for a continuous period of not less than 12 months, and who is eligible for tax-free health coverage as a “qualifying child” or “qualifying relative” under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively. Proof of the disability must be submitted to the Plan Administrator or its designee, Benefits Services, within 31 days of the date the dependent reaches the age at which coverage normally ends. If coverage is extended, proof of disability will be required from time to time.

- An individual under age 26 who is married or unmarried, with respect to whom the employee or retiree has legal guardianship under a court order (proof of guardianship may be requested).

**Children not eligible for coverage**: A foster child, a spouse of a dependent child (e.g., son-in-law, daughter-in-law) and a child of a dependent child (e.g., grandchild) are not eligible for coverage under the Plan.

With the exception of a dependent child who is permanently and totally disabled, coverage for a covered individual shall terminate at the pay period in which the individual attains age 26.

**Dependent child(ren)**: See the definition of dependent.

**Disabled (physically or mentally)**: The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, or psychosis, or who is otherwise totally disabled, provided the condition was diagnosed by a physician and accepted by the Plan Administrator or its designee as a permanent and continuing condition. See the definition of totally disabled.

**Durable medical equipment (DME)**: Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose; and is not disposable or non-durable; and is appropriate for the patient’s home. DME includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See the definitions of corrective appliances, nondurable supplies, orthotic appliance (or device) and prosthetic appliance (or device).

**Elective hospital admission, service or procedure**: Any non-emergency hospital admission, service or procedure that can be scheduled or performed at the patient’s or physician’s convenience without jeopardizing the patient’s life or causing serious impairment of body function.

**Eligible dependent**: Your lawful spouse and your dependent child(ren), as those terms are defined in this plan and in Definitions in this section of the Handbook. An eligible dependent may be enrolled for coverage under the plan by following the procedures required by the plan discussed in the Eligibility for Coverage section. Once an eligible dependent is duly enrolled for coverage under the plan, coverage begins in accordance with the terms and provisions of the plan, as described in Eligibility for Coverage in this section of the Handbook, and that person is a covered dependent and remains a covered dependent until his or her coverage ends in accordance with the terms and provisions of the plan. See the definition of dependent.

**Eligible expenses, eligible medical expenses, eligible dental expenses**: Expenses for health care expenses or supplies, to the extent that such services or supplies are medically necessary; are not excluded from plan coverage; and do not exceed any plan annual, lifetime or other limitation. See the definitions of exclusions, medically necessary, allowed charge and maximum plan benefits.
Emergency care: Medical or dental care and treatment provided after the sudden, unexpected onset of a medical or dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or in the case of a pregnant woman, the health of her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. In the event of a behavioral health disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

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

Employee: Unless specifically indicated otherwise, when used in this Handbook, the term employee refers to a person who is recorded as being an employee on the employer’s payroll records (including any such person who is subsequently reclassified by a court of law or regulatory body as a common-law employee of the employer) and who is eligible to enroll for coverage under a plan (benefits eligible) described in the Eligibility section of the Handbook. Consistent with the foregoing and for purposes of clarification only, the term “employee” does not include a leased employee, or any individual who performs services for the employer as an independent contractor, or under any other non-employee classification, or through a temporary help firm, employee leasing firm or professional employer organization. The purpose of this provision is to exclude from participation in the plan any individual who may actually be a common-law employee of the employer but who is not paid as though he or she is an employee, regardless of the reason he or she is excluded from the payroll and regardless of whether that exclusion is correct.

Employer: Salt River Project (SRP).

Endodontics: Services related to the diagnosis, treatment or prevention of diseases related to the dental pulp and its surrounding tissues.

Enroll, enrollment: The process of enrolling in the plan. See Eligibility for Coverage, Initial (New Employee) Enrollment, Special Enrollment and Open Enrollment Period in this section of the Handbook for details regarding the process of enrollment.

Exclusions: Specific conditions, circumstances and limitations, as set forth in the Exclusions and Limitations: SRP Medical PPO or EPO Option, Exclusions and Limitations: SRP Dental Program and Exclusions and Limitations: SRP Vision Plan in this section of the Handbook, for which the plan does not provide plan benefits.

Exclusive Provider Organization (EPO): A group or network of health care providers (e.g., hospitals, physicians, laboratories, pharmacies) under contract with the plan to provide eligible expenses at agreed-upon discounted/reduced rates. Generally, no coverage is available for the use of non-EPO providers except in the case of an emergency. See also Preferred Provider Organization (PPO).

Experimental and/or investigational: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as experimental and/or investigational. A service or supply will be deemed to be experimental and/or investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for precertification under the plan’s Utilization Review Program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

Need more help? See the Quick Reference Chart in the front of this section.
1. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the physician or health care practitioner that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States and written by experts in the field that shows that recognized medical, dental or scientific experts classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current Investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will NOT be considered experimental and/or investigational if it is:
   » Approved by the FDA as an “investigational new drug for treatment use”;
   » Classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a “life-threatening disease” as that term is defined in FDA regulations; or
   » Approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was NOT approved for general use, and the FDA has NOT determined that such drug should not be prescribed for a given type of cancer.
5. The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials, or Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

In determining if a service or supply is or should be classified as experimental and/or investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided or considered for precertification under the Plan’s Utilization Review program:
1. Medical, dental or other health care records of the covered person
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply
3. Protocols of the physician or health care practitioner that renders the prescribed service or prescribes or dispenses the supply
4. Authoritative peer-reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person’s diagnosis, including but not limited to “United States Pharmacopeia Dispensing Information” and “American Hospital Formulary Service”
5. The published opinions of the American Medical Association (AMA) or specialty organizations recognized by the AMA; the National Institutes of Health (NIH); the Center for Disease Control (CDC); the Office of Technology Assessment; the published screening criteria of national insurance companies such as Aetna, CIGNA or Milliman Care Guidelines; or the American Dental Association (ADA), with respect to dental services or supplies
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply
To determine how to obtain a precertification of any procedure that might be deemed to be experimental and/or investigational, see Precertification: Utilization Review (UR) Program in this section of the Handbook.

**Extended care facility:** See the definition of *skilled nursing facility*.

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**Family deductible:** The maximum amount that a family of two or more is responsible for paying toward eligible expenses before the Plan begins to pay benefits. The family deductible is met when the combined total of all eligible expenses submitted by two or more covered family members reaches the family deductible amount.

**Federal legend drugs:** See the definition of *prescription drugs*.

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

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

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**Genetic counseling:** Counseling services provided before or in the absence of genetic testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of genetic testing; and provided after genetic testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman. See also Genetic Testing and Counseling in the Schedule of Medical Benefits in this section of the Handbook.

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

**Genetic testing:** Tests that involve the extraction of DNA from an individual’s cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual’s predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person’s child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations. See also Genetic Testing and Counseling in the Schedule of Medical Benefits in this section of the Handbook.
Health care facilities: For the purposes of this plan, health care facilities include ambulatory surgical facilities, behavioral health treatment facilities, birthing centers, hospices, skilled nursing facilities, long-term acute care facilities and subacute care facilities, as those terms are defined in Definitions in this section.

Health care practitioner: A physician; behavioral health practitioner; chiropractor; dental hygienist; dentist; nurse; nurse practitioner; physician assistant; podiatrist; occupational, physical, respiratory or speech therapist; speech pathologist; optometrist; optician; master’s prepared audiologist; medicine man; or Christian Science practitioner who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered, acts within the scope of his or her license and/or scope of practice, and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Health care professional: A physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law. See Claim Filing and Appeals Information in this section of the Handbook.

Health care provider: A health care practitioner or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility or subacute care facility, as those terms are defined in Definitions in this section of the Handbook.

Home health care: Intermittent skilled nursing care services provided by a licensed home health care agency, as those terms are defined in Definitions in this section of the Handbook.

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

1. It is approved by Medicare or is licensed as a home health care agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. If licensing is not required, it meets all of the following requirements:
   » It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a physician or registered nurse (RN) to the home.
   » It has a full-time administrator.
   » It is run according to rules established by a group of professional physicians and health care practitioners.
   » It maintains written clinical records of services provided to all patients.
   » Its staff includes at least one RN or it has nursing care by an RN available.
   » Its employees are bonded.
   » It maintains malpractice insurance coverage.

Hospice: An agency or organization that administers a program of palliative care and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of six months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home hospice services) or in a home-like setting (inpatient hospice), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family. “Palliative
“care” refers to care of a patient whose disease is not responsive to curative treatment and includes control of pain and other symptoms, along with psychological, social and spiritual support.

The agency must meet one of the following tests:

1. It is approved by Medicare or is licensed as a hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. If licensing is not required, it meets all of the following requirements:
   » It provides 24-hour-a-day, seven-day-a-week service.
   » It is under the direct supervision of a duly qualified physician.
   » It has a full-time administrator.
   » It has a nurse coordinator who is a registered nurse (RN) with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
   » The main purpose of the agency is to provide hospice services.
   » It maintains written records of services provided to the patient.
   » It maintains malpractice insurance coverage.

A hospice that is part of a hospital, as defined in Definitions in this section of the Handbook, will be considered a hospice for the purposes of this plan.

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

1. Is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO);
2. Is approved by Medicare as a hospital; and
3. Provides care and treatment by physicians and nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises.

A hospital may include facilities for behavioral health treatment that are licensed and operated according to law. Any portion of a hospital used as an ambulatory surgical facility, a birth (or birthing) center, a hospice, a skilled nursing facility, a subacute care facility, or another residential treatment facility or place for rest, custodial care or the aged shall not be regarded as a hospital for any purpose related to this plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a physician and as compared to the person’s previous condition. Pregnancy of a covered employee or covered spouse will be considered to be an illness only for the purpose of coverage under the health care benefits of this plan.

Implantology: Services related to the diagnosis, treatment or prevention of diseases related to attachment of permanent artificial replacement of teeth directly to the jaw using artificial root structures.

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

Individual deductible: The maximum amount one covered person has to pay toward eligible expenses before the Plan begins to pay benefits, even if the covered person has elected family coverage.

Injury: Any damage to a body part resulting from trauma from an external source.
Inlay: A restoration made to fit a prepared tooth cavity and then cemented into place. See the definition of restoration.

In-network services: Services provided by a health care provider that is a member of the plan’s Preferred Provider Organization (PPO) or Exclusive Provider Organization (EPO), as distinguished from out-of-network services that are provided by a health care provider that is not a member of the PPO or EPO.

Inpatient services: Services provided in a hospital or other health care facility during the period when charges are made for room and board.

Investigational: See the definition of experimental and/or investigational.

-L-

Lifetime benefit: This term does not denote, nor should it be construed to denote, any obligation by the plan to pay any benefits for the lifetime of the plan participant. Rather, it is a popular term that describes the maximum amount of benefits payable by the plan during the entire time a plan participant is covered under this plan and any previous medical and/or dental expense plan provided by SRP. See the definition of maximum plan benefits.

-M-

Maintenance care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Maintenance rehabilitation: See the definition of rehabilitation therapy.

Managed care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result.

Maximum plan benefits: Three types of maximum amounts of benefits payable on account of medical and/or dental expenses incurred by any covered plan participant under the SRP Medical PPO or EPO and the SRP Dental Program.

General overall ("lifetime") maximum Medical PPO/EPO benefit — The maximum amount of benefits payable by the SRP Medical PPO Plan or EPO Plan during the entire time a participant is covered under the Medical PPO Plan or EPO Plan and any previous medical expense plan provided by SRP. The general overall ("lifetime") maximum benefit for the Medical PPO Plan and Medical EPO Plan is unlimited for you and each of your covered dependents.

Limited overall maximum Medical PPO/EPO benefits — Certain eligible medical expenses are subject to limited overall maximums for each covered individual. Once the SRP Medical PPO Plan or EPO Plan has paid the limited overall maximum benefits for any of those services or supplies on behalf of any covered individual, it will not pay any further benefits for those services or supplies on account of that covered individual, even though the general overall lifetime maximum SRP Medical PPO Plan or EPO Plan benefit has not been reached. The services or supplies that are subject to limited overall maximum plan benefits and the amounts of the limited overall maximum SRP Medical PPO Plan or
EPO Plan benefits are identified in the SRP Medical PPO and EPO Schedule of Medical Benefits in this section of the Handbook.

**Annual maximum Medical PPO/EPO benefits** — Certain eligible medical expenses are subject to annual maximums per covered individual or family during each calendar year. Once the Medical PPO Plan or EPO Plan has paid the annual maximum benefits for any of those services or supplies on behalf of any covered individual or family, it will not pay any further benefits for those services or supplies on account of that individual or family for the balance of the calendar year. This maximum does not include the deductible or any amounts over the allowed charge. The services or supplies that are subject to annual maximum Medical PPO Plan or EPO Plan benefits are identified in the Schedule of Medical Benefits in this section of the Handbook.

**Annual maximum Dental Plan benefits** — Certain eligible dental expenses are subject to annual maximums per covered person each calendar year. Once the Dental Plan has paid the annual maximum, it will not pay further benefits for the balance of the calendar year. This maximum does not include the deductible, any amounts over the allowed charge or orthodontia expenses. Preventive services are not subject to the annual maximum SRP Dental Plan benefit.

**Overall lifetime orthodontia maximum benefits** — The maximum amount of orthodontia expenses payable by the SRP Dental Plan during the entire lifetime a person is eligible for the SRP Dental Plan.

**Medically necessary:**

A. A service or supply will be determined to be medically necessary by the Plan Administrator or its designee if it:
   1. Is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it or a dentist if a dental service or supply is involved;
   2. Is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical standards; and
   3. Is determined by the Plan Administrator or its designee to meet all of the following requirements:
      • It is consistent with the symptoms or diagnosis and treatment of the illness or injury;
      • It is not provided solely for the convenience of the patient, physician, hospital, health care practitioner or health care facility;
      • It is an appropriate service or supply given the patient’s circumstances and condition;
      • It is a cost-efficient service or level of service that can be safely provided to the patient; and
     • It is safe and effective for the illness or injury for which it is used.

B. A service or supply will be considered to be appropriate if:
   1. It is a diagnostic procedure that is called for by the health status of the patient and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient’s overall health condition.
   2. It is care or treatment that is as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient’s overall health condition.

C. A service or supply will be considered to be cost-efficient if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.
D. The fact that your physician or dentist may provide, order, recommend, or approve a service or supply does not mean that the service or supply will be considered to be medically necessary for the medical or dental coverage provided by the plan.

E. A hospitalization or confinement to a health care facility will not be considered to be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

F. A service or supply that can safely and appropriately be furnished in a physician’s or dentist’s office or other less costly facility will not be considered to be medically necessary if it is furnished in a hospital or health care facility or other more costly facility.

G. The non-availability of a bed in another health care facility or the non-availability of a health care practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.

H. A service or supply will not be considered to be medically necessary if it does not require the technical skills of a health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient’s family, any person who cares for the patient, any health care practitioner, or any hospital or health care facility.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Mental disorder; mental and nervous disorder: See the definition of behavioral health disorder.

Midwife, nurse midwife: A person legally licensed as a midwife or certified as a certified nurse midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking; performing physical examinations; ordering laboratory tests and X-ray procedures; managing labor, delivery and the post-delivery period; administering intravenous fluids and certain medications; providing emergency measures while awaiting aid; performing newborn evaluation; signing birth certificates; and billing and being paid in his or her own name, and who acts within the scope of his or her license and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient. A midwife may not independently manage moderate or high-risk mothers, admit to a hospital or prescribe all types of medications. See the definition of nurse.

Nondurable supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. See the definitions of corrective appliances, durable medical equipment, orthotic appliance (or device) and prosthetic appliance (or device). See also the SRP Medical PPO Plan and EPO Plan Schedule of Medical Benefits in this section of the Handbook for what nondurable supplies are covered by the SRP Medical PPO Plan or EPO Plan.

Non-network: See the definition of out-of-network services.

Non-participating provider: A health care provider that does not participate in the plan’s Preferred Provider Organization (PPO) or Exclusive Provider Organization (EPO).

Nurse: A person legally licensed as a registered nurse (RN), certified registered nurse anesthetist (CRNA), certified nurse midwife or licensed midwife, nurse practitioner (NP), licensed practical nurse (LPN), licensed vocational nurse (LVN), psychiatric mental health nurse or any equivalent...
designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license, and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

**Nurse anesthetist:** A person legally licensed as a certified registered nurse anesthetist (CRNA), registered nurse anesthetist (RNA) or nurse anesthetist (NA), and authorized to administer anesthesia in collaboration with a physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

**Nurse practitioner:** A person legally licensed as a nurse practitioner (NP) or registered nurse practitioner (RNP) who acts within the scope of his or her license and who in collaboration with a physician, examines patients; establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests; identifies, develops, implements and evaluates a plan of patient care; prescribes and dispenses medication; refers to and consults with appropriate health care practitioners; and bills and is able to be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

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**Occupational therapist:** A person legally licensed as a professional occupational therapist who acts within the scope of his/her license and who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a physician to assess the presence of defects in an individual’s ability to perform self-care skills and activities of daily living and who formulates and carries out a plan of action to restore or support the individual’s ability to perform such skills in order to regain independence.

**Occupational therapy:** Rehabilitation directed at restoring or supporting an individual’s ability to perform self-care skills and activities of daily living in order to regain independence.

**Office visit:** A direct personal contact between a physician or other health care practitioner and a patient in the health care practitioner’s office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association or the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CPT or CDT coding. Neither a telephone discussion with a physician or other health care practitioner nor a visit to a health care practitioner’s office solely for such services as blood drawing, leaving a specimen or receiving a routine injection is considered to be an office visit for the purposes of this plan.

**Onlay:** An inlay restoration that is extended to cover the biting surface of the tooth but not the entire tooth. It is often used to restore lost and weakened tooth structure.

**Open Enrollment Period:** The period during which participants in the plan may drop coverage or select among the alternate health benefit programs that are offered by the plan, or eligible individuals not currently enrolled may enroll for coverage. The plan’s annual Open Enrollment Period is described in Eligibility for Coverage in this section of the Handbook.

**Ophthalmologist:** A physician licensed to practice ophthalmology, including surgery and prescription of drugs.

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Need more help? See the Quick Reference Chart in the front of this section.
Optician: A person licensed to dispense ophthalmic materials (manufacture and sell eyeglasses and/or contact lenses).

Optometrist: A person licensed to practice optometry.

Oral surgery: Services related to the diagnosis, treatment or prevention of diseases related to extractions and surgical procedures of the mouth.

Orthodontia treatment (dental): The active course of treatment begins when the first orthodontic appliance is installed and ending when the last active appliance is removed.

Orthodontic, orthodontia: Services related to the diagnosis, treatment or prevention of diseases related to abnormally positioned or aligned teeth. The science of the movement of teeth in order to correct a malocclusion or “crooked teeth.”

Orthognathic services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as to shorten or lengthen the horizontal, vertical or transverse dimensions of the jaw so that facial soft tissue, teeth and/or other facial structures are in aesthetic alignment/balance. Malposition can produce conditions such as a prognathism, retrognathism or TMJ syndrome. See the definitions of prognathism, retrognathism and TMJ syndrome.

Orthotic appliance (or device): A type of corrective appliance or device, either customized or available “over the counter,” designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints and walkers. For the purposes of the SRP Medical PPO Plan and EPO Plan options, this definition does not include dental orthotics. See the definitions of corrective appliance, durable medical equipment, nondurable supplies and prosthetic appliance (or device).

Out-of-network services (non-network): Services provided by a health care provider that is not a member of the plan’s Preferred Provider Organization (PPO) or Exclusive Provider Organization (EPO), as distinguished from in-network services that are provided by a health care provider that is a member of the PPO or EPO.

Out-of-pocket maximum: The maximum amount of coinsurance each covered person or family is responsible for paying during a calendar year before the coinsurance required by the PPO Plan ceases to apply. When the out-of-pocket maximum is reached, the plan will pay 100% of any additional covered expenses for the remainder of the calendar year. Certain expenses such as deductibles, copays, penalty for failure to precertify, expenses for medical services or supplies that are not covered by the plan, and charges in excess of the allowed charges as determined by the Plan Administrator or its designee do not count toward the out-of-pocket maximum. See also the SRP Medical PPO and EPO Plan Option section of the Handbook for a complete list of expenses that do not count toward the out-of-pocket maximum.

Outpatient services: Services provided either outside of a hospital or health care facility setting or at a hospital or health care facility when room and board charges are not incurred.

-P-

Partial denture: A prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures. The denture may be removable or fixed.
Participant: See covered individual or plan participant.

Participating dental providers: A group or network of dental care providers (e.g., dentists, dental hygienists) under contract with the plan to provide dental care services and supplies at agreed-upon discounted/reduced rates.

Participating provider: A health care provider that participates in the plan’s Preferred Provider Organization (PPO) or Exclusive Provider Organization (EPO).

Passive rehabilitation: See the definition of rehabilitation therapy.

Pedodontics: Services related to the diagnosis and treatment of dental problems of children.

Periodontics: Services related to the diagnosis, treatment or prevention of diseases related to the structures that support the teeth (gingivae, alveolar bone, periodontal membrane or ligament, cementum).

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical therapist: A person legally licensed as a professional physical therapist who acts within the scope of his or her license and who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a physician to perform physical therapy services, including the evaluation, treatment and education of a person using physical measures, therapeutic exercise, thermal (hot/cold) techniques, and/or electrical stimulation to correct or alleviate a physical disability.

Physical therapy: Rehabilitation directed at restoring function following disease, injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform activities of daily living such as walking and getting in and out of bed.

Physician: A person legally licensed as a medical doctor (MD) or doctor of osteopathy (DO) and authorized to practice medicine, to perform surgery and to administer drugs, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Physician assistant (PA): A person legally licensed as a physician assistant who acts within the scope of his or her license and acts under the supervision of a physician to examine patients; establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising physician; and bill and be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered, and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Plan: When used to describe self-insured health benefits, the term “Plan” refers to separate District and Association plans that provide similar benefits to eligible employees and dependents of the sponsoring employer. When used to describe insured health benefits, the term “Plan” refers to a
plan jointly sponsored by the District and the Association. Together, these self-insured and insured plans are known as the Salt River Project Health and Life Plan.

Plan Administrator: The SRP Benefits Manager is the Plan Administrator and is the person or legal entity designated by the plan as the party who has the fiduciary responsibility for the overall administration of the plan.

Plan participant, participant: The employee or individual who has enrolled for coverage under the Plan. As used in this Handbook, this term does not include the spouse or dependent child(ren) of the plan participant.

Plan year: The 12-month period from January 1 to December 31.

Podiatrist: A person legally licensed as a doctor of podiatric medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Pontic: The part of a fixed bridge that is suspended between two abutments and replaces a missing tooth.

Pre-admission testing: Laboratory tests, X-rays and other medically necessary tests performed on an outpatient basis prior to a scheduled hospital admission or outpatient surgery.

Precertification: Precertification is a review procedure performed by the Utilization Review Company or the SRP Behavioral Health Program for in-network services before services are rendered, to ensure that health care services meet or exceed accepted standards of care and that the service, admission and/or length of stay in a health care facility is appropriate and medically necessary.

Preferred Provider Organization (PPO): A group or network of health care providers (e.g., hospitals, physicians, laboratories, pharmacies) under contract with the Plan to provide eligible expenses at agreed-upon discounted/reduced rates. See also Exclusive Provider Organization (EPO).

Prescription drugs: For the purposes of this Plan, prescription drugs include:

- **Federal legend drug**: Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, “Caution: Federal law prohibits dispensing without prescription.”

- **Other prescription drugs**: Drugs that require a prescription under state law but not under federal law.

- **Compound drug**: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

- **Brand drug**: A drug that has been approved by the U.S. Food and Drug Administration (FDA) and has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company that holds the patent has the right to sell that brand drug. A brand drug cannot have competition from a generic drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.

- **Generic drug**: A generic version of a brand-name drug. The generic drug must be the same (or bio-equivalent) in several respects: the active ingredients (those ingredients that are responsible for the drug’s effects), the dosage amount, the way in which the drug is taken must be the same as the brand-name drug, the safety must be the same and the amount of
time the generic drug takes to be absorbed into the body must be the same as the brand-name drug. A generic drug has been approved by the U.S. Food and Drug Administration (FDA), and is basically a “copy” of a brand-name drug. Generic drugs can have different names, shapes, colors and inactive ingredients than the original brand-name drug.

- **Preferred drug:** A prescription drug that is in a therapeutic class of drugs that is included as a preferred drug by the Plan’s contracted Prescription Drug Program.

- **Non-preferred drug:** A prescription drug that is in a therapeutic class of drugs that is NOT included as a preferred drug by the Plan’s contracted Prescription Drug Program.

- **Specialty drug:** Generally refers to high-cost, low-volume, biotechnology-engineered FDA-approved, non-experimental medications used to treat complex, chronic or rare diseases. These medications may also have one or more of the following qualities: are injected, infused, taken orally or inhaled; may need to be administered by a health care practitioner; have side effects or compliance issues that need monitoring; require substantial patient education/support before administration; and/or have unique manufacturing, handling and distribution issues that make them unable to be purchased from a retail and/or mail-order service. Specialty drugs are managed by the Prescription Drug Program under contract to the Plan. See the Drug row of the Schedule of Medical Benefits for more information. Examples of specialty drugs can include medications to treat hemophilia, immunity disorders, multiple sclerosis, rheumatoid arthritis, hepatitis or certain types of cancer.

**Prognathism:** The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

**Prophylactic surgery:** A surgical procedure performed for the purpose of (1) avoiding the possibility or risk of an illness, disease, or physical or mental disorder or condition based on genetic information or genetic testing, or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages. An example of prophylactic surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer and/or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

**Prophylaxis:** The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth is performed by a dentist or dental hygienist.

**Prosthesis (dental):** An artificial replacement of one or more natural teeth and/or associated structures.

**Prosthetic appliance (or device):** A type of corrective appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers or corrective lenses needed after cataract surgery. See the definitions of corrective appliances, durable medical equipment, nondurable supplies and orthotic appliance (or device).

**Prosthodontics:** Services related to the diagnosis, treatment or prevention of diseases related to the construction of artificial appliances for the mouth (bridges, dentures, crowns.)

**Provider:** See the definition of health care provider.
Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an employee to provide health care coverage for a dependent child and requiring that benefits payable on account of that dependent child be paid directly to the health care provider that rendered the services or to the custodial parent of the dependent child.

Reconstructive surgery: A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy. See the definition of medically necessary.

Rehabilitation therapy: Physical, occupational or speech therapy that is prescribed by a physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license. See Schedule of Medical Benefits and Exclusions and Limitations: SRP Medical PPO and EPO Plan Option in this section of the Handbook to determine the extent to which rehabilitation therapies are covered. See the definitions of physical therapy, occupational therapy, speech therapy and cardiac rehabilitation.

- **Active rehabilitation** refers to therapy in which a patient who has the ability to learn and remember actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

- **Maintenance rehabilitation** refers to therapy in which a patient actively participates that is provided after a patient has met the functional goals of active rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support and/or preserve the patient’s functional level. **Maintenance rehabilitation is not covered by the SRP Medical PPO Plan or EPO Plan.**

- **Passive rehabilitation** refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive rehabilitation may be covered by the Plan, but only during a course of hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation. **Continued hospitalization for the sole purpose of providing passive rehabilitation will not be considered to be medically necessary for the purposes of this Plan.**

Restoration: A broad term applied to any filling, crown, bridge, partial denture or complete denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape and function of part or all of the tooth or teeth.

Retiree: See the Retirement Benefits (RET) section of this Handbook for information describing retiree eligibility.
Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Retrospective review: Review of health care services after they have been provided to determine if those services were medically necessary and/or if the charges for them are allowed charges. See the definitions of medically necessary and allowed charge.

Root canal (endodontic) therapy: Treatment of a tooth having a damaged pulp. The treatment is usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with a sealing material.

-S-

Scale: To remove calculus (tartar) and stains from the teeth with special instruments.

Second opinion: A consultation and/or examination, preferably by a board-certified physician not affiliated with the primary attending physician, to evaluate the medical necessity and advisability of undergoing surgery or receiving a health care service.

Skilled nursing care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a physician; are intermittent and part-time, generally not exceeding 16 hours a day; are usually provided on a less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of skilled nursing care services include, but are not limited to, the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled nursing facility (SNF): A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care; that rehabilitates injured, disabled or sick people; and that meets all of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) as a skilled nursing facility or is recognized by Medicare as a skilled nursing facility;
2. It is regularly engaged in providing room and board and continuously provides 24-hour-a-day skilled nursing care of sick and injured persons at the patient’s expense during the convalescent stage of an injury or illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed physician;
3. It provides services under the supervision of physicians;
4. It provides nursing services by or under the supervision of a licensed registered nurse (RN), with one licensed RN on duty at all times;
5. It maintains a daily medical record of each patient who is under the care of a licensed physician;
6. It is not (other than incidentally) a home for maternity care, rest, domiciliary care (non-skilled/custodial), or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient or mentally ill; and
7. It is not a hotel or motel.

A skilled nursing facility that is part of a hospital, as defined in Definitions in this section of the Handbook, will be considered a skilled nursing facility for the purposes of this Plan. A skilled nursing facility is sometimes referred to as an extended care facility.
**Specialty care unit:** A section, ward or wing within a hospital that offers specialized care for the patient’s needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by registered nurses or other highly trained personnel. Examples include intensive care units (ICUs) and cardiac care units (CCUs).

**Speech therapist:** A person legally licensed as a professional speech therapist who acts within the scope of their license and who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a physician to perform speech therapy services, including the application of principles, methods and procedures for the measurement, testing, evaluation, prediction, counseling, instruction or rehabilitation related to disorders of speech, voice, language, swallowing or feeding.

**Speech therapy:** Rehabilitation directed at treating defects and disorders of spoken and written communication to restore normal speech or to correct dysphasic or swallowing defects and disorders lost due to illness, injury or surgical procedure. Speech therapy for functional purposes, including but not limited to a speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin or childhood developmental speech delays/disorders, are excluded from coverage.

**Spinal manipulation:** The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal manipulation is commonly performed by chiropractors, but it can be performed by a physician.

**Spouse:** Under this Plan, a spouse is defined as a legal spouse of the opposite sex. Spouses lose eligibility once legally separated.

**SRP:** The Salt River Project Agricultural Improvement and Power District, the Salt River Valley Water Users’ Association, New West Energy Corporation, Papago Park Center, Inc., Salt River Project Employees’ Recreational Association, Inc., Salt River Project Employees’ Recreational Association Coronado Generating Station, Inc., and Salt River Employees’ Recreational Association Navajo Generation Station, Inc.

**SRP Health Care Program:** The benefits and provisions described in the SRP Health Care Program in this section of the Handbook.

**Subacute care facility:** A public or private facility, either free-standing, hospital-based or based in a skilled nursing facility, licensed and operated according to law and authorized to provide subacute care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement, generally not to exceed 60 days, to the patient’s home or to a suitable skilled nursing facility, and that meets all of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) as a subacute care facility or is recognized by Medicare as a subacute care facility;
2. It maintains on its premises all facilities necessary for medical care and treatment;
3. It provides services under the supervision of physicians;
4. It provides nursing services by or under the supervision of a licensed registered nurse;
5. It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient or suffering from tuberculosis; and
6. It is not a hotel or motel.

Subacute facility is sometimes referred to as a specialty hospital or long-term acute care facility.

**Subrogation:** This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the Third-Party Liability provision in this Handbook for an explanation of how the Plan may use the right of subrogation to be substituted in place of a covered individual in that person’s claim against a third party who wrongfully caused that person’s injury or illness, so that the Plan may recover medical and/or dental benefits paid if the covered individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

**Substance abuse:** A psychological and/or physiological dependence or addiction to alcohol, drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the International Classification of Disease (ICD) manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Substance abuse/substance use is sometimes referred to as chemical dependency. See the definition of behavioral health disorders.

**Surgery:** Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits. When the procedures will be considered to be separate procedures, the following percentages of the allowed charge will be allowed as the Plan’s benefit:

1. Allowances for multiple surgeries through the same incision or operational field:
   - Primary procedure: 100% of allowed charge
   - Secondary and additional procedures: 50% of allowed charge per procedure

2. Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:
   - First site primary procedure: 100% of allowed charge
   - First site secondary and additional procedures: 50% of allowed charge per procedure
   - Second site primary and additional procedures: 50% of allowed charge per procedure

**Surgical assistant:** See the definition of certified surgical assistant.

**Temporomandibular joint (TMJ), temporomandibular joint (TMJ) dysfunction or syndrome:** The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including but not limited to masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking), myofacial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures or internal derangement of the TMJ.
Therapist: A person trained in and skilled in giving therapy in a specific field of health care, such as occupational, physical, radiation, respiratory and speech therapy. See the definitions of occupational therapy, physical therapy and speech therapy.

Topical: Painting the surface of teeth as in a fluoride treatment or application of a cream-like anesthetic formula to the surface of the gum.

Total disability, totally disabled: The inability of a covered employee to perform all the duties of his or her occupation with SRP as a result of a non-occupational illness or injury, or the inability of a covered dependent to perform the normal activities or duties of a person of the same age and sex. See the definition of disabled.

Transplant, transplantation: The transfer of organs (such as the heart, kidney or liver) or living tissues or cells (such as bone marrow or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted tissue in the recipient.

- Autologous refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.
- Allogenic refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are always allogenic.
- Xenographic refers to transplants of organs, tissues or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Xenographic transplants are not covered by this Plan, except heart valves.

See Schedule of Medical Benefits and Exclusions and Limitations: SRP Medical PPO or EPO Plan Option in this section of the Handbook for additional information regarding transplants. See also Precertification: The Utilization Review (UR) Program in this section of the Handbook for information about precertification requirements for transplantation services.

-U-

Urgent care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate even though health and life is not in jeopardy. Examples of medical conditions that require urgent care include, but are not limited to, fever, sprains, bone or joint injuries, continuing diarrhea or vomiting, or bladder infections.

Urgent care facility: A public or private hospital-based or free-standing facility that is licensed or legally operating as an urgent care facility, that primarily provides minor emergency and episodic medical care in which one or more physicians, nurses and X-ray technicians are in attendance at all times when the facility is open, and that includes X-ray and laboratory equipment and a life-support system.

Utilization Review (UR): A managed care procedure to determine the medical necessity, appropriateness, location and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include, but is not limited to, precertification and/or preauthorization; concurrent and/or continued stay review; discharge planning; retrospective review; case management; hospital or other health care provider bill audits; and health care provider fee negotiation. Utilization Review services (sometimes referred to as utilization management, UM services, UM program, utilization management and review services, or UMR services) are provided by licensed health care professionals employed by the Utilization Review Company operating under a contract with the Plan. See the definition of medically necessary.
Utilization Review Company: The independent Utilization Review organization, staffed with licensed health care professionals, operating under a contract with the Plan to administer the Plan’s Utilization Review services.

-V-

Vision exam: A professional examination and an eye refraction, including an assessment of your health history particularly as it is relevant to your vision; an external exam of the eyes for pathological abnormalities of the eyes, including but not limited to pupil, lens and lashes/eyelids; and an internal exam, including but not limited to an assessment of the lens and retina along with tonometry (measurement of the fluid pressure in the eye to help detect signs of glaucoma), visual field testing (checks peripheral visual capabilities), biomicroscopy (retina examination) and inspection of the retina with an ophthalmoscope, visual acuity (the ability to see clearly at all distances) and refraction (testing the eyes’ ability to focus light rays on the retina from a distance and close up).

Visit: See the definition of office visit.

-W, X-

Well baby care, well child care: Health care services provided to a healthy newborn or child that are determined by the Plan to be medically necessary even though they are not provided as a result of illness, injury or congenital defect. The Plan’s coverage of well baby care is described under wellness/preventive care in the Schedule of Medical Benefits in this section of the Handbook.

-Y, Z-

You, your: When used in this Handbook, these words refer to the eligible employee or retiree who is covered by the Plan. They do not refer to any dependent of the employee or retiree.
General Information — SRP Health and Life Plan (the “Plan”)

Name of Plan
Salt River Project Health and Life Plan

The term “Salt River Project Health and Life Plan” refers to (1) plans maintained separately by the District and the Association that provide self-insured Medical PPO/EPO, dental and vision, and (2) a plan jointly maintained by the District and the Association that provides fully insured prepaid dental and life insurance benefits.

Name and Address of Plan Sponsors
In this General Information section, the Salt River Project Agricultural Improvement and Power District [District] and the Salt River Valley Water Users’ Association [Association] together are known as “SRP.” The address of SRP is:

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<tbody>
<tr>
<td>SRP</td>
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<tr>
<td>Benefits Services PAB242</td>
<td>Benefits Services PAB242</td>
</tr>
<tr>
<td>1521 N. Project Drive</td>
<td>P.O. Box 52025</td>
</tr>
<tr>
<td>Tempe, AZ 85281</td>
<td>Phoenix, AZ 85072-2025</td>
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The following employers also participate:

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<tr>
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<td>New West Energy Corporation</td>
</tr>
<tr>
<td>PAB200</td>
<td>PAB200</td>
</tr>
<tr>
<td>1521 N. Project Drive</td>
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<tr>
<td>Tempe, AZ 85281</td>
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<tr>
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<td>Papago Park Center, Inc.</td>
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<tr>
<td>PAB343</td>
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<tr>
<td>Tempe, AZ 85281</td>
<td>Phoenix, AZ 85072-2025</td>
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<tr>
<td>Salt River Project Employees’</td>
<td>Salt River Project Employees’</td>
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<tr>
<td>Recreational Association, Inc.</td>
<td>Recreational Association, Inc.</td>
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<tr>
<td>(PERA Valley)</td>
<td>(PERA Valley)</td>
</tr>
<tr>
<td>1 E. Continental Drive</td>
<td>P.O. Box 52025</td>
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<tr>
<td>Tempe, AZ 85281</td>
<td>Phoenix, AZ 85072-2025</td>
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<tr>
<td>Recreational Association</td>
<td>Recreational Association</td>
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<tr>
<td>Coronado Generating Station, Inc.</td>
<td>Coronado Generating Station, Inc.</td>
</tr>
<tr>
<td>(PERA CGS)</td>
<td>(PERA CGS)</td>
</tr>
<tr>
<td>Highway 191, 7 miles NE</td>
<td>P.O. Box 1018</td>
</tr>
<tr>
<td>St. Johns, AZ 85936</td>
<td>St. Johns, AZ 85936</td>
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Plan Identification Numbers

The Internal Revenue Service has assigned the following employer identification numbers (EINs) to the plan sponsors:

- **District:** 86-6000727
- **Association:** 86-0053220
- **New West Energy Corp.:** 86-0873645
- **Papago Park Center, Inc.:** 86-0631031
- **PERA Valley:** 86-0113325
- **PERA CGS:** 86-0652066
- **PERA NGS:** 86-0652064

The Plan sponsors have assigned a plan identification number of 507 to the insured plans maintained by the Association and the District, and 519 to the self-insured plan maintained by the Association.

Type of Plan

Plans that comprise the Health and Life Plan are welfare benefit plans providing medical (including behavioral health, prescription drugs and hearing aid), dental, vision, life, and accidental death and dismemberment benefits.

Funding

Benefits under the following programs are **self-insured** out of the sponsoring employer’s general assets:

- SRP Medical PPO/EPO Option(s) (including prescription drugs, behavioral health and hearing aids)
- SRP Dental Program
- SRP Vision Plan

The following welfare plan benefits are **fully insured** with the following insurance companies:

- The prepaid Dental plan (as listed on the Quick Reference Chart in the front of this section of the Handbook).
- The EAP Program (as listed on the Quick Reference Chart in the front of this section of the Handbook).

SRP contracts with a company to provide stop-loss insurance that will reimburse a benefit program it insures for certain self-funded Medical Plan losses in excess of amounts described in the stop-loss insurance policy. This policy does not insure or guarantee, and has no obligation to pay, any Plan benefits or to make any other payment to plan participants.

The Plan’s **Life and AD&D Benefits** are fully insured through insurance policies with a selected insurance carrier.
For the address and phone number of the above-noted insurance companies, refer to the Quick Reference Chart in the front of this section of the Handbook or contact SRP Benefits Services.

**Type of Administration**

Claims are administered by a variety of sources as outlined below:

- **Claims for the self-insured SRP Medical PPO/EPO Option (including behavioral health, prescription drug and hearing aid benefits) and SRP Dental Program** are administered by an independent Claims Administrator, whose name and address are listed under “Claims Administrator” on the Quick Reference Chart in the front of this section of the Handbook.

- **Claims for outpatient prescription drugs for the SRP Medical PPO/EPO Option** are administered by an independent prescription drug Claims Administrator, whose name and address are listed under “Prescription Drug Program” on the Quick Reference Chart in the front of this section of the Handbook.

- **Claims for the SRP Vision Plan** are administered by an independent vision Claims Administrator, whose name and address are listed under “SRP Vision Plan” on the Quick Reference Chart in the front of this section of the Handbook.

- **Claims for the Employer’s Dental Plan** are administered by that insurance company at its address listed on the Quick Reference Chart in the front of this section of the Handbook.

- **Claims for the Life and AD&D insurance** are administered by that insurance company at its address listed on the Quick Reference Chart in the SRP Life and AD&D Insurance Program section of the Handbook.

- **Claims for the EAP Program** are administered by that insurance company at its address listed on the Quick Reference Chart in the Employee Guidelines section of the Handbook.

**Discretionary Authority of the Plan Administrator**

The Plan Administrator is the SRP Benefits Manager. Under the terms of the Plan, the Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to administer the Plan, to construe and apply all Plan provisions, and to resolve any ambiguities in the application or terms of the Plan. The Plan Administrator may delegate to any other individual or organization any of its powers and duties with respect to the operation of the Plan. The Plan Administrator’s powers and duties, unless properly delegated, include, but are not limited to:

- Determining all questions relating to the administration of the Plan, including the power to resolve all questions of fact relating to the eligibility of any individual to participate in, or receive benefits under or provided in connection with, the Plan.

- Deciding disputes that may arise with regard to the rights of employees, participants, and their legal representatives or beneficiaries under the terms of the Plan. The decisions by the Plan Administrator will be final.

- Obtaining any information from an employer with respect to its employees as is necessary to determine the rights and benefits of the employees under the Plan. The Plan Administrator may rely conclusively upon the information furnished by the employer.

- Compiling and maintaining all records necessary for the Plan.

- Furnishing the employer, upon request, such reports with respect to the administration of the Plan as are reasonable and appropriate.

- Engaging the legal, administrative, actuarial, investment, accounting, consulting and other professional services the Plan Administrator deems proper.
g. Adopting rules and regulations for the administration of the Plan.
h. Doing and performing any other actions as may be provided for in the Plan.

Any action on matters within the discretion of the Plan Administrator shall be conclusive, final, and binding upon all participants in the Plan and upon all individuals claiming any rights under the Plan, including beneficiaries, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Name, Business Telephone Number and Business Address of Plan Administrator

Salt River Project Agricultural Improvement and Power District: (602) 236-3600

Name and Address of Person Designated as Agent for Service of Legal Process

The person designated as agent for the service of legal process is the SRP Corporate Secretary, whose address is:

SRP
PAB215
Attn: Corporate Secretary
1521 N. Project Drive
Tempe, AZ 85281

Hourly Employee Information

For hourly employees of SRP, the Plan is maintained pursuant to SRP’s three collective bargaining agreements with Local Union #266 of the International Brotherhood of Electrical Workers. Copies of the agreements have been distributed to SRP’s hourly employees and are available for examination at SRP Benefits Services, PAB242, 1521 N. Project Drive, Tempe, AZ 85281. A copy of the agreements may be obtained by hourly employees and their beneficiaries upon written request to the Plan Administrator.

Eligibility for Participation and Benefits

Eligibility for Medical Plan benefits is discussed in Eligibility for Coverage in this section of the Handbook. Eligibility for Life/AD&D insurance is discussed in the Life and AD&D Insurance Program section of this Handbook.

Loss of Benefits

Furnishing false information or omitting information, such as not telling SRP of a divorce or claiming an individual who you are not married to as your spouse, may be cause for cancellation of benefit coverage under the Plan. Such actions also may result in disciplinary action up to and including discharge.

Need more help? See the Quick Reference Chart in the front of this section.
Employees, their dependents and beneficiaries who are covered by the Plan have a duty to cooperate with the Plan Administrator or Claims Administrator with regard to any claim for benefits under the Plan. This includes, but is not limited to, providing the Plan Administrator or Claims Administrator with copies of all records, receipts and bills that are relevant to the Plan Administrator’s or Claims Administrator’s assessment of the claim for benefits. In the event the covered employee, dependent or beneficiary refuses to cooperate with the Plan Administrator or Claims Administrator, the Plan Administrator or Claims Administrator, at its discretion, may deny the claim and/or terminate the claimant’s coverage under the Plan.

In the event that the Plan Administrator or Claims Administrator determines that an overpayment has been made to the claimant, the Plan Administrator or Claims Administrator, at its discretion, may offset the amount of the overpayment against subsequent claims of the claimant or may request reimbursement in the amount of the overpayment from the claimant.

The foregoing shall not limit in any way the rights or remedies the Plan Administrator or Claims Administrator may have at law or in equity. Specific information on each component of the Plan describing the circumstances that may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of benefits is discussed elsewhere in this Handbook.

Sources of Contributions to the Plan

Nearly all of the contributions relating to health care benefits are made by the employers. A portion of the contributions relating to health care benefits are made by the employers pursuant to salary reduction agreements between participants and the employers under the Salt River Project Flexible Benefits Plan. The remainder of the contributions relating to health care benefits made by the employers are non-elective employer contributions based on participants’ selection or purchase. A very small portion of the contributions relating to health care are made by participants (such as those covered under COBRA) through the Salt River Project Flexible Benefits Plan or survivors of retirees.

Employer and employee contributions are used to purchase the Plan’s Life and AD&D insurance coverage. The employee’s portion of contributions for all eligible benefits is announced each year during the Open Enrollment Period.

Fiscal Year

The Plan’s fiscal year ends on December 31.

Claim Procedure

For life insurance (including accidental death and dismemberment coverage), claims for benefits should be submitted to SRP Benefits Services, PAB242, P.O. Box 52025, Phoenix, AZ 85072-2025.

Claim Filing and Appeals Information in the SRP Health Care Program section of this Handbook describes the claims process for the self-insured benefits: SRP Medical PPO/EPO Option, SRP Dental Program and SRP Vision Plan.

See “Employees Assistance Program (EAP)” in the SRP Medical PPO/EPO Option and Employers Dental Services in this section of the Handbook for specific claims procedures for those insured benefits. The Quick Reference Chart in the front of the SRP Health Care Program section of this Handbook lists the name, address and phone number for all Claims Administrators.
Your Rights Under ERISA

If you participate in the self-insured health plan sponsored by the Association or the fully insured Dental Plan sponsored jointly by the District and the Association, your rights under ERISA are discussed in the ERISA Rights section of this Handbook.

Plan Amendment and Termination

In some instances, Union consent may be necessary before a plan described in this section of the Handbook can be amended or terminated. The Board of Directors of the District and the Board of Governors of the Association have the right, at any time and without advance notice to participants, to amend a plan that company sponsors by written amendment to any extent and in any manner that they or their designee deem advisable. In addition, the General Manager of the District and the General Manager of the Association have the right to adopt an amendment to a plan company sponsors that:

(a) Does not significantly affect the monetary obligations of the employer or the employer’s employees;

(b) Does not materially alter the nature, investment strategy or administration of the plan; or

(c) Is required by future or existing laws.

Plan amendments adopted by the District (by either the Board or the General Manager) automatically apply to New West Energy Corporation, Papago Park Center, Inc., PERA Valley, PERA CGS and PERA NGS without further action by New West Energy Corporation, Papago Park Center, Inc., PERA Valley, PERA CGS or PERA NGS.

Each plan described in this section of the Handbook has been established with the bona fide intention and expectation that it will be continued indefinitely, but the employers do not have an obligation to maintain the plan for any given length of time.

The Board of Directors of the District, the Executive Committee of the Board of Directors of New West Energy Corporation, the Board of Directors of Papago Park Center, Inc., and the Board of Governors of the Association or their respective designees have the right, at any time and without advance notice to participants, to adopt a resolution causing the termination of a plan described in this section of the Handbook. If the District adopts a resolution terminating a plan described in this section of the Handbook, it shall serve to automatically terminate a plan described in this section of the Handbook for PERA Valley, PERA CGS and PERA NGS. Any employer shall be permitted to discontinue or revoke its participation in a plan described in this section of the Handbook upon the presentation of satisfactory evidence thereof to the Plan Administrator. Upon termination or discontinuance or revocation of participation in a plan described in this section of the Handbook, all elections and reductions in compensation related to the plan shall terminate.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans like the Salt River Project Medical Reimbursement Tax Saver Plan (Plan), maintain the privacy of your personally identifiable health information called “protected health information,” or “PHI.”

A complete description of your rights under HIPAA’s Privacy Rule can be found in the Plan’s Privacy Notice, which was previously distributed to you and is available from SRP Benefits Services at the phone number listed on the Quick Reference Chart in the front of this section of the Handbook. The
Privacy Notice is also available on the SRP Intranet (_insideSRP/hrnet). Select HIPAA Privacy Act. Information about HIPAA’s Privacy Rule in this Handbook is not intended and cannot be construed as the Plan’s Privacy Notice.

The following terms are defined to aid your understanding of the next two subsections:

- The term “Plan Sponsor” means the Salt River Valley Water Users’ Association, the Salt River Project Agricultural Improvement and Power District, New West Energy Corporation and Papago Park Center, Inc.
- The term “Privacy Rule” means the regulations adopted pursuant to HIPAA, entitled “Standards for Privacy of Individually Identifiable Health Information” and set forth in 45 CFR part 160 and part 164, subparts A and E.
- The term “Protected Health Information” (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form. PHI does not include health information contained in employment records held by SRP in its role as an employer, including but not limited to health information needed to carry out SRP’s obligations under the Americans with Disabilities Act of 1990 (ADA), the Family and Medical Leave Act of 1993 (FMLA), the Occupational Safety and Health Act (OSHA) and similar laws; records relating to occupational illness/injury; records relating to disability, life, and accidental death and dismemberment (AD&D) insurance eligibility; sick leave requests and justifications; drug screening results; and fitness-for-work tests.
- The term “Plan” means the Salt River Project Medical Reimbursement Tax Saver Plan.

Protected Health Information

The Plan and the Plan Sponsor will not use or further disclose PHI without your written authorization except as necessary for treatment, payment, health plan operations and plan administration, payroll purposes, or as permitted or required by law. In accordance with HIPAA, the Plan requires all of its business associates to also observe the Privacy Rule. In particular, the Plan will not, without authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the PHI, receive an accounting of certain disclosures of the PHI and, under certain circumstances, amend the PHI. You also have the right to file a complaint with the Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

If you have questions about the privacy of your health information or you wish to file a complaint under HIPAA, you may contact the Plan’s Privacy Officer at:

SRP Self-Insured Health Benefits Plan Privacy Officer
PAB242
P.O. Box 52025
Phoenix, AZ 85072-2025
(602) 236-3600 (press 0) or 1-800-491-8846 (press 0); fax: (602) 236-3606
Disclosure of Protected Health Information by Plan to Plan Sponsor

The provisions in this subsection allow the Plan to disclose certain PHI to the Plan Sponsor for purposes permitted and under the conditions specified in the Privacy Rule.

A. Limitations on the use and disclosure of PHI: The Plan Sponsor may use and disclose PHI received from the Plan only as permitted by this paragraph A and in accordance with the Privacy Rule. The Plan Sponsor may use and disclose PHI received from the Plan solely for purposes of performing the plan administration functions on behalf of the Plan specified in this paragraph A. These functions include eligibility and enrollment functions, quality assurance, claims processing, auditing, monitoring, trend analysis and such other activities necessary to manage and operate the Plan, provided these activities qualify as payment or health care operations functions under the Privacy Rule. The Plan Sponsor may not use or disclose such PHI for any employment-related functions, or any functions in connection with any other benefit or employee benefit plan of the Plan Sponsor.

- PHI may be disclosed by the Plan to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions contained in this paragraph A and that the Plan Sponsor agrees to these provisions. Specifically, the Plan Sponsor agrees to:
  - Not use or further disclose PHI received from the Plan other than as permitted by this section or as required by law;
  - Ensure that any agents, including a subcontractor, to whom it 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 the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless authorized by the individual or disclosed in the Plan’s Privacy Notice;
  - Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for in this subsection of which it becomes aware;
  - Make the PHI available to the individual in accordance with the access requirements of the Privacy Rule;
  - Make the PHI available for amendment and incorporate any amendments to PHI in accordance with the requirements of the Privacy Rule;
  - Make available the information required to provide an accounting of PHI disclosures in accordance with the requirements of the Privacy Rule;
  - 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 Department of Health and Human Services for purposes of determining the Plan’s compliance with the Privacy Rule;
  - 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 information when no longer needed for the purpose for which disclosure was made to it. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
  - Ensure that adequate firewalls, as described in paragraph B below, are established to (1) identify the employees or classes of employees or other persons under the control of the Plan Sponsor who will have access to PHI received from the Plan; (2) restrict access
to the PHI solely to these employees or workforce members, and ensure that their access is only for purposes of performing plan administration functions on behalf of the Plan; and (3) provide a mechanism for resolving any issues of noncompliance by these employees or workforce members of the Plan Sponsor.

B. **Firewalls:** In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with the Privacy Rule, only the following employees will be given access to PHI received from the Plan:

1. Employees in, or contractors working under the direct control of, the Benefits and Health Services Department of the Plan Sponsor (“Benefits Personnel”). Benefits Personnel will be given access to, and allowed to use, PHI received from the Plan solely for purposes of performing plan administration functions on behalf of the Plan.

2. The following employees of the Plan Sponsor will be given access to, and allowed to use, PHI received from the Plan solely for purposes of performing plan administration functions on behalf of the Plan that relate to eligibility and enrollment:
   - Except as otherwise provided in paragraph B(1) above, employees in the Human Resources Services Department;
   - Employees in the Accounts Payable/Payroll Department whose job responsibilities include payroll functions;
   - Employees in the Information Systems Administrative Systems Department whose job responsibilities include design, operation and maintenance of the Plan Sponsor’s Human Resources Management System; and
   - Employees in the Financial Accounting Department who are responsible for payments to Plan contractors.

Any issues of noncompliance with these restrictions on the access to, and use of, PHI by Benefits Personnel or employees described in paragraph B(2) above will be subject to sanctions in accordance with the Plan Sponsor’s procedure for resolving issues of noncompliance, including disciplinary sanctions.

C. Effective April 21, 2005, in compliance with HIPAA Security regulations, the Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan;
- Ensure that the adequate separation discussed in paragraph B (Firewalls) above, specific to electronic PHI (also called ePHI), is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.
General Information — SRP Flexible Benefits Plan

Name of Plan
Salt River Project Flexible Benefits Plan

Name and Address of Plan Sponsors
The Salt River Project Agricultural Improvement and Power District (District) and the Salt River Valley Water Users’ Association (Association) together are known as “SRP.” SRP sponsors the Plan. The address of SRP is:

Street Address
SRP
Benefits Services PAB242
1521 N. Project Drive
Tempe, AZ 85281

Mailing Address
SRP
Benefits Services PAB242
P.O. Box 52025
Phoenix, AZ 85072-2025

The following employers also participate:

Street Address
New West Energy Corporation
PAB200
1521 N. Project Drive
Tempe, AZ 85281

Mailing Address
New West Energy Corporation
PAB200
P.O. Box 61868
Phoenix, AZ 85082-1868

Papago Park Center, Inc.
PAB343
1521 N. Project Drive
Tempe, AZ 85281

Mailing Address
Papago Park Center, Inc.
PAB343
P.O. Box 52025
Phoenix, AZ 85072-2025

Plan Identification Numbers
The Internal Revenue Service has assigned the following employer identification numbers (EINs) to the plan sponsors:

District: 86-6000727
Association: 86-0053220
New West Energy Corp.: 86-0873645
Papago Park Center, Inc.: 86-0631031

The plan sponsors have assigned a Plan identification number of 502 to the Plan.

Type of Plan
The Plan is a fringe benefit plan that provides participants with a choice between a portion of their cash compensation and benefits offered under the Salt River Project Dependent Care Assistance Tax Saver Plan, the Salt River Project Medical Reimbursement Tax Saver Plan and health care benefits under the Salt River Project Health and Life Plan.

Funding
The Plan is self-funded out of the employer’s general assets.

Need more help? See the Quick Reference Chart in the front of this section.
Type of Administration
The type of administration is employer administration.

Discretionary Authority of the Plan Administrator
Under the terms of the Plan, the Plan Administrator, and other plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to administer the Plan, to construe and apply all plan provisions, and to resolve any ambiguities in the application or terms of the Plan. The Plan Administrator may delegate to any other individual or organization any of its powers and duties with respect to the operation of the Plan. The Plan Administrator’s powers and duties, unless properly delegated, include, but are not limited to:

a. Determining all questions relating to the administration of the Plan, including the power to resolve all questions of fact relating to the eligibility of any individual to participate in, or receive benefits under or provided in connection with, the Plan.

b. Deciding disputes that may arise with regard to the rights of employees, participants, and their legal representatives or beneficiaries under the terms of the Plan. The decisions by the Plan Administrator will be final.

c. Obtaining any information from an employer with respect to its employees as is necessary to determine the rights and benefits of the employees under the Plan. The Plan Administrator may rely conclusively upon the information furnished by the employer.

d. Compiling and maintaining all records necessary for the Plan.

e. Furnishing the employer, upon request, such reports with respect to the administration of the Plan as are reasonable and appropriate.

f. Engaging the legal, administrative, actuarial, investment, accounting, consulting and other professional services the Plan Administrator deems proper.

g. Adopting rules and regulations for the administration of the Plan.

h. Doing and performing any other actions as may be provided for in the Plan.

Any action on matters within the discretion of the Plan Administrator shall be conclusive, final, and binding upon all participants in the Plan and upon all individuals claiming any rights under the Plan, including beneficiaries, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Name, Business Telephone Number and Business Address of Plan Administrator
Salt River Project Agricultural Improvement and Power District: (602) 236-3600

Street Address
SRP
Benefits Services PAB242
1521 N. Project Drive
Tempe, AZ 85281

Mailing Address
SRP
Benefits Services PAB242
P.O. Box 52025
Phoenix, AZ 85072-2025
Name and Address of Person Designated as Agent for Service of Legal Process

The person designated as agent for the service of legal process is the SRP Corporate Secretary, whose address is:

SRP
PAB215
Attn: Corporate Secretary
1521 N. Project Drive
Tempe, AZ 85281

Hourly Employee Information

For hourly employees of SRP, the Plan is maintained pursuant to SRP’s three collective bargaining agreements with Local Union #266 of the International Brotherhood of Electrical Workers. Copies of the agreements have been distributed to SRP’s hourly employees and are available for examination at SRP Benefits Services, PAB242, 1521 N. Project Drive, Tempe, AZ 85281. A copy of the agreements may be obtained by hourly employees and their beneficiaries upon written request to the Plan Administrator.

Eligibility for Participation and Benefits

Any regular full-time, three-quarter-time, half-time or provisional SRP employee is eligible to participate. Participants (except provisional employees) are eligible for benefits under the Salt River Project Health and Life Plan, the Salt River Project Medical Reimbursement Tax Saver Plan and the Salt River Project Dependent Care Assistance Tax Saver Plan based on elections made in this Plan. Provisional employees are eligible for benefits under the Salt River Project Health and Life Plan, but not the Medical Reimbursement or Dependent Care Assistance tax saver plans based on elections made in this Plan.

Benefits Provided Under Plan

Based on elections made in this Plan, participants (except provisional employees) are eligible for benefits under the Salt River Project Health and Life Plan, the Salt River Project Medical Reimbursement Tax Saver Plan and the Salt River Project Dependent Care Assistance Tax Saver Plan. Provisional employees are eligible for benefits under the Salt River Project Health and Life Plan, but not the Medical Reimbursement or Dependent Care Assistance tax saver plans. Specific information on benefits under these plans is discussed in SRP Health Care Program, Salt River Project Medical Reimbursement Tax Saver Plan and Salt River Project Dependent Care Assistance Tax Saver Plan in this section of the Handbook.

Loss of Benefits

As a funding medium, the Plan does not directly provide benefits to participants. Instead, based on elections made in this Plan, benefits are provided under the Salt River Project Health and Life Plan, the Salt River Project Medical Reimbursement Tax Saver Plan and the Salt River Project Dependent Care Assistance Tax Saver Plan. Specific information on those plans, describing the circumstances that may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of benefits, is discussed in this section of the Handbook.

Need more help? See the Quick Reference Chart in the front of this section.
Sources of Contributions to Plan
The Plan receives contributions pursuant to salary reduction agreements between participants and the employers to pay benefits under the Salt River Project Medical Reimbursement Plan, the Salt River Project Dependent Care Assistance Plan and health care benefits under the Salt River Project Health and Life Plan. A very small portion of the contributions relating to the Salt River Project Health and Life Plan and the Salt River Project Medical Reimbursement Plan are made by the participants, such as those covered under COBRA. Specific information on the sources of contributions to this Plan and the method of calculating the amount of the contributions can be found in this section of the Handbook.

Fiscal Year
The Plan’s fiscal year ends on December 31.

Claim Procedure
Claims are not filed with the Plan. Instead, claims relating to health benefits are made in accordance with the claim procedure discussed in Claim Filing and Appeals Information in this section of the Handbook. Claims relating to Medical Reimbursement Tax Saver Account benefits are filed in accordance with the claim procedure described in Filing a Medical Reimbursement TSA Claim in this section of the Handbook. Claims relating to Dependent Care Assistance Tax Saver Account benefits are filed in accordance with the claim procedure described in Filing a Dependent Care Assistance TSA Claim in this section of the Handbook.

Plan Amendment and Termination
In some instances, Union consent may be necessary before the Plan can be amended or terminated. The Board of Directors of the District and the Board of Governors of the Association have the right, at any time and without advance notice to participants, to amend the Plan by written amendment to any extent and in any manner that they or their designee deem advisable. In addition, the General Manager of the District and the General Manager of the Association have the right to adopt an amendment to the Plan that:

(a) Does not significantly affect the monetary obligations of the employer or the employer’s employees;
(b) Does not materially alter the nature, investment strategy or administration of the Plan; or
(c) Is required by future or existing laws.

Plan amendments adopted by the District (by either the Board or the General Manager) shall automatically apply to New West Energy Corporation and Papago Park Center, Inc., without further action by New West or Papago Park.

The Plan has been established with the bona fide intention and expectation that it will be continued indefinitely, but the employers do not have an obligation to maintain the Plan for any given length of time.

The Board of Directors of the District, the Board of Governors of the Association, the Executive Committee of the Board of Directors of New West and the Board of Directors of Papago Park, or their respective designees, have the right, at any time and without advance notice to participants, to adopt a resolution causing the termination of the Plan. Any employer shall be permitted to discontinue or revoke its participation in the Plan upon the presentation of satisfactory evidence thereof to the Plan Administrator. Upon termination, discontinuance or revocation of participation in the Plan, all elections and reductions in compensation related to the Plan shall terminate.
SRP Medical Reimbursement Tax Saver Plan

While SRP’s health care program provides comprehensive coverage for most of your needs, there are treatments, services and supplies that are not completely covered. The SRP Medical Reimbursement Tax Saver Plan (also called Tax Saver Account, or TSA) gives you the opportunity to set aside a portion of your pay on a before-tax basis to cover these expenses, such as deductibles and coinsurance. The money you set aside into your TSA is exempt from federal and Federal Insurance Contribution Act (FICA) taxes.

Eligibility

If you are a regular full-time, three-quarter time or half-time employee, you are eligible to participate in the SRP Medical Reimbursement Tax Saver Plan. Provisional and retirees are not eligible to participate.

Contribution Limits on Medical Reimbursement Tax Saver Accounts (TSA)

During each annual Open Enrollment Period, SRP gives you the opportunity to participate in a Medical Reimbursement Tax Saver Account (TSA) for the next year and to decide how much you will contribute. The Medical Reimbursement TSA applies to medical, dental, behavioral health, vision and hearing aid expenses for you and any of your eligible dependents, as allowed under the Internal Revenue Service (IRS) regulations.

The Open Enrollment Period is the only time during the year that you may elect to open a TSA. You may deposit into your TSA any amount of money up to $208.33 per pay period to a maximum of 24 pay periods ($5,000 pre-tax) per year.

- **Minimum contribution allowed:** $120 annually ($5 a pay period)
- **Maximum contribution allowed:** $5,000 annually ($208.33 a pay period)

Your before-tax contributions will be deducted in equal amounts from your first two paychecks each month for a total of 24 paychecks per year. By the end of the calendar year, your full contribution will have been deposited into your Medical Reimbursement TSA. Your Medical Reimbursement TSA will not earn interest.

If you are hired or become eligible for a Medical Reimbursement TSA after the first of a calendar year, your contributions will be deducted in equal amounts from the first two paychecks of each month after you are hired. Your total contribution must be no less than $120 annually and no more than $5,000 (pre-tax).

Changing Your Medical Reimbursement TSA Election

Medical Reimbursement TSAs are governed by Internal Revenue Service (IRS) rules. Once you have made your Medical Reimbursement TSA contribution amount decision, you generally cannot increase or decrease your contributions until the beginning of the next calendar year, even if tax laws for the current year change. Limited changes are allowed if you experience a change in status. See Changing Elections in this section of the Handbook for information on what events are considered changes in status events under this Plan.

Need more help? See the **Quick Reference Chart** in the front of this section.
Avoiding Forfeiture of Unused TSA Dollars

IRS regulations require that any unused amounts remaining in your Medical Reimbursement TSA at the end of the calendar year be forfeited. However, you have until March 31 of the following calendar year to submit claims for out-of-pocket expenses that were incurred between January 1 and December 31 of the preceding year. If you do not use all of the money you contribute to your Medical Reimbursement TSA by March 31, you will lose the remaining balance in your TSA. Because there is the possibility of forfeiture, you must plan ahead carefully before you make your annual TSA election. Additionally, if you terminate or retire from SRP, you have 90 days from your termination date to submit TSA claims for reimbursement.

Estimating Your Future TSA Needs

1. As a guide to projecting how much money you should set aside in your TSA this year, you may want to add up all the out-of-pocket expenses you accumulated in the previous year. Consider out-of-pocket expenses such as deductibles, copays, coinsurance and amounts not paid because they exceeded the Plan’s allowable charge.

2. Then decide which expenses were one-time expenses and which expenses are likely to reoccur in the next year.

3. Consider too the types of predictable health care expenses you expect to have during the coming year (e.g., you are currently pregnant and you plan to deliver in the upcoming year). When estimating major expenses, you should investigate the costs associated with the major expense before making your election.

4. Consider the implications of choosing a TSA or taking deductions on your income tax preparation (as discussed below under “TSAs and Income Tax Deductions”).

5. Finally, contribute to your TSA no more money than you expect to spend on out-of-pocket expenses during the upcoming calendar year. Forecasting your expenses will help you avoid forfeitures at year-end.

TSAs and Income Tax Deductions

The kind of medical, dental, behavioral health, vision and hearing aid expenses paid through your Medical Reimbursement TSA would normally be deductible on your federal income tax return to the extent they exceed 7.5% of your adjusted gross income (the current level determined by the IRS). However, when you pay these health care expenses through a Medical Reimbursement TSA, you give up the opportunity to take a tax deduction for them.

Therefore, before you elect to contribute to a TSA, you must choose whether you want to take the deduction for health care expenses on your normal income tax preparation or pay those expenses through a Medical Reimbursement TSA. You cannot legally do both. Generally, if you do not itemize deductions for your income tax preparation or if your health care expenses are less than 7.5% of your adjusted gross income, you will have greater savings with a Medical Reimbursement TSA than with the tax deduction for health care expenses. Keep in mind, if you decide to itemize your tax deductions, any amounts you contribute to a Medical Reimbursement TSA cannot be counted toward the 7.5%.

It is important to note that tax savings will depend on your personal situation and income level. Because tax laws are complicated and subject to frequent change, you should talk with a qualified tax adviser before deciding on whether to use a Medical Reimbursement TSA, the income tax deduction for health care expenses or some combination of both.
Expenses Eligible for Medical Reimbursement TSAs

Generally, a health care expense that qualifies as a federal income tax deduction and is incurred during the TSA plan year is also eligible for reimbursement from your Medical Reimbursement TSA. For more information on the types of expenses that qualify as federal income tax deductions, refer to the most current IRS Publication 502. However, unlike IRS Publication 502, a Medical Reimbursement TSA requires that expenses be **incurred** during the TSA plan year.

The IRS publication uses the term “medical care” and defines it as amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease and for treatments affecting any part or function of the body. The medical care must be primarily to alleviate or prevent a physical or mental defect of illness. You cannot include medical expenses that were paid by an insurance company or other source.

However, any health care expense paid or eligible to be paid by your medical, dental, behavioral health, vision and hearing aid coverage (or any expense paid or eligible to be paid by any other source) cannot be reimbursed through a Medical Reimbursement TSA since it is not an out-of-pocket expense. In addition, any health care expense that you actually deduct on your federal income tax return cannot be reimbursed through a Medical Reimbursement TSA.

The following out-of-pocket health care expenses incurred by you or eligible dependents are examples of currently eligible medical care expenses.

- Health care deductibles and copayments (the portion of medical charges you pay)
- Dental expenses not covered by a Dental Plan, such as orthodontia expenses over the lifetime limit (but that are prescribed by a dentist or orthodontist)
- Abortion
- Acupuncture
- Alcoholism or drug dependency, payment to a treatment center
- Ambulance
- Artificial limb
- Birth control pills
- Capital expenses (amounts you pay for special equipment installed in your home or for improvements whose main purpose is medical care)
- Car controls, special controls for the disabled
- Chiropractor, Christian Science practitioner
- Contact lenses
- Crutches, purchase or rental
- Dental fees, X-rays, fillings, braces, extractions, artificial teeth/dentures
- Drug addiction (inpatient treatment)
- Eyeglasses, optometrist and eye exams
- Fertility enhancement (in vitro fertilization, temporary storage of eggs/sperm, reversal of a prior sterilization surgery)
- Guide dog for visually or hearing impaired person
- Hearing aids
- Hospital services

Need more help? See the **Quick Reference Chart** in the front of this section.
• Laboratory fees
• Laser eye surgery
• Lead-based paint removal
• Learning disability
• Legal fees to authorize treatment for mental illness
• Lodging
• Qualified long-term care services
• Over-the-counter drugs used to treat a medical condition (e.g., allergy medications, antacids, pain relievers)
• Oxygen
• Psychiatric care, psychologist, psychoanalysis
• Sterilization
• Stop-smoking programs
• Therapy
• Weight loss programs undertaken at a physician’s direction to treat an existing disease such as diabetes, heart disease, etc.
• Wheelchair

Where this list deviates from a more current IRS regulation, that IRS regulation will prevail. For more information about the medical care expenses that may be allowed under a TSA, refer to IRS Publication 502. However, note that some of the statements in the IRS publication do not apply to a Medical Reimbursement TSA because the IRS publication was written to explain what is deductible as medical care on your personal income tax forms, not what is medical care under Code Section 213d. For more information, you may also contact the TSA Administrator, whose name and address are listed on the Quick Reference Chart in the front of this section of the Handbook.

Expenses Ineligible for Reimbursement by the Medical Reimbursement TSAs

Generally, a health care expense that does not qualify as a federal income tax deduction is also ineligible for reimbursement from your Medical Reimbursement TSA. The following expenses incurred by you or your eligible dependents are examples of currently ineligible expenses:

• Baby-sitting, child care and nursing services for a normal, healthy baby
• Certain nonprescription drugs and medications (e.g., vitamins, herbal supplements, toiletries)
• Controlled substances
• Cosmetic surgery
• Diaper service
• Electrolysis/hair removal
• Funeral/burial services
• Hair transplant
• Health club dues
• Household help

Need more help? See the Quick Reference Chart in the front of this section.
• Illegal operations and treatments
• Insurance premiums for medical care
• Maternity clothes
• Nutritional supplements
• Personal-use items
• Weight loss programs used to maintain general good health

Where this list deviates from a more current IRS regulation, that IRS regulation will prevail. For a complete description of medical care expenses allowed and not allowed under a TSA, refer to IRS Publication 502. For more information, you may also contact the TSA Administrator, whose name and address are listed on the Quick Reference Chart in the front of this section of the Handbook.

**Withdrawing Funds from a Medical Reimbursement TSA**

Once you begin having eligible expenses, you are entitled to make a claim for withdrawal from your Medical Reimbursement TSA. Eligible expenses must have been performed/provided, not just billed, charged, paid or prepaid. The claim form to use with the withdrawal is available online on the SRP Intranet (insideSRP) or from SRP Benefits Services, whose phone number is listed on the Quick Reference Chart in the front of this section of the Handbook. Mail or fax the claim form and a copy of the receipt or Explanation of Benefits (EOB) to the TSA Administrator listed on the Quick Reference Chart in the front of this section of the Handbook.

Currently, the minimum withdrawal amount is $25. If you file a claim for less than $25, it will be held until you make additional claims and your total request reaches or exceeds $25. No minimum applies to withdrawing the balance remaining of your elected annual contribution.

The maximum withdrawal amount is the total amount of your elected annual contribution less year-to-date withdrawals even if you have not yet contributed that amount to your Medical Reimbursement TSA.

**Filing a Medical Reimbursement TSA Claim**

You can file a Medical Reimbursement TSA claim for withdrawal at any time during the plan year or until March 31 of the following year. In order to make a withdrawal, follow these steps:

1. **Complete and sign a TSA claim form.** Claim forms are available online on SRP’s Intranet (insideSRP) or from Benefits Services at the phone number listed on the Quick Reference Chart in the front of this section of the Handbook.

2. When available, include a copy of your **Explanation of Benefits (EOB)** to support your claim. When an EOB is not available, submit bills that clearly state:
   • The name of the individual receiving the service or supplies
   • A description of the service or supplies
   • The name and address of the provider of the service or supplies
   • The amount charged for the service or supplies
   • The date the service was rendered or supplies were purchased

Mail or fax your completed and signed form and supporting documentation to the TSA Administrator listed on the Quick Reference Chart in the front of this section of the Handbook. A tax-free check will be sent to you from your TSA.
To Appeal a Denied Medical Reimbursement TSA Claim
See Claim Filing and Appeals Information in this section of the Handbook.

How Loss of Coverage Affects Your TSA
See COBRA Continuation Coverage in this section of the Handbook for information on when your coverage ends, your rights and the rights of your eligible dependents if your coverage ends.
General Information — SRP Medical Reimbursement Tax Saver Plan

Name of Plan
Salt River Project Medical Reimbursement Tax Saver Plan

Name and Address of Plan Sponsors
The Salt River Project Agricultural Improvement and Power District (District) and the Salt River Valley Water Users’ Association (Association) together are known as “SRP.” SRP sponsors the Plan. The address of SRP is:

Street Address
SRP
Benefits Services PAB242
1521 N. Project Drive
Tempe, AZ 85281

Mailing Address
SRP
Benefits Services PAB242
P.O. Box 52025
Phoenix, AZ 85072-2025

The following employers also participate:

Street Address
New West Energy Corporation
PAB200
1521 N. Project Drive
Tempe, AZ 85281

Mailing Address
New West Energy Corporation
PAB200
P.O. Box 61868
Phoenix, AZ 85082-1868

Street Address
Papago Park Center, Inc.
PAB343
1521 N. Project Drive
Tempe, AZ 85281

Mailing Address
Papago Park Center, Inc.
PAB343
P.O. Box 52025
Phoenix, AZ 85072-2025

Plan Identification Numbers
The Internal Revenue Service has assigned the following employer identification numbers (EINs) to the Plan sponsors:

District: 86-6000727
Association: 86-0053220
New West Energy Corp.: 86-0873645
Papago Park Center, Inc.: 86-0631031

The plan sponsors have assigned a Plan identification number of 502 to the Plan.

Type of Plan
The Plan is a welfare benefit plan permitting participants to elect to receive cash reimbursements of their medical expenses that are excluded from income from Section 105(b) of the Internal Revenue Code.

Funding
All of the Plan’s medical reimbursement benefits are funded out of the employer’s general assets.

Need more help? See the Quick Reference Chart in the front of this section.
Type of Administration

Claims are administered by an independent Medical Reimbursement Tax Saver Account Claims Administrator, whose name and address are listed under “Tax Saver Accounts” on the Quick Reference Chart in the front of this section of the Handbook.

Discretionary Authority of the Plan Administrator

Under the terms of the Plan, the Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to administer the Plan, to construe and apply all Plan provisions, and to resolve any ambiguities in the application or terms of the Plan. The Plan Administrator may delegate to any other individual or organization any of its powers and duties with respect to the operation of the Plan. The Plan Administrator’s powers and duties, unless properly delegated, include, but are not limited to:

- Determining all questions relating to the administration of the Plan, including the power to resolve all questions of fact relating to the eligibility of any individual to participate in, or receive benefits under or provided in connection with, the Plan.
- Deciding disputes that may arise with regard to the rights of employees, participants, and their legal representatives or beneficiaries under the terms of the Plan. The decisions by the Plan Administrator will be final.
- Obtaining any information from an employer with respect to its employees as is necessary to determine the rights and benefits of the employees under the Plan. The Plan Administrator may rely conclusively upon the information furnished by the employer.
- Compiling and maintaining all records necessary for the Plan.
- Furnishing the employer, upon request, such reports with respect to the administration of the Plan as are reasonable and appropriate.
- Engaging the legal, administrative, actuarial, investment, accounting, consulting and other professional services the Plan Administrator deems proper.
- Adopting rules and regulations for the administration of the Plan.
- Doing and performing any other actions as may be provided for in the Plan.

Any action on matters within the discretion of the Plan Administrator shall be conclusive, final, and binding upon all participants in the Plan and upon all individuals claiming any rights under the Plan, including beneficiaries, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Name, Business Telephone Number and Business Address of Plan Administrator

Salt River Project Agricultural Improvement and Power District: (602) 236-3600

Street Address
SRP Benefits Manager
Benefits Services PAB242
1521 N. Project Drive
Tempe, AZ 85281

Mailing Address
SRP Benefits Manager
Benefits Services PAB242
P.O. Box 52025
Phoenix, AZ 85072-2025

Need more help? See the Quick Reference Chart in the front of this section.
Name and Address of Person Designated as Agent for Service of Legal Process

The person designated as agent for the service of legal process is the SRP Corporate Secretary, whose address is:

SRP
PAB215
Attn: Corporate Secretary
1521 N. Project Drive
Tempe, AZ 85281

Hourly Employee Information

For hourly employees of SRP, the Plan is maintained pursuant to SRP’s three collective bargaining agreements with Local Union #266 of the International Brotherhood of Electrical Workers. Copies of the agreements have been distributed to hourly employees and are available for examination at SRP Benefits Services, PAB242, 1521 N. Project Drive, Tempe, AZ 85281. A copy of the agreements may be obtained by hourly employees and their beneficiaries upon written request to the Plan Administrator.

Eligibility for Participation and Benefits

Eligibility for participation and benefits is discussed in SRP Medical Reimbursement Tax Saver Plan in this section of the Handbook.

Loss of Benefits

Furnishing false information or omitting information, such as not telling SRP of a divorce or claiming an individual who you are not married to as your spouse, may be cause for cancellation of benefit coverage under the Plan. Such actions also may result in disciplinary action up to and including discharge.

Employees and their dependents who are covered by the Plan have a duty to cooperate with the Plan Administrator with regard to any claim for benefits under the Plan. This includes, but is not limited to, providing the Plan Administrator with copies of all records, receipts and bills that are relevant to the Plan Administrator’s assessment of the claim for benefits. In the event the covered employee or dependent refuses to cooperate with the Plan Administrator, the Plan Administrator, at its discretion, may deny the claim and/or terminate the claimant’s coverage under the Plan. In the event that the Plan Administrator determines that an overpayment has been made to the claimant, the Plan Administrator may offset the amount of the overpayment against subsequent claims of the claimant.

The foregoing shall not limit in any way the rights or remedies the Plan Administrator may have at law or in equity.

Specific information describing the circumstances that may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of benefits is discussed elsewhere in this Handbook.
Sources of Contributions to Plan
The Plan receives no contributions. All of the Plan’s benefits are funded by the employers pursuant to salary reduction agreements between participants and the employers under the Salt River Project Flexible Benefits Plan. COBRA participants fund a very small portion of the Plan’s benefits. See SRP Medical Reimbursement Tax Saver Plan in this section of the Handbook for information on the method by which Plan contributions are calculated.

Fiscal Year
The Plan’s fiscal year ends on December 31.

Claim Procedure
See SRP Medical Reimbursement Tax Saver Plan in this section of the Handbook for a discussion of claim procedures.

Your Rights Under ERISA
Your rights under ERISA are discussed in the ERISA Rights section of this Handbook.

Plan Amendment and Termination
In some instances, Union consent may be necessary before the Plan can be amended or terminated.

The Board of Directors of the District and the Board of Governors of the Association, have the right, at any time and without advance notice to participants, to amend the Plan by written amendment to any extent and in any manner that they or their designee deem advisable. In addition, the General Manager of the District and the General Manager of the Association have the right to adopt an amendment to the Plan that:

(a) Does not significantly affect the monetary obligations of the employer or the employer’s employees;
(b) Does not materially alter the nature, investment strategy or administration of the Plan; or
(c) Is required by future or existing laws.

Plan amendments adopted by the District (by either the Board or the General Manager) shall automatically apply to New West Energy Corporation and Papago Park Center, Inc., without further action by New West or Papago Park.

The Plan has been established with the bona fide intention and expectation that it will be continued indefinitely, but the employers do not have an obligation to maintain the Plan for any given length of time.

The Board of Directors of the District, the Board of Governors of the Association, the Executive Committee of the Board of Directors of New West and the Board of Directors of Papago Park, or their respective designees, have the right, at any time and without advance notice to participants, to adopt a resolution causing the termination of the Plan. Any employer shall be permitted to discontinue or revoke its participation in the Plan upon the presentation of satisfactory evidence thereof to the Plan Administrator. Upon termination, discontinuance or revocation of participation in the Plan, all elections and reductions in compensation related to the Plan shall terminate. Participants will be able to receive reimbursements under the Plan for eligible expenses incurred through the date the last contribution related to the Plan was made.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans like the Salt River Project Medical Reimbursement Tax Saver Plan (Plan), maintain the privacy of your personally identifiable health information called “protected health information,” or “PHI.”

A complete description of your rights under HIPAA’s Privacy Rule can be found in the Plan’s Privacy Notice, which was previously distributed to you and is available from SRP Benefits Services at the phone number listed on the Quick Reference Chart in the front of this section of the Handbook. The Privacy Notice is also available on the SRP Intranet (insidesrp/hrnet). Select HIPAA Privacy Act. Information about HIPAA’s Privacy Rule in this Handbook is not intended and cannot be construed as the Plan’s Privacy Notice.

The following terms are defined to aid your understanding of the next two subsections:

- The term “Plan Sponsor” means the Salt River Valley Water Users’ Association, the Salt River Project Agricultural Improvement and Power District, New West Energy Corporation and Papago Park Center, Inc.
- The term “Privacy Rule” means the regulations adopted pursuant to HIPAA, entitled “Standards for Privacy of Individually Identifiable Health Information” and set forth in 45 CFR part 160 and part 164, subparts A and E.
- The term “Protected Health Information” (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form. PHI does not include health information contained in employment records held by SRP in its role as an employer, including but not limited to health information needed to carry out SRP’s obligations under the Americans with Disabilities Act of 1990 (ADA), the Family and Medical Leave Act of 1993 (FMLA), the Occupational Safety and Health Act (OSHA) and similar laws; records relating to occupational illness/injury; records relating to disability, life, and accidental death and dismemberment (AD&D) insurance eligibility; sick leave requests and justifications; drug screening results; and fitness-for-work tests.
- The term “Plan” means the Salt River Project Medical Reimbursement Tax Saver Plan.

Protected Health Information

The Plan and the Plan Sponsor will not use or further disclose PHI without your written authorization except as necessary for treatment, payment, health plan operations and plan administration, payroll purposes, or as permitted or required by law. In accordance with HIPAA, the Plan requires all of its business associates to also observe the Privacy Rule. In particular, the Plan will not, without authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the PHI, receive an accounting of certain disclosures of the PHI and, under certain circumstances, amend the PHI. You also have the right to file a complaint with the Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

If you have questions about the privacy of your health information or you wish to file a complaint under HIPAA, you may contact the Plan’s Privacy Officer at:
Disclosure of Protected Health Information by Plan to Plan Sponsor

The provisions in this subsection allow the Plan to disclose certain PHI to the Plan Sponsor for purposes permitted and under the conditions specified in the Privacy Rule.

A. Limitations on the use and disclosure of PHI: The Plan Sponsor may use and disclose PHI received from the Plan only as permitted by this paragraph A and in accordance with the Privacy Rule. The Plan Sponsor may use and disclose PHI received from the Plan solely for purposes of performing the plan administration functions on behalf of the Plan specified in this paragraph A. These functions include eligibility and enrollment functions, quality assurance, claims processing, auditing, monitoring, trend analysis and such other activities necessary to manage and operate the Plan, provided these activities qualify as payment or health care operations functions under the Privacy Rule. The Plan Sponsor may not use or disclose such PHI for any employment-related functions, or any functions in connection with any other benefit or employee benefit plan of the Plan Sponsor.

PHI may be disclosed by the Plan to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions contained in this paragraph A and that the Plan Sponsor agrees to these provisions. Specifically, the Plan Sponsor agrees to:

- Not use or further disclose PHI received from the Plan other than as permitted by this section or as required by law;
- Ensure that any agents, including a subcontractor, to whom it 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 the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless authorized by the individual or disclosed in the Plan’s Privacy Notice;
- Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for in this subsection of which it becomes aware;
- Make the PHI available to the individual in accordance with the access requirements of the Privacy Rule;
- Make the PHI available for amendment and incorporate any amendments to PHI in accordance with the requirements of the Privacy Rule;
- Make available the information required to provide an accounting of PHI disclosures in accordance with the requirements of the Privacy Rule;
- 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 Department of Health and Human Services for purposes of determining the Plan’s compliance with the Privacy Rule;
- 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 information when no longer needed for the purpose for which disclosure was made to it. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that adequate firewalls, as described in paragraph B below, are established to (1) identify the employees or classes of employee or other
persons under the control of the Plan Sponsor who will have access to PHI received from the Plan; (2) restrict access to the PHI solely to these employees or workforce members and ensure that their access is only for purposes of performing plan administration functions on behalf of the Plan; and (3) provide a mechanism for resolving any issues of noncompliance by these employees or workforce members of the Plan Sponsor.

B. **Firewalls:** In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with the Privacy Rule, only the following employees will be given access to PHI received from the Plan:

1. Employees in, or contractors working under the direct control of, the Benefits and Health Services Department of the Plan Sponsor (“Benefits Personnel”). Benefits Personnel will be given access to, and allowed to use, PHI received from the Plan solely for purposes of performing plan administration functions on behalf of the Plan.

2. The following employees of the Plan Sponsor will be given access to, and allowed to use, PHI received from the Plan solely for purposes of performing plan administration functions on behalf of the Plan that relate to eligibility and enrollment:
   - Except as otherwise provided in paragraph B(1) above, employees in the Human Resources Services Department;
   - Employees in the Accounts Payable/Payroll Department whose job responsibilities include payroll functions;
   - Employees in the Information Systems Administrative Systems Department whose job responsibilities include design, operation and maintenance of the Plan Sponsor’s Human Resources Management System; and
   - Employees in the Financial Accounting Department who are responsible for payments to Plan contractors.

   Any issues of noncompliance with these restrictions on the access to, and use of, PHI by Benefits Personnel or employees described in paragraph B(2) above will be subject to sanctions in accordance with the Plan Sponsor’s procedure for resolving issues of noncompliance, including disciplinary sanctions.

C. Effective April 21, 2005, in compliance with HIPAA Security regulations, the Plan Sponsor will:

   - Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan;
   - Ensure that the adequate separation discussed in paragraph B (Firewalls) above, specific to electronic PHI (also called ePHI), is supported by reasonable and appropriate security measures;
   - Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
   - Report to the Plan any security incident of which it becomes aware concerning electronic PHI.
SRP Dependent Care Assistance Tax Saver Plan

Day care expenses for children or for an elderly parent who lives with you can add up fast. The SRP Dependent Care Assistance Tax Saver Plan allows you to save money by paying for day care with before-tax dollars. The Plan provides you with a way to reduce one of your biggest weekly expenses and increase your spendable income.

Eligibility

If you are a regular full-time, three-quarter-time or half-time employee, you are eligible to participate in the SRP Dependent Care Assistance Tax Saver Plan. Provisional employees and retirees are not eligible to participate.

Contribution Limits on Dependent Care Assistance Tax Saver Accounts (TSA)

During each annual Open Enrollment Period, SRP gives you the opportunity to participate in a Dependent Care Assistance Tax Saver Account (TSA) for the next year and to decide how much you will contribute. The Dependent Care Assistance TSA applies to child day care expenses, in-home dependent care, nursery school and adult day care expenses.

The Open Enrollment Period is the only time during the year that you may elect to open a TSA. You may deposit into your TSA any amount of money up to $208.33 per pay period to a maximum of $5,000 per year. The contribution limits are:

Minimum contribution allowed: $120 annually ($5 a pay period)

Maximum contribution allowed:

The least of:

a. $5,000 annually ($208.33 a pay period) or $2,500 if you are married and file separate federal income tax returns;

b. Your earned income for the calendar year; or

c. If you are married at the end of the calendar year, your spouse’s earned income for the calendar year.

If you and your spouse both participate in Dependent Care Assistance TSAs, your total combined contributions for the calendar year are still limited to $5,000 under the Dependent Care Assistance TSA rules. In addition, any amount exceeding $5,000 is considered by the IRS to be taxable income and must be reported to the IRS when you file your yearly taxes.

If the case of an employee whose spouse is incapacitated or a full-time student, the spouse will be treated as having earned income at the rate of $250 for each month that he or she is incapacitated or a full-time student if the employee has one dependent who qualifies for dependent care assistance, excluding the spouse, or $500 for each month if more than one dependent qualifies for care, excluding the spouse. The dollar amounts may change periodically as allowed by law.

Your before-tax contributions will be deducted in equal amounts from your first two paychecks of each month for a total of 24 paychecks. By the end of the calendar year, your full contribution will have been deposited into your Dependent Care Assistance TSA. Your Dependent Care Assistance TSA will not earn interest.
If you are hired or become eligible for a Dependent Care Assistance TSA after the first of a calendar year, your contributions will be deducted in equal amounts from the first two paychecks of each month after you are hired. Your total contribution must be no less than the annual minimum and no more than the annual maximum.

**Changing Your Dependent Care Assistance TSA Election**

Dependent Care Assistance TSAs are governed by Internal Revenue Service (IRS) rules. Once you have made your Dependent Care Assistance TSA decision, generally you cannot increase or decrease your contributions until the beginning of the next calendar year, even if tax laws for the current year change. Limited changes are allowed if you experience a change in status. See Changing Elections in this section of the Handbook for more information on changes in status.

**Avoiding Forfeitures of Unused TSA Dollars**

IRS regulations require that any unused amounts remaining in your Dependent Care Assistance TSA at the end of the calendar year be forfeited. However, you have until March 31 of the following calendar year to submit claims for expenses that were incurred between January 1 and December 31 of the preceding year. If you do not use all of the money you contribute to your Dependent Care Assistance TSA by that time, you will lose the remaining balance in your TSA. Because there is the possibility of forfeiture, you must plan ahead carefully before you make your annual TSA election. Additionally, if you terminate or retire from SRP, you have 90 days from your termination date to submit TSA claims for reimbursement.

**Estimating Your Future TSA Needs**

As a guide to projecting how much money you should set aside in your TSA this year, you may want to add up all the dependent care assistance expenses you had in the previous year. Then decide whether you anticipate any changes for the coming calendar year (for example, a child turning age 13 or a child starting elementary school). Then, contribute no more than you expect to spend during the calendar year. Forecasting your expenses will help you avoid forfeitures at year-end.

**TSAs and Income Tax Credit**

Expenses paid through your Dependent Care Assistance TSA could normally be used for the dependent care tax credit on your federal income tax return. However, when you pay these dependent care expenses through a Dependent Care Assistance TSA, you give up the opportunity to use them for the dependent care tax credit.

Therefore, you have to choose whether you want to apply dependent care expenses to the federal dependent care tax credit or be reimbursed through a Dependent Care Assistance TSA. Keep in mind that if you decide to use the dependent care tax credit, any amount you contribute to a Dependent Care Assistance TSA cannot be used for the dependent care tax credit.

It is important to note that tax savings will depend on your personal situation and income level. Because tax laws are complicated and subject to frequent change, you should talk with a qualified tax adviser before deciding on whether to use a Dependent Care Assistance TSA, the federal dependent care tax credit or some combination of both.
Individuals Eligible for Reimbursement Under Dependent Care Assistance TSA

In order to be reimbursed for dependent care assistance in a TSA, an expense must be for the care of the following individuals:

- Your child(ren) or stepchild(ren) who (1) lives with you for more than half of the year, (2) does not provide more than half of his or her own support for the year, and (3) was under age 13 when the dependent care was provided. If you are divorced, separated or living apart from your spouse, you must have custody of the child for the greater part of the year, whether or not you can claim the child as a deduction on your federal income tax return.

- Your spouse who was physically or mentally incapable of self-care (self-care includes the inability to dress, clean and feed oneself) and who has the same principal place of abode as you for more than half of the year.

- Your other dependents of any age, if (1) they were physically or mentally incapable of self-care, (2) they have the same principal place of abode as you for more than half of the year, and (3) for whom you can claim a tax exemption on your federal tax return (or for whom you would be able to claim a tax exemption but for the “dependent of a dependent” limitation, the “married dependent” limitation or the “gross income” limitation).

See the most current IRS Publication 503 for more information on eligible dependent care expenses. However, unlike IRS Publication 503, a Dependent Care Assistance TSA requires that expenses be incurred during the TSA plan year.

Dependent Care Assistance Providers

Dependent care assistance may be provided in your home or in a dependent care center. If the care is provided in a dependent care center, the center must:

- Comply will all applicable state and local laws and regulations;
- Provide care for more than six individuals who do not reside at the facility on a regular basis; and
- Receive a fee, payment or grant for providing dependent care assistance.

If the dependent care assistance provider is related to you, the relative cannot be:

- Your spouse;
- Someone you or your spouse can claim as a deduction on your federal income tax return; or
- A child, stepchild or foster child who has not attained the age of 19 by the end of the calendar year.

Discrimination Testing

The Dependent Care Assistance TSAs of highly compensated employees may be reduced depending upon the total elections made by all eligible employees in order to comply with IRS regulations. You will be notified if this affects your Dependent Care Assistance TSA.

Expenses Eligible for Dependent Care Assistance TSAs

Generally, a dependent care assistance expense that may be used for the dependent care credit on your federal income tax return is also eligible for reimbursement from your Dependent Care Assistance TSA. However, any dependent care assistance expense paid from any other source cannot be reimbursed through a Dependent Care Assistance TSA since it is not an out-of-pocket expense. In addition, any dependent care assistance expense that you actually use in claiming a dependent care tax credit on your federal income tax return cannot be reimbursed through a Dependent Care Assistance TSA.
Generally, a dependent care assistance expense eligible for reimbursement from a Dependent Care Assistance TSA is an expense that:

- Is incurred during the TSA plan year for the care of an eligible dependent or for related household services;
- Is paid or payable to a dependent care assistance provider; and
- Allows you to work for any period during which you have one or more eligible dependents. If you are married, your spouse must also be gainfully employed, actively looking for work, incapable of self-care or a full-time student.

You also can be reimbursed for expenses incurred for services outside your home for a dependent who is under the age of 13 or for other dependents who regularly spend at least eight hours each day in your household. The following out-of-pocket dependent care assistance expenses incurred by you or your eligible dependents are examples of currently eligible expenses:

- Care at a day care center for your child
- In-home care for an elderly parent or spouse who is not capable of self-care
- Household services (cleaning, cooking, etc.) if they are necessary to run the home and at least partly benefit the dependent for whom the dependent care assistance is being claimed
- Summer day camp if the educational and food services provided are incidental and inseparable from the main service of assuring your dependent’s well-being and protection
- Nursery school expenses
- Day camps, when used for the care of a qualifying child/relative (but not overnight camps)

For more information, contact the TSA Administrator, whose name and address are listed on the Quick Reference Chart in the front of this section of the Handbook.

**Expenses Ineligible for Reimbursement by the Dependent Care Assistance TSAs**

Generally, a dependent care assistance expense that cannot be used for the dependent care credit on your federal income tax return is also ineligible for reimbursement from a Dependent Care Assistance TSA. See IRS Publication 503 for additional information.

While not comprehensive, the IRS does not recognize the following expenses as dependent care expenses that can be used for the dependent care credit, so they cannot be reimbursed through a Dependent Care Assistance TSA:

- Care provided by your spouse or a child under age 19
- Clothing
- Education and expenses to attend kindergarten or higher
- Entertainment
- Food
- Overnight camp
- Services provided by a chauffeur or gardener

For questions, contact the TSA Administrator, whose name and address are listed on the Quick Reference Chart in the front of this section of the Handbook.
Withdrawing Funds from Your Dependent Care Assistance TSA

Once you begin having eligible expenses, you are entitled to make a claim for withdrawal from your Dependent Care Assistance TSA. Currently, the minimum withdrawal amount is $25. If you file a claim for less than $25, it will be held until you make additional claims and your total request exceeds $25. No minimum applies to withdrawing the balance remaining in your Dependent Care Assistance TSA at year-end.

The maximum withdrawal amount is the amount in your Dependent Care Assistance TSA on the date of withdrawal. If you file a claim for more than the amount in your Dependent Care Assistance TSA on the date of withdrawal, it will be held until there are sufficient funds available in your Dependent Care Assistance TSA.

Loss of Coverage

If you are transitioned to a benefits-ineligible position or you leave SRP for any reason during the calendar year and you are making contributions to a Dependent Care Assistance TSA, you will no longer be able to make contributions to a Dependent Care Assistance TSA. However, you may continue to file claims for eligible dependent care assistance expenses after your SRP employment ends or you are transitioned to a benefits-ineligible position as long as the expenses were incurred during the portion of the calendar year you were employed by SRP in a benefits-eligible position.

Filing a Dependent Care Assistance TSA Claim

Once you begin having eligible expenses, you can file a claim for withdrawal from your Dependent Care Assistance TSA at any time during the plan year and up until March 31 of the following year. In order to make a withdrawal, follow these steps:

1. Complete and sign a TSA claim form. (The claim form to use for withdrawal is available from SRP Benefits Services or the TSA Administrator listed on the Quick Reference Chart in the front of this section of the Handbook.)

2. To support your claim, include a signed receipt from your dependent care provider containing the name, address and Social Security number (if care is provided by an individual) or taxpayer identification number (if care is provided by an organization or center) of your dependent care provider. Receipts should clearly indicate:
   - The name and age of each dependent receiving the service, and for each dependent listed, the date the service was provided and the amount you paid for the service.
   - Mail or fax your completed and signed form and supporting documentation to SRP’s TSA Administrator listed on the Quick Reference Chart in the front of this section of the Handbook.

3. The Claims Administrator will notify you of the Plan’s benefit determination within a reasonable period of time but not later than 90 calendar days after the Claims Administrator receives the claim.
   - The Claims Administrator may extend the 90-calendar-day period one time for up to 90 additional calendar days if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan. The Claims Administrator will notify you of the extension and of the date by which the Plan expects to make a decision prior to the expiration of the initial 90-day period using a written Notice of Extension.
   - If a period of time is extended due to failure to submit information required to process the claim, the Notice of Extension will specifically describe the required information and you will be given 45 calendar days after receipt of the Notice to provide...
the specified information. If the Plan cannot process a claim without the required information, the time period for the Plan to process the claim will be tolled from the date on which the Notice of Extension is sent until the date on which the Claims Administrator receives your response.

4. If your claim is approved, a tax-free check will be sent to you from your TSA. If your claim is denied and you wish to appeal the denial, follow the procedures listed in the “Claims Procedures” section below.

Claims Procedures

1. If your claim is denied in whole or in part, a notice of the denial will be provided to you in writing (or electronically as applicable). The notice of denial will:
   - Give the specific reason(s) for the denial;
   - Reference the specific Plan provision(s) on which the denial is based;
   - Describe any additional information needed to perfect the claim and an explanation of why such additional information is necessary;
   - Provide an explanation of the Plan’s appeal procedure along with time limits; and
   - Contain a statement that you have the right to bring a civil action under ERISA Section 502(a) if your claim is denied on appeal.

2. If you disagree with a denial of a claim, you, your beneficiary or your authorized representative (a “Claimant”) may appeal the decision by filing an appeal in accordance with the Plan’s appeal procedure for denial of claims. A Claimant has 60 calendar days after receipt of the denial to file an appeal. The Plan will not accept appeals filed after this 60-calendar-day period.

Appeal of a Denial of a Claim

This Plan maintains a two-level appeal procedure for appeals of claims.

1. Appeals must be made in writing to the Claims Administrator for the first level of appeal review and to the Plan Administrator for the second level of appeal review. Their mailing addresses are listed on the Quick Reference Chart in the front of this section of the Handbook.

2. At each appeal review level, the Claimant will be provided with:
   - Upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to the claim for benefits (whether a document, record or other information is relevant will be determined solely by the reviewer in accordance with applicable regulations);
   - The opportunity to submit to the reviewer written comments, documents, records and other information relating to the claim for benefits; and
   - A full and fair review that takes into account all comments, documents, records and other information the Claimant submitted, without regard to whether such information was submitted or considered in the initial benefit determination.

3. Under this Plan’s two-level appeal procedure, the Plan subcontracts the first level of appeal review to the Claims Administrator, who will make the first-level determination on the claim appeal within a reasonable period of time but not later than 60 calendar days after receipt of the appeal.

Need more help? See the Quick Reference Chart in the front of this section.
• Under special circumstances, the Claims Administrator may take up to an additional 60 days to make its decision if it notifies the Claimant in writing prior to the end of the 60-day period that (1) additional time is needed to process the claim, (2) the special circumstances for this extension, and (3) the date by which the Plan expects to render its determination.

• The Claims Administrator’s receipt of the Claimant’s appeal starts the running of the applicable time period in which the Claims Administrator must respond to the appeal, without regard to whether all the information necessary to make a benefit determination accompanies the filing. However, the time period in which the Claims Administrator is required to make its determination will be tolled from the date on which the notification of extension is sent to the Claimant until the earlier of (1) the date on which the Claimant responds to the Claims Administrator’s request for additional information or (2) the deadline set by the Claims Administrator for the Claimant to respond.

• The Claimant will be sent a written notice of the appeal determination as discussed below.

• If still dissatisfied with the first-level appeal determination, the Claimant will have a reasonable period of time (180 calendar days under this Plan) after receipt of the first-level appeal determination to request a second-level appeal review by writing to the Plan Administrator.

• The Plan Administrator or its designee then will make a second-level appeal determination within a reasonable period of time but not later than 60 calendar days after receipt of the second-level appeal.

• The Plan Administrator may extend the 60-calendar-day period one time for up to 60 additional calendar days if the Plan Administrator determines that an extension is necessary due to matters beyond the control of the Plan. The Plan Administrator will notify the Claimant of the extension and of the date by which the Plan expects to make a decision prior to the expiration of the initial 60-day period using a written Notice of Extension.

4. A written notice of the appeal determination will be provided to the Claimant (at each level of the appeal review procedure). If the claim is denied on appeal, the notice of appeal determination will include:
   • The specific reason(s) for the adverse appeal review decision;
   • Reference to the specific Plan provision(s) on which the denial is based;
   • A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of documents, records and other information relevant to the claim (whether a document, record or other information is relevant will be determined solely by the reviewer in accordance with applicable regulations);
   • A statement that the Claimant has the right to bring a civil action under ERISA Section 502(a) following the appeal;
   • If the denial is based on an internal rule, guideline, protocol or other similar criterion, the denial will contain a statement that such rule, guideline, protocol or criterion was relied upon and that it will be provided free of charge to the Claimant upon request; and
   • The notice of first-level appeal determination will describe the procedure to proceed to a second-level appeal review with time frames if dissatisfied with the determination.

5. This concludes the claim appeal procedure under this Plan. The Plan does not offer a voluntary claim appeal procedure.
General Information — SRP Dependent Care Assistance Tax Saver Plan

Name of Plan
Salt River Project Dependent Care Assistance Tax Saver Plan

Name and Address of Plan Sponsors
The Salt River Project Agricultural Improvement and Power District (District) and the Salt River Valley Water Users’ Association (Association) together are known as “SRP.” SRP sponsors the Plan. The address of SRP is:

<table>
<thead>
<tr>
<th>Street Address</th>
<th>Mailing Address</th>
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<tbody>
<tr>
<td>SRP</td>
<td>SRP</td>
</tr>
<tr>
<td>Benefits Services PAB242</td>
<td>Benefits Services PAB242</td>
</tr>
<tr>
<td>1521 N. Project Drive</td>
<td>P.O. Box 52025</td>
</tr>
<tr>
<td>Tempe, AZ 85281</td>
<td>Phoenix, AZ 85072-2025</td>
</tr>
</tbody>
</table>

The following employers are also Plan sponsors:

<table>
<thead>
<tr>
<th>Street Address</th>
<th>Mailing Address</th>
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</thead>
<tbody>
<tr>
<td>New West Energy Corporation</td>
<td>New West Energy Corporation</td>
</tr>
<tr>
<td>PAB200</td>
<td>PAB200</td>
</tr>
<tr>
<td>1521 N. Project Drive</td>
<td>P.O. Box 61868</td>
</tr>
<tr>
<td>Tempe, AZ 85281</td>
<td>Phoenix, AZ 85082-1868</td>
</tr>
<tr>
<td>Papago Park Center, Inc.</td>
<td>Papago Park Center, Inc.</td>
</tr>
<tr>
<td>PAB343</td>
<td>PAB343</td>
</tr>
<tr>
<td>1521 N. Project Drive</td>
<td>P.O. Box 52025</td>
</tr>
<tr>
<td>Tempe, AZ 85281</td>
<td>Phoenix, AZ 85072-2025</td>
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Type of Plan
The Plan is a fringe benefit plan permitting participants to elect to receive cash reimbursements of their dependent care expenses that are excludable from income under Section 129 of the Internal Revenue Code.

Funding
All of the Plan’s dependent care assistance benefits are funded out of the employer’s general assets.

Type of Administration
Claims are administered by an independent Dependent Care Assistance Tax Saver Account Claims Administrator, whose name and address are listed under “Tax Saver Accounts” on the Quick Reference Chart in the front of this section of the Handbook.

Discretionary Authority of the Plan Administrator
Under the terms of the Plan, the Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to administer the Plan, to construe and apply all Plan provisions, and
to resolve any ambiguities in the application or terms of the Plan. The Plan Administrator may delegate to any other individual or organization any of its powers and duties with respect to the operation of the Plan. The Plan Administrator’s powers and duties, unless properly delegated, include, but are not limited to:

a. Determining all questions relating to the administration of the Plan, including the power to resolve all questions of fact relating to the eligibility of any individual to participate in, or receive benefits under or provided in connection with, the Plan.

b. Deciding disputes that may arise with regard to the rights of employees, participants, and their legal representatives or beneficiaries under the terms of the Plan. The decisions by the Plan Administrator will be final.

c. Obtaining any information from an employer with respect to its employees as is necessary to determine the rights and benefits of the employees under the Plan. The Plan Administrator may rely conclusively upon the information furnished by the employer.

d. Compiling and maintaining all records necessary for the Plan.

e. Furnishing the employer, upon request, such reports with respect to the administration of the Plan as are reasonable and appropriate.

f. Engaging the legal, administrative, actuarial, investment, accounting, consulting and other professional services the Plan Administrator deems proper.

g. Adopting rules and regulations for the administration of the Plan.

h. Doing and performing any other actions as may be provided for in the Plan.

Any action on matters within the discretion of the Plan Administrator shall be conclusive, final, and binding upon all participants in the Plan and upon all individuals claiming any rights under the Plan, including beneficiaries, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Name, Business Telephone Number and Business Address of Plan Administrator

Salt River Project Agricultural Improvement and Power District: (602) 236-3600

<table>
<thead>
<tr>
<th>Street Address</th>
<th>Mailing Address</th>
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<tr>
<td>SRP Benefits Manager</td>
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<tr>
<td>Benefits Services PAB242</td>
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</tbody>
</table>

Name and Address of Person Designated as Agent for Service of Legal Process

The person designated as agent for the service of legal process is the SRP Corporate Secretary, whose address is:

SRP
PAB215
Attn: Corporate Secretary
1521 N. Project Drive
Tempe, AZ 85281
Hourly Employee Information

For hourly employees of SRP, the Plan is maintained pursuant to SRP’s three collective bargaining agreements with Local Union #266 of the International Brotherhood of Electrical Workers. Copies of the agreements have been distributed to hourly employees and are available for examination at SRP Benefits Services, PAB242, 1521 N. Project Drive, Tempe, AZ 85281. A copy of the agreements may be obtained by hourly employees and their beneficiaries upon written request to the Plan Administrator.

Eligibility for Participation and Benefits

Eligibility for participation and benefits is discussed in SRP Dependent Care Assistance Tax Saver Plan in this section of the Handbook.

Loss of Benefits

Furnishing false information or omitting information, such as not telling SRP of a divorce or claiming an individual who you are not married to as your spouse, may be cause for cancellation of benefit coverage under the Plan. Such actions also may result in disciplinary action up to and including discharge.

Employees and their dependents who are covered by the Plan have a duty to cooperate with the Plan Administrator with regard to any claim for benefits under the Plan. This includes, but is not limited to, providing the Plan Administrator with copies of all records, receipts and bills that are relevant to the Plan Administrator’s assessment of the claim for benefits. In the event the covered employee or dependent refuses to cooperate with the Plan Administrator, the Plan Administrator, at its discretion, may deny the claim and/or terminate the claimant’s coverage under the Plan. In the event that the Plan Administrator determines that an overpayment has been made to the claimant, the Plan Administrator may offset the amount of the overpayment against subsequent claims of the claimant.

The foregoing shall not limit in any way the rights or remedies the Plan Administrator may have at law or in equity.

Specific information describing the circumstances that may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of benefits is discussed elsewhere in this Handbook.

Sources of Contributions to Plan

The Plan receives no contributions. All of the Plan’s benefits are funded by the employers pursuant to salary reduction agreements between participants and the employers under the Salt River Project Flexible Benefits Plan.

Fiscal Year

The Plan’s fiscal year ends on December 31.

Claim Procedure

See Filing a Dependent Care Assistance TSA Claim in this section of the Handbook for a discussion of claim and appeal procedures.
Plan Amendment and Termination

In some instances, Union consent may be necessary before the Plan can be amended or terminated.

The Board of Directors of the District and the Board of Governors of the Association, have the right, at any time and without advance notice to participants, to amend the Plan by written amendment to any extent and in any manner that they or their designee deem advisable. In addition, the General Manager of the District and the General Manager of the Association have the right to adopt an amendment to the Plan that:

(a) Does not significantly affect the monetary obligations of the employer or the employer’s employees;
(b) Does not materially alter the nature, investment strategy or administration of the Plan; or
(c) Is required by future or existing laws.

Plan amendments adopted by the District (by either the Board or the General Manager) shall automatically apply to New West Energy Corporation and Papago Park Center, Inc., without further action by New West or Papago Park.

The Plan has been established with the bona fide intention and expectation that it will be continued indefinitely, but the employers do not have an obligation to maintain the Plan for any given length of time.

The Board of Directors of the District, the Board of Governors of the Association, the Executive Committee of the Board of Directors of New West and the Board of Directors of Papago Park, or their respective designees, have the right, at any time and without advance notice to participants, to adopt a resolution causing the termination of the Plan. Any employer shall be permitted to discontinue or revoke its participation in the Plan upon the presentation of satisfactory evidence thereof to the Plan Administrator. Upon termination, discontinuance or revocation of participation in the Plan, all elections and reductions in compensation related to the Plan shall terminate. Participants will be able to receive reimbursements under the Plan for eligible expenses incurred through the date the last contribution related to the Plan was made.

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