HonorHealth

Employee Health Plan
Plan Document
and Summary Plan Description

Effective
January 1, 2022

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SECTION I—INTRODUCTION

This document is a description of The HonorHealth Employee Health Plan (*Plan*). No oral interpretations can change this *Plan*. The *Plan* described is designed to protect *plan participants* against certain catastrophic health expenses. This *Plan* has a *high deductible health plan* which is designed to be used with a *health savings account (HSA)*. Terms which have special meanings when used in this Plan will be italicized. For a list of these terms and their meanings, please see the **Defined Terms** section of the plan document. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise. Coverage under the *Plan* will take effect for an eligible *employee* and designated *dependents* when the *employee* and such *dependents* satisfy the *waiting period* and all of the eligibility requirements of the *Plan*.

The *employer* fully intends to maintain this *Plan* indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the *Plan* at any time and for any reason.

Changes in the *Plan* may occur in any or all parts of the *Plan* including benefit coverage, *deductibles*, maximums, *co-payments*, exclusions, limitations, defined terms, eligibility, and the like.

This *Plan* is not a 'grandfathered health plan' under Health Care Reform. Questions regarding the *Plan's* status can be directed to the *Plan Administrator*. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272, or visit **www.dol.gov/ebsa/healthreform**.

Failure to follow the eligibility or enrollment requirements of this *Plan* may result in delay of coverage or no coverage at all. Reimbursement from the *Plan* can be reduced or denied because of certain provisions in the *Plan*, such as coordination of benefits, subrogation, exclusions, timeliness of Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) elections, utilization review or other cost management requirements, lack of *medical necessity*, lack of timely filing of *claims*, or lack of coverage. These provisions are explained in summary fashion in this document. Additional information is available from the *Plan Administrator* at no extra cost.

Read your benefit materials carefully. Before you receive any services you need to understand what is covered and excluded under your benefit *Plan*, your cost sharing obligations, and the steps you can take to minimize your out-of-pocket costs. For complete terms of the *Plan* and information about benefits which are not outlined in this summary plan description, refer to your *Plan's* wrap document, which can be obtained from your Human Resources representative.

Review your *Explanation of Benefits (EOB)* forms, other *claim* related information, and available *claims* history. Notify the *Third Party Administrator* of any discrepancies or inconsistencies between amounts shown and amounts you actually paid.

The *Plan* will pay benefits only for the expenses *incurred* while this coverage is in force. No benefits are payable for expenses *incurred* before coverage began or after coverage terminates. An expense for a service or supply is *incurred* on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this *Plan* until the *appeal* rights provided have been exercised and the *Plan* benefits requested in such *appeals* have been denied in whole or in part.

If the *Plan* is terminated or amended, or if benefits are eliminated, the rights of *plan participants* are limited to *covered charges incurred* before termination, amendment, or elimination.

A *plan participant* should contact the *Plan Administrator* to obtain additional information, free of charge, about *Plan* coverage of a specific benefit, particular drug, treatment, test, or any other aspect of *Plan* benefits or requirements.

If you do not understand English and have questions about a claim denial, contact the appropriate *Claims Administrator* (see the Quick Reference Chart for contact information) to find out if assistance is available.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-602-231-8855

TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-602-231-8855

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-602-231-8855

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-602-231-8855

A. Quick Reference Chart - For Help or Information

When you need information, please check this document first. If you need further help, call the appropriate phone number listed in the following Quick Reference Chart:

QUICK REFERENCE INFORMATION	
Information Needed	**Whom to Contact**
Plan Administrator	HonorHealth Attn: Employee Benefits Department 8125 N. Hayden Road Scottsdale, AZ 85258 1-623-580-5800 Benefits Communication Specialists Phone: 1-480-583-4588 Fax: 1-480-882-5802 www.**HonorHealthBenefits**.com **mailto:employee.benefits@honorhealth.com**
Medical Claims Administrator/Third Party Administrator *(Medical)* • Claim Forms (Medical) • Medical Claims and Post-Service Appeals • Eligibility for Coverage • Plan Benefit Information	AmeriBen P.O. Box 7186 Boise, ID 83707 1-602-231-8855 **www.MyAmeriBen.com**
Medical Management Administrator • Pre-Certification, Concurrent Review, and Case Management • Medical Claim Pre-Service Appeals	ICP Health Phone: 1-800-250-6647 Fax: 1-833-665-1252 **www.ICPPatient.com/PriorAuth** **Behavioral Health Services:** Magellan Health P.O. Box 1659 Maryland Heights, MO 63043 1-800-424-4138
PPO Provider Network *Names of Physicians & Hospitals* • Network Provider Directory – see website	HonorHealth Employee Physician Network 1-480-696-4020 **www.innovationcarepartners.com/physiciansearch** BlueCross BlueShield of Arizona (BCBSAZ) 1-800-650-5656 **www.azblue.com/chsnetworkmayo** PHCS 1-800-678-7427 **www.multiplan.com/search**
	HonorHealth Facilities: **Call AmeriBen at 1-602-231-8855 for additional network facilities.** **Osborn Medical Center** 7400 E. Osborn Road Scottsdale, AZ 85251 1-480-882-4000 **Shea Medical Center** 9003 E. Shea Blvd. Scottsdale, AZ 85260 1-480-323-3000 **Thompson Peak Medical Center** 7400 E. Thompson Peak Parkway Scottsdale, AZ 85255 1-480-324-7000 **Virginia G. Piper Cancer Center** 10460 N. 92nd St. **Scottsdale Medical Imaging Limited (SMIL) dba Southwest Diagnostic Imaging** For locations visit **www.eSMIL.com** **Deer Valley Medical Center** 19829 N. 27th Ave. Phoenix, AZ 85027 1-623-879-6100 **John C. Lincoln Medical Center** 250 E. Dunlap Ave. Phoenix, AZ 85020 1-602-870-6060 **Sonoran Crossing Medical Center** 33400 N. 32nd Ave. Phoenix, AZ 85085 1-623-683-5000 **Union Hills Pain Partners LLC dba HonorHealth Pain Management Center** 4727 E. Union Hills, Suite 300

	Scottsdale, Arizona 85258 1-480-323-1000 **Greenbaum Surgical Specialty Hospital (Osborn Campus)** 3535 N. Scottsdale Rd. Scottsdale, AZ 85251 1-480-882-4588 **Piper Surgery Center (Shea Campus)** 9007 E. Shea Blvd., Scottsdale, AZ 85258 1-480-323-3950 **Biltmore Surgical Center** **Dba Deer Valley Surgical & Endoscopy Center** 19646 N. 27th Ave. Suite 204 Phoenix, AZ 85027 1-602-633-3097 Fax: 1-602-633-3098 **North Valley Surgery Center** 8901 E. Raintree Dr. Suite 100 Scottsdale, AZ 85260 1-480-767-2100 Fax: 1-480-767-2101	Phoenix, AZ 85050 1-480-207-3737 Fax: 1-623-266-0053 **Global Rehab Hospital—Scottsdale, LLC** **dba HonorHealth Rehabilitation Hospital** 8850 E. Pima Center Parkway Scottsdale, AZ 85258 1-480-800-3900 **Spine Group of Arizona** 3621 N. Wells Fargo Ave. Scottsdale, AZ 85251 1-480-882-5566 **http://www.spinegrouparizona.com** **OrthoArizona** 8405 N Pima Center Pkwy, Suite 102 Scottsdale, AZ 85258 Phone: 1-480-454-4211 Fax: 1-480-454-4212
Behavioral Health Provider Network *Names of Physicians & Hospitals* • Behavioral health Claims Administrator • Network Provider Directory – see website	Magellan Health P.O. Box 1659 Maryland Heights, MO 63043 1-800-424-4138 **www.MagellanAscend.com**	
Prescription Drug Program • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information & Formulary • Preauthorization of Certain Drugs • Reimbursement for Non-Network Retail Pharmacy Use • Specialty Pharmacy Program	**Retail** OptumRx P.O. Box 29044 Hot Springs, AR 71903 1-844-368-9854 **www.optumrx.com**	**Mail Order** OptumRx P.O. Box 2975 Mission, KS 66201 1-844-368-9854 **www.optumrx.com**
FSA Vendor	WEX 4321 20th Ave. S. Fargo, ND 58103 1-866-451-3399 **www.wexinc.com**	
Employee Assistance Program (EAP) • EAP Counseling and Referral Services	ComPsych 1-866-676-3524 **www.guidanceresources.com** (ID: HonorHealth)	
COBRA Administrator • Continuation Coverage	WEX P.O. Box 869 Fargo, ND 58107-0869 Phone: 1-866-451-3399 Fax: 1-888-408-7224 cobraadmin@wexhealth.com **www.wexinc.com**	

B. Plan is Not an Employment Contract

The *Plan* is not to be construed as a contract for or of employment.

C. Plan Administrator

The *employer* is the *Plan Administrator*. The name, address, and telephone number of the *Plan Administrator* are:

HonorHealth
Attn: Employee Benefits Department
8125 N. Hayden Road
Scottsdale, AZ 85258
Phone: 1-623-580-5800
Fax: 1-480-882-5802

The *Plan* is administered by the *Plan Administrator* within the purview of Employee Retirement Income Security Act of 1974 (ERISA), and in accordance with these provisions. An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* shall appoint a new *Plan Administrator* as soon as reasonably possible.

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

Service of legal process may be made upon the *Plan Administrator*.

D. Duties of the Plan Administrator

The duties of the *Plan Administrator* are to:

1. administer the *Plan* in accordance with its terms
2. interpret the *Plan*, including the right to remedy possible ambiguities, inconsistencies, or omissions
3. decide disputes that may arise relative to a *plan participant's* rights
4. prescribe procedures for filing a *claim* for benefits and to review *claim* denials
5. keep and maintain the plan documents and all other records pertaining to the *Plan*
6. appoint a *Third Party Administrator* to pay *claims*
7. perform all necessary reporting as required by ERISA
8. establish and communicate procedures to determine whether a *Medical Child Support Order* is qualified under ERISA Sec. 609
9. delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate

E. Amending and Terminating the Plan

The *Plan Sponsor* expects to maintain this *Plan* indefinitely; however, as the settlor of the *Plan*, the *Plan Sponsor*, through its directors and officers, may, in its sole discretion, at any time, amend, suspend, or terminate the *Plan* in whole or in part. This includes amending the benefits under the *Plan* or the Trust Agreement (if any).

Any such amendment, suspension, or termination shall be enacted, if the *Plan Sponsor* is a corporation, by resolution of the *Plan Sponsor's* directors and officers, which shall be acted upon as provided in the *Plan Sponsor's* Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. *Notice* shall be provided as required by ERISA. In the event that either:

1. the *Plan Sponsor* is a different type of entity, then such amendment, suspension, or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents
2. the *Plan Sponsor* is a sole proprietorship, then such action shall be taken by the sole proprietor, in his/her own discretion

If the *Plan* is terminated, the rights of the *plan participant* are limited to expenses *incurred* before termination. All amendments to this *Plan* shall become effective as of a date established by the *Plan Sponsor*.

F. Plan Administrator Compensation

The *Plan Administrator* serves **without** compensation; however, all expenses for *Plan* administration, including compensation for hired services, will be paid by the *Plan*.

G. Fiduciary Duties

A *fiduciary* must carry out his/her duties and responsibilities for the purpose of providing benefits to the *employees* and their *dependent(s)* and defraying reasonable expenses of administering the *Plan*. These are duties which must be carried out:

1. with care, skill, prudence, and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation
2. by diversifying the investments of the *Plan* so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so
3. in accordance with the plan documents to the extent that they agree with ERISA

H. The Named Fiduciary

A named *fiduciary* is the one named in the *Plan*. A named *fiduciary* can appoint others to carry out *fiduciary* responsibilities (other than as a trustee) under the *Plan*. These other persons become fiduciaries themselves and are responsible for their acts under the *Plan*. To the extent that the named *fiduciary* allocates its responsibility to other persons, the named *fiduciary* shall not be liable for any act or omission of such person unless one (1) of the following occurs:

1. The named *fiduciary* has violated its stated duties under ERISA in appointing the *fiduciary*, establishing the procedures to appoint the *fiduciary*, or continuing either the appointment or the procedures.
2. The named *fiduciary* breached its *fiduciary* responsibility under Section 405(a) of ERISA.

HonorHealth
8125 N. Hayden Road
Scottsdale, AZ 85258
1-623-580-5800

A *Third Party Administrator* is **not** a *fiduciary* under the *Plan*.

I. Type of Administration

The *Plan* is a self-funded group health plan, and the *claims* administration is provided through a *Third Party Administrator*. The *Plan* is not insured. An insurance company under contract to HonorHealth provides stop-loss insurance that will reimburse HonorHealth for certain losses in excess of amounts described in the stop-loss insurance policy. Under this policy, the insurer does not insure or guarantee, and has no obligation to pay, any *Plan* benefits or to make any other payments to any *plan participant*.

J. Employer Information

The *employer's* legal name, address, telephone number, and federal Employer Identification Number are:

HonorHealth
Attn: Employee Benefits Department
8125 N. Hayden Road
Scottsdale, AZ 85258
Phone: 1-623-580-5800
Fax: 1-480-882-5802
EIN 86-0181654

K. Plan Name

The name of the *Plan* is the HonorHealth Employee Health Plan.

L. Plan Number

501

M. Type of Plan

The *Plan* is commonly known as an employee welfare benefit plan. The *Plan* has been adopted to provide *plan participants* certain benefits as described in this document. The HonorHealth Employee Health Plan is to be administered by the *Plan Administrator* in accordance with the provisions of ERISA Section 4(a).

N. Plan Year

The *plan year* is the twelve (12) month period beginning January 1 and ending December 31.

O. Plan Effective Date

January 1, 2022

P. Plan Sponsor

The *employer* is the *Plan Sponsor*.

Q. Plan's HIPAA Privacy Officer and HIPAA Security Officer

HonorHealth
Attn: Employee Benefits
HIPAA Privacy/Security
8125 N. Hayden Road
Scottsdale, AZ 85258
Phone: 1-623-580-5800

R. Third Party Administrator

The *Plan Administrator* has contracted with a *Third Party Administrator (TPA)* to assist the *Plan Administrator* with *claims* adjudication. The *TPA's* name, address, and telephone number are:

AmeriBen
P.O. Box 7186
Boise, ID 83707
1-602-231-8855

A *Third Party Administrator* is not a *fiduciary* under the *Plan*.

S. Employer's Right to Terminate

The *employer* reserves the right to amend or terminate this *Plan* at any time. Although the *employer* currently intends to continue this *Plan*, the *employer* is under absolutely no obligation to maintain the *Plan* for any given length of time. If the *Plan* is amended or terminated, an authorized officer of the *employer* will sign the documents with respect to such amendment or termination.

T. Agent for Service of Legal Process

The name of the person designated as agent for service of legal process and the address where a processor may serve legal process upon the *Plan* are:

HonorHealth
8125 N. Hayden Road
Scottsdale, AZ 85258
Phone: 1-623-580-5800
Fax: 1-480-882-5802

SECTION II—ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

A. Eligibility

Eligible Classes of Employees

All *active employees* of the *employer*, including contract employees on the payroll, who are in a budgeted position to work thirty-two (32) hours or more each pay period (excluding per diem employees), and are employed in a benefits-eligible position.

Eligibility Requirements for Employee Coverage

A person is eligible for *employee* coverage from the first day that he or she:

1. is an *active employee* of the *employer,* whether full-time or part-time

   An *employee* is considered to be full-time if he or she normally works at least sixty (60) hours per pay period and is on the regular payroll of the *employer* for that work.

   An *employee* is considered to be part-time if he or she normally works at least thirty-two (32) hours per pay period and is on the regular payroll of the *employer* for that work.

2. is in a class eligible for coverage
3. completes the employment *waiting period* to the first day of the month following your first day of work as an *active employee* in a benefits-eligible position

   A *waiting period* is the time between the first day of *active employment* and the first day of coverage under the *Plan*.

Effective Date of Employee Coverage

An *employee* will be covered under this *Plan* as of the first day of the calendar month following the date that the *employee* satisfies all of the following:

1. the eligibility requirement
2. the *active employee* requirement
3. the enrollment requirements of the *Plan*

Active Employee Requirement

An *employee* must be an *active employee* (as defined by this *Plan*) for this coverage to take effect.

Eligible Classes of Dependents

A *dependent* is any of the following persons:

1. a covered *employee's* spouse

   The term 'spouse' shall mean the person recognized as the covered *employee's* legally married husband or wife and shall include common law marriages. The *Plan Administrator* may require documentation proving a legal marital relationship.

   The term 'spouse' shall also mean the person who is registered with the *employer* as the domestic partner of the *employee*; this includes opposite sex and same sex couples. An individual is a domestic partner of an *employee* if that individual and the *employee* meet each of the following requirements:

   a. The *employee* and individual are eighteen (18) years of age or older and are mentally competent to enter into a legally binding contract.
   b. The *employee* and the individual are not married to anyone.
   c. The *employee* and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.

d. The *employee* and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other, and have a long-term committed personal relationship in which each partner is the other's sole domestic partner. Each of the foregoing characteristics of the domestic partner relationship must have been in existence for a period of at least twelve (12) consecutive months and be continuing during the period that the applicable benefit is provided. The *employee* and the individual must have the intention that their relationship will be indefinite.

e. The *employee* and the individual are not in the relationship solely for the purpose of obtaining benefits.

f. The domestic partner is not a staff member who is eligible for his or her own benefits under this *Plan*.

g. The *employee* and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence, or similar type of ownership.

To become enrolled, the *employee* and domestic partner complete and submit the *Plan's* required Domestic Partner Enrollment Form. There is no coverage under this *Plan* for *dependent* children of a domestic partner unless those children are also eligible *dependent* children of the *employee*. To obtain more detailed information or to apply for this benefit, the employee must contact the *Plan Administrator*, HonorHealth,8125 N. Hayden Road, Scottsdale, AZ 85258, 1-480-583-4588.

In the event the domestic partnership is terminated, either partner is required to inform HonorHealth of the termination of the partnership.

2. a covered *employee's* child(ren)

For the purposes of the *Plan*, an *employee's* child includes his/her:

a. natural child or stepchild

b. adopted child or a child placed with the *employee* for adoption

An *employee's* child will be an eligible *dependent* until reaching the limiting age of twenty-six (26), without regard to student status, marital status, financial dependency, or residency status with the *employee* or any other person. To determine when coverage will end for a child who reaches the applicable limiting age, please refer to the When Dependent Coverage Terminates subsection.

The phrase 'placed for adoption' refers to a child whom a person intends to adopt, whether or not the adoption has become final, and who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term 'placed' means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption, and the legal process must have commenced.

3. a covered *employee's* qualified *dependents*

The term 'qualified *dependents'* shall include children for whom the *employee* is a *legal guardian*. To be eligible for *dependent* coverage under the *Plan*, a qualified *dependent* must be under the limiting age of twenty-six (26) years. To determine when coverage will end for a qualified *dependent* who reaches the applicable limiting age, please refer to the When Dependent Coverage Terminates subsection.

Any child of a *plan participant* who is an *alternate recipient* under a *Qualified Medical Child Support Order (QMCSO),* including a National Medical Support Notice, shall be considered as having a right to *dependent* coverage under this *Plan*. Eligibility provisions and contributions required for coverage under a *QMCSO* are the same as are required of all similarly situated *employees*.

A *participant* of this *Plan* may obtain, without charge, a copy of the procedures governing *QMCSO* determinations from the *Plan Administrator*.

The *Plan Administrator* may require documentation proving eligibility for *dependent* coverage, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

4. a covered *dependent* child or covered qualified *dependent* who reaches the limiting age and is totally disabled, incapable of self-sustaining employment by reason of mental or physical disability, primarily dependent upon the covered *employee* for support and maintenance, and is unmarried

The *Plan Administrator* may require, at reasonable intervals, continuing proof of the *total disability* and dependency. The *Plan Administrator* reserves the right to have such *dependent* examined by a *physician* of the *Plan Administrator's* choice, at the *Plan's* expense, to determine the existence of such incapacity.

A *dependent* child who is not covered under the *Plan* or becomes disabled after reaching the *Plan's dependent* age limit is not eligible to enroll as a *dependent* under this *Plan*.

Effective Date of Dependent Coverage

A *dependent's* coverage will take effect on the day that the eligibility requirements are met, the *employee* is covered under the *Plan*, and all enrollment requirements are met.

Ineligible Plan Participants

Unless otherwise provided in this plan document, the following are not considered eligible *participants* under this *Plan*:

1. any staff member regularly scheduled to work less than thirty-two (32) hours per pay period
2. all per-diem employees of HonorHealth
3. temporary employees
4. agency employees
5. contract employees not on the payroll
6. board members
7. staff physicians
8. other individuals living in the covered *employee's* home, but who are not eligible as defined
9. the legally separated or divorced former spouse of the *employee*
10. any person who is on active duty in any military service of any country
11. a person who is covered as an *employee* under the *Plan*
12. the spouse of a *dependent* child
13. foster children
14. children of a domestic partner
15. any other person not defined above in the subsection entitled Eligible Classes of Dependents

Restrictions on Elections

If a *plan participant* changes status from *employee* to *dependent* or *dependent* to *employee*, and the person is covered continuously under this *Plan* before, during, and after the change in status, credit will be given for *deductibles,* and all amounts will be applied to maximums.

If two (2) *employees* (spouses) are covered under the *Plan* and the *employee* who is covering the *dependent* children terminates coverage, the *dependent* coverage may be continued by the other covered *employee* with no *waiting period* as long as coverage has been continuous.

If both spouses or domestic partners are *employees*, their children will be covered as *dependents* of one (1) *employee*, but not of both.

Accumulators will transfer if a dependent changes from coverage under one parent *employee* to coverage under another parent *employee*.

Eligibility Requirements for Dependent Coverage

A *dependent* of an *employee* will become eligible for *dependent* coverage on the first day that the *employee* is eligible for *employee* coverage and the family member satisfies the requirements for *dependent* coverage.

At any time, the *Plan* may require proof that a spouse, domestic partner, qualified *dependent,* or a child qualifies or continues to qualify as a *dependent* as defined by this *Plan*.

B. Enrollment

Enrollment Requirements

An *employee* must enroll for coverage for themselves and their *dependents* by completing the enrollment process along with the appropriate payroll deduction authorization. The covered *employee* is also required to enroll for *dependent* coverage. The employee and eligible dependents must be enrolled for the same health plan option.

Enrollment Requirements for Newborn Children

A newborn child, child placed for adoption, or newly adopted child of a covered *employee* is not automatically enrolled in this *Plan*, even if the covered *employee* has previously elected coverage for other *dependents*. An *employee* must complete an enrollment application as shown in the Qualifying Events Chart subsection. Your *claim* for maternity expenses is not considered as notification to your *employer* for coverage.

Charges for covered nursery care will be applied toward the newborn child and routine *physician* care will be applied toward the *Plan* of the mother. If the newborn child is not enrolled in this *Plan* on a timely basis, there will be no payment from the *Plan,* and the covered parent will be responsible for all costs. You will also have to wait until the next *open enrollment period* to add the child as a *dependent*.

C. Timely Enrollment

The enrollment will be timely if the completed form is received by the *Plan Administrator* no later than thirty (30) days after the person initially becomes eligible for coverage, or as shown in the Qualifying Events Chart subsection for each type of special enrollment period.

Late Enrollment

An enrollment is late if it is not made on a timely basis or during a special enrollment period. *Late enrollees* and their *dependents* who are not eligible to join the *Plan* during the special enrollment period may join only during the *open enrollment period*.

The time between the date a *late enrollee* first becomes eligible for enrollment under the *Plan* and the first day of coverage is not treated as a *waiting period*. Coverage begins January 1.

D. Special Enrollment Rights

Federal law provides special enrollment provisions under some circumstances. If an *employee* is declining enrollment for themselves or their *dependents* (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this *Plan* if there is a loss of eligibility for that other coverage (or if the *employer* stops contributing towards the other coverage). However, a request for enrollment must be made as shown in the Qualifying Events Chart subsection after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, registration of a domestic partnership, adoption, or placement for adoption, there may be a right to enroll in this *Plan*. However, a request for enrollment must be made as shown in the Qualifying Events Chart subsection.

Because domestic partner coverage is imputed income, an eligible domestic partner can be added or cancelled at any time of the year. However, if you are not already enrolled in the *Plan*, you cannot add your domestic partner to the *Plan* until such time as you are eligible to enroll both yourself and your domestic partner (for example, during an *open enrollment period*).

The special enrollment rules are described in more detail below. To request special enrollment or obtain more detailed information of these portability provisions, contact the *Plan Administrator*, HonorHealth, 8125 N. Hayden Road, Scottsdale, AZ 85258, 1-480-583-4588.

E. Special Enrollment Periods

The *enrollment date* for anyone who enrolls under a special enrollment period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the *Plan* and the first day of coverage is not treated as a *waiting period*.

Individuals Losing Other Coverage, Creating a Special Enrollment Right

An *employee* or *dependent* who is eligible, but not enrolled in this *Plan*, may enroll if loss of eligibility for coverage meets any of the following conditions and substitute coverage is not offered:

1. The *employee* or *dependent* was covered under a group health plan or had health insurance coverage at the time coverage under this *Plan* was previously offered to the individual.
2. If required by the *Plan Administrator*, the *employee* stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
3. The coverage of the *employee* or *dependent* who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.
4. The *employee* or *dependent* requests enrollment in this *Plan* no later than as shown in the Qualifying Events Chart subsection after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of *employer* contributions, described above.

For purposes of these rules, a loss of eligibility occurs if one (1) of the following occurs:

1. The employee or *dependent* has a loss of eligibility due to the *Plan* no longer offering any benefits to or significantly curtailing coverage for a class of similarly situated individuals (e.g., part-time *employees*).
2. The *employee* or *dependent* has a loss of eligibility as a result of legal separation, divorce, cessation of *dependent* status (such as attaining the maximum age to be eligible as a *dependent* child under the *Plan*), death, termination of employment, reduction in the number of hours of employment, or contributions towards the coverage were terminated.
3. The *employee* or *dependent* has a loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual).
4. The *employee* or *dependent* has a loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual.

Covered *employees* or *dependents* will not have a special enrollment right if the loss of other coverage results from either:

1. the *employee's* failure to pay premiums or required contributions
2. the *employee* or dependent making a fraudulent *claim* or an intentional misrepresentation of a material fact in connection with the *Plan*

Dependent Beneficiaries

If both of the following conditions are met, then the *dependent* (and if not otherwise enrolled, the *employee* and any other eligible *dependents*) may be enrolled under this *Plan*:

1. The employee is a *plan participant* under this *Plan* (or has met the *waiting period* applicable to becoming a *plan participant* under this *Plan* and is eligible to be enrolled under this *Plan* but for a failure to enroll during a previous enrollment period).
2. A person becomes a *dependent* of the *employee* through marriage, birth, adoption, or placement for adoption.

In the case of the birth or adoption of a child, the *spouse* or domestic partner of the covered *employee* may be enrolled as a *dependent* of the covered *employee* if the spouse is otherwise eligible for coverage.

If the *employee* is not enrolled at the time of the event, the *employee* must enroll under this special enrollment period in order for eligible *dependents* to enroll.

The *dependent* special enrollment period is a period as shown in the Qualifying Events Chart subsection To be eligible for this special enrollment, the *dependent* and/or *employee* must request enrollment during the timeframe shown in the Qualifying Events Chart subsection. **Medicaid and State Child Health Insurance Programs**

An *employee* or *dependent* who is eligible, but not enrolled in this *Plan*, may enroll if:

1. The *employee* or *dependent* is covered under a Medicaid plan under Title XIX of the Social Security Act or a state Children's Health Insurance Program (CHIP) under Title XXI of such Act, and coverage of the *employee* or *dependent* is terminated due to loss of eligibility for such coverage, and the *employee* or *dependent* requests enrollment in this *Plan* as shown in the Qualifying Events Chart subsection.
2. The *employee* or *dependent* becomes eligible for assistance with payment of *employee* contributions to this *Plan* through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the *employee* or *dependent* requests enrollment in this *Plan* as shown in the Qualifying Events Chart subsection.

If a *dependent* becomes eligible to enroll under this provision and the *employee* is not then enrolled, the *employee* must enroll in order for the *dependent* to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the *employer* or by regulation.

Coverage may be cancelled for a spouse or *dependent* child who becomes entitled to coverage under Medicaid or Medicare.

F. Qualifying Events Chart

This chart is only a summary of some of the permitted health plan changes and is not all-inclusive.

Qualifying Event	Effective Date	Forms and Notification must be Received Within:	You May Make the Following Changes(s)
Marriage or registration of domestic partnership	Date after the enrollment request is received	thirty (30) days of marriage	Enroll yourself, if applicable Enroll your new spouse and other eligible *dependents*
Divorce or annulment	First of the month following the date of the event	thirty (30) of the date of final divorce decree or annulment	Coverage will terminate for your spouse Enroll yourself and *dependent* child(ren) if you, or they, were previously enrolled in your spouse's plan
Birth of your child	Date of event	thirty (30) days of birth	Enroll yourself Enroll the newborn child and all other eligible dependents
Adoption, placement for adoption, or legal guardianship of a child	Date of event	thirty (30) days of adoption	Enroll yourself Enroll the newly adopted child and all other eligible dependents
Your *dependent* child reaches maximum age for coverage	First of the month following the date of the event	thirty (30) days of loss of eligibility	Coverage will terminate for the child who lost eligibility from your health coverage
Death of your spouse or *dependent* child	Date of event	thirty (30) days of spouse's or *dependent's* death	Coverage will terminate for the *dependent* from your health coverage
A *change in employment status* (including a change from one *employment* classification to another, you or your spouse taking a qualified unpaid *leave of absence,* a strike or lockout, or a change in worksite)	First of the month following the date of the event	thirty (30) days of *change in employment status* classification.	Enroll yourself, if your employment change results in you being eligible for a new set of benefits Enroll your spouse and other eligible *dependents* Drop health coverage Drop your spouse and other eligible *dependents* from your health coverage

Qualifying Event	Effective Date	Forms and Notification must be Received Within:	You May Make the Following Changes(s)
Significant change in or cost of your or your spouse's health coverage due to spouse's employment, including open enrollment	First of the month following the date of the event	thirty (30) days of effective date of change in coverage	Enroll yourself and other eligible *dependents*
A change in the place of residence of the employee, spouse, or dependent	First of the month following the date of the event	thirty (30) days of effective date of change in coverage	Enroll or drop coverage for yourself, your spouse, or covered *dependent* children
Special requirements relating to the Family and Medical Leave Act	First of the month following the date of the event	thirty (30) days of effective date of change in coverage	Enroll or drop coverage for yourself, your spouse, or covered *dependent* children
Spouse or covered *dependent* obtains coverage in another group health plan	First of the month following the date of the event	thirty (30) days of gain of coverage	Drop coverage for yourself, your spouse, or covered *dependent* children
Loss of other coverage, including COBRA coverage	First of the month following the date of the event	thirty (30) days of the date of loss of coverage	Enroll yourself, your spouse and eligible *dependent* children
Spouse's loss of coverage, including COBRA coverage	Date of event	thirty (30) days of the date of loss of coverage	Enroll your spouse and eligible *dependent* children Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse's plan
Eligibility for government-sponsored plan, such as *Medicare* (excluding the government-sponsored Marketplace)	First of the month following the date of the event	thirty (30) days of eligibility date	Drop coverage for the person who became entitled to *Medicare*, Medicaid, or other eligible coverage
CHIP Special Enrollment – loss of eligibility for coverage under a state Medicaid or CHIP program, or eligibility for state premium assistance under Medicaid or CHIP	First of the month following the date of the event	sixty (60) days of loss of eligibility or eligibility date	Enroll yourself, if applicable Add the person who lost entitlement to CHIP Drop coverage for the person entitled to CHIP coverage
Qualified Medical Support Order affecting a *dependent* child's coverage	Date enrollment is received by the *Plan*	thirty (30) days of order	Enroll yourself, if applicable Enroll the eligible child named on *QMCSO*

G. Termination of Coverage

Rescission of Coverage

The *employer* or *Plan* has the right to rescind any coverage of the *employee* and/or *dependents* for cause, making a fraudulent *claim,* or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the *Plan*. The *employer* or *Plan* may either void coverage for the *employee* and/or covered *dependents* for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the *Plan's* discretion, or may immediately terminate coverage. In accordance with the requirements of 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. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the *Plan* will provide at least thirty (30) days' advance written notice of such action.

When Employee Coverage Terminates

Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered *employee* may be eligible for COBRA continuation coverage):

1. the date the *Plan* is terminated
2. the last day of the calendar month in which the covered *employee* ceases to be in one (1) of the eligible classes

   This includes termination of *active employment* of the covered *employee*. It also includes an *employee* on disability, *leave of absence*, or other *leave of absence*, unless the *Plan* specifically provides for continuation during these periods.
3. the date of the *employee's* death
4. the last day of the month for which the required contribution has been paid if the charge for the next period is not paid when due

For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled **Continuation Coverage Rights Under COBRA**.

When Dependent Coverage Terminates

A *dependent's* coverage will terminate on the earliest of these dates (except in certain circumstances, a covered *dependent* may be eligible for COBRA continuation coverage):

1. the date the *Plan* or *dependent* coverage under the *Plan* is terminated
2. the date that the *employee's* coverage under the *Plan* terminates
3. the last day of the calendar month in with the *employee's* coverage ends due to death
4. the date of the *dependent's* death
5. the last day of the calendar month in which a covered spouse loses coverage due to loss of dependency
6. the last day of the calendar month in which a *dependent* child ceases to be a *dependent* as defined by the *Plan* due to age as listed in the Eligible Classes of Dependents provisions
7. the expiration of the period of coverage stated in a QMCSO
8. the last day of the calendar month for which the required contribution has been paid if the charge for the next period is not paid when due

You, your spouse, your domestic partner, or any of your *dependent* children must notify the *Plan,* preferably within thirty (30) days, but no later than sixty (60) days after the date a spouse ceases to meet the *Plan's* definition of spouse (such as in a divorce), a domestic partner ceases to meet the *Plan's* definition of domestic partner; or a *dependent* child ceases to meet the *Plan's* definition of *dependent* (such as the *dependent* child reaches the *Plan's* limiting age or the *dependent* child ceases to have any physical or mental disability).

Failure to notify the *Plan* within sixty (60) days of one of these events will cause your spouse and/or *dependent* child(ren) to lose their right to obtain COBRA Continuation Coverage or will cause the coverage of a *dependent* child who has a physical or mental disability to end when it otherwise might continue. Domestic partners are not eligible for COBRA Continuation Coverage. Notwithstanding the sixty (60) day notice above, if you do not provide notice within thirty (30) days to the *Plan Administrator*, any election you made for your *dependent's* coverage on a pre-tax basis under the terms of the HonorHealth Flexible Benefits Plan may not be revoked or otherwise changed until the next annual Open Enrollment period under the terms of that Flexible Benefits Plan. Furthermore, any contributions you made due to your failure to notify the *Plan Administrator* in a timely manner are not refunded, even though coverage ends as of the date indicated above.

For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled **Continuation Coverage Rights Under COBRA.**

H. Continuation During Periods of Employer-Certified Disability, Leave of Absence, or Layoff

A person may remain eligible for a limited time if active, full-time work ceases due to disability, *leave of absence,* or layoff. This continuance will end as follows:

1. for disability leave only: the date the *employer* ends the continuance
2. for *leave of absence* or layoff only: the date the *employer* ends the continuance

While continued, coverage will be that which was in force on the last day worked as an *active employee*. However, if benefits are reduced for others in the class, they will also be reduced for the continued person.

I. Continuation During Family and Medical Leave

Regardless of the established leave policies mentioned above, this *Plan* shall at all times comply with the *Family and Medical Leave Act of 1993 (FMLA)* as promulgated in regulations issued by the Department of Labor.

During any leave taken under *FMLA*, the *employer* will maintain coverage under this *Plan* on the same conditions as coverage would have been provided if the covered *employee* had been continuously employed during the entire leave period.

If *Plan* coverage terminates during the *FMLA leave*, coverage will be reinstated for the *employee* and his/her covered *dependents* if the *employee* returns to work in accordance with the terms of the *FMLA leave*. Coverage will be reinstated only if the person(s) had coverage under this *Plan* when the *FMLA leave* started, and will be reinstated to the same extent that it was in force when that coverage terminated.

J. Rehiring a Terminated Employee

A terminated *employee* who is rehired within thirty (30) days will have their coverage reinstated on the date of rehire. A terminated *employee* who is rehired after thirty (30) days will be treated as a new hire and required to satisfy all eligibility and enrollment requirements to the extent permitted by the terms of the *Plan* and applicable law.

K. Open Enrollment

Every year during the annual *open enrollment period*, covered *employees* and their covered *dependents* will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Every year during the annual *open enrollment period*, *employees* and their *dependents* who are *late enrollees* will be able to enroll in the *Plan*.

Benefit choices made during the *open enrollment period* will become effective January 1 and remain in effect until the next January 1 unless there is a special enrollment event or change in family status during the year (birth, death, marriage, registration of a domestic partnership, divorce, adoption) or loss of coverage due to loss of a spouse's employment. To the extent previously satisfied, coverage *waiting periods* will be considered satisfied when changing from one benefit option under the *Plan* to another benefit option under the *Plan*.

Benefit choices for *late enrollees* made during the *open enrollment period* will become effective January 1.

A *plan participant* who fails to make an election during an active *open enrollment period* will no longer be covered under this *Plan*. A *plan participant* will automatically retain their present coverages during a passive *open enrollment period*. *Plan participants* will receive detailed information regarding open enrollment from their *employer*.

SECTION III—CONSOLIDATED APPROPRIATIONS ACT OF 2021

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Billing Act as well the provider transparency requirements that are described below. Enforcement dates, standards for implementation (good faith, reasonable), and guidance offered by federal entities directly impact actions or availability of the below outlined services by the *Third Party Administrator* and the *network*.

A. Surprise Billing Claims

Surprise billing claims are claims that are subject to the No Surprises Billing Act requirements:

1. emergency services provided by *non-network* providers
2. covered services provided by a *non-network* provider at a *network* facility
3. *non-network* air ambulance services

B. No Surprises Billing Act Requirements

Emergency Services

As required by the CAA, emergency services are covered under your *Plan*:

1. without the need for *pre-certification*
2. whether the provider is *network* or *non-network*

If the emergency services you receive are provided by a *non-network* provider, covered services will be processed at the *network* benefit level.

Note that if you receive emergency services from a *non-network* provider, your out-of-pocket costs will be limited to amounts that would apply if the covered services had been furnished by a *network* provider. However, *non-network cost-sharing amounts* (i.e., *co-payments*, *deductibles,* and/or *co-insurance*) will apply to your *claim* if the treating *non-network* provider determines you are stable, meaning you have been provided necessary emergency care such that your condition will not materially worsen and the *non-network* provider determines that:

1. you are able to travel to a *network* facility by non-emergency transport
2. the *non-network* provider complies with the *notice* and consent requirement
3. you are in condition to receive the information and provide informed consent

If you continue to receive services from the *non-network* provider after you are stabilized, you will be responsible for the *non-network cost-sharing amounts*, and the *non-network* provider will also be able to charge you any difference between the *maximum allowable amount* and the *non-network* provider's billed charges.

This *notice* and consent exception does not apply if the covered services furnished by a *non-network* provider result from unforeseen and urgent medical needs arising at the time of service.

Non-Network Services Provided at a Network Facility

When you receive covered services from a *non-network* provider at a *network* facility, your *claims* will be paid at the *non-network* benefit level if the *non-network* provider gives you proper *notice* of its charges, and you give written consent to such charges. This means you will be responsible for *non-network cost-sharing amounts* for those services and the *non-network* provider can also charge you any difference between the *maximum allowable amount* and the *non-network* provider's billed charges.

This requirement does not apply to ancillary services. Ancillary services are the following services:

1. emergency services
2. anesthesiology
3. pathology
4. radiology

5. neonatology
6. diagnostic services
7. assistant surgeons
8. hospitalists
9. intensivists
10. any services set out by the U.S. Department of Health & Human Services

In addition, this *notice* and consent process will not apply to you if there is no *network* provider in your area who can perform the services you require.

Non-network providers satisfy the *notice* and consent requirement by one (1) of the following:

1. by obtaining your written consent not later than seventy-two (72) hours prior to the delivery of services
2. if the *notice* and consent is given on the date of the service, if you make an appointment within seventy-two (72) hours of the services being delivered

The *network* is required to confirm the list of *network* providers in its provider directory every ninety (90) days. If you can show that you received inaccurate information from the *network* that a provider was *in-network* on a particular *claim*, then you will only be liable for *network cost sharing amounts* (i.e., *co-payments*, *deductibles*, and/or *co-insurance*) for that *claim*. Your *network* cost-shares will be calculated based upon the *maximum allowed amount*. In addition to your *network* cost-shares, the *non-network* provider can also charge you for the difference between the *maximum allowed amount* and their billed charges.

C. How Cost-Shares Are Calculated

Your cost shares for emergency services or for covered services received by a *non-network* provider at a *network* facility, will be calculated using the median plan *network* contract rate that we pay *network* providers for the geographic area where the covered service is provided. Any out-of-pocket cost shares you pay to a *non-network* provider for either emergency services or for covered services provided by a *non-network* provider at a *network* facility will be applied to your *network out-of-pocket limit*.

D. Appeals

If you receive emergency services from a *non-network* provider or covered services from a *non-network* provider at a *network* facility and believe those services are covered by the No Surprise Billing Act, you have the right to appeal that *claim*. If your appeal of a *surprise billing claim* is denied, then you have a right to appeal the adverse decision to an independent review organization as set out in the **Claims and Appeals** section of this summary plan description.

E. Transparency Requirements

The *network* provides the following information on its website (refer to the Quick Reference Chart):

1. protections with respect to *surprise billing claims* by providers
2. information on contacting state and federal agencies in case you believe a provider has violated the No Surprise Billing Act's requirements

The *network* through Member Services at the phone number on the back of you ID card, will allow you to get a list of all *network* providers.

In addition, the *network* will provide access through its website to the following information:

1. *network* negotiated rates
2. historical *non-network* rates

F. Continuity of Care

If the *network* provider leaves the *network* for any reason other than termination for cause, and you are in active treatment, you may be able to continue seeing that provider for a limited period of time and still get *network* benefits. "Active treatment" includes:

1. an ongoing course of treatment for a life-threatening condition
2. an ongoing course of treatment for a serious acute condition (e.g., chemotherapy, radiation therapy, and post-operative visits)
3. the second or third trimester of pregnancy and through the postpartum period
4. an ongoing course of treatment for a health condition for which the *physician* or health care provider attests that discontinuing care by the current *physician* or provider would worsen your condition or interfere with anticipated outcomes

An 'ongoing course of treatment' includes treatments for mental health and substance use disorders.

In these cases, you may be able to continue seeing that provider until treatment is complete, or for ninety (90) days, whichever is shorter. If you wish to continue seeing the same provider, you or your doctor should contact customer care for details. Any decision by *Third Party Administrator* regarding a request for Continuity of Care is subject to the process as listed out **in the Claims and Appeals** section.

SECTION IV—MEDICAL NETWORK INFORMATION

A. Network and Non-Network Services

Network Provider Information

The *Plan* has entered into an agreement with a medical *network* that maintains contractual agreements with certain *hospitals*, *physicians*, and other health care providers which are called *network* providers. Because these *network* providers have agreed to charge reduced fees to persons covered under the *Plan*, the *Plan* can afford to reimburse a higher percentage of their fees.

Therefore, when a *plan participant* uses a *network* provider, that *plan participant* will receive better benefits from the *Plan* than when a *non-network* provider is used. It is the *plan participant's* choice as to which provider to use.

Non-Network Provider Information

Non-network providers have no agreements with the *Plan* or the *Plan's* medical *network* and are generally free to set their own charges for the services or supplies they provide. The *Plan* will reimburse for the *allowable charges* for any *medically necessary* services or supplies, subject to the *Plan's deductibles*, *co-insurance*, *co-payments*, limitations, and exclusions. *Plan participants* must submit proof of *claim* before any such reimbursement will be made.

Before you obtain services or supplies from a *non-network* provider, you can find out whether the *Plan* will provide *network* or *non-network* benefits for those services or supplies by contacting the *Third Party Administrator*.

Refer to the **Consolidated Appropriations Act of 2021** section for additional provisions pertaining to *balance billing/surprise billing*.

Provider Non-Discrimination

To the extent that an item or service is a *covered charge* under the *Plan*, the terms of the *Plan* shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable state law. This provision does not preclude the *Plan* from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided, and does not require the *Plan* to accept all types of providers as a *network* provider.

B. Choosing a Physician – Patient Protection Notice

The *Plan* does not require you to select a *primary care physician (PCP)* to coordinate your care, and you do not have to obtain a referral to see a specialist.

You do not need prior authorization from the *Plan* or *Third Party Administrator*, or from any other person (including your *PCP*) in order to obtain access to obstetrical or gynecological care from a health care professional in the *network* who specializes in obstetrics or gynecology. The health care provider, however, may be required to comply with certain procedures, including obtaining *pre-certification* for certain services, following a pre-approved treatment plan, or procedures for making referrals.

C. Special Reimbursement Provisions

Under the following circumstances, the higher *network* payment will be made for certain *non-network* services:

1. **Medical Emergency.** In a *medical emergency*, a *plan participant* should try to access a *network* provider for treatment. However, if immediate treatment is required and this is not possible, the services of *non-network* providers will be covered until the *plan participant's* condition has stabilized to the extent that they can be safely transferred to a *network* provider's care. At that point, if the transfer does not take place, *non-network* services will be covered at *non-network* benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for notifying the *Third Party Administrator* for a review of any *claim* that meets this definition.

2. **No Choice of Provider.** If, while receiving treatment at a *network* facility, a *plan participant* receives ancillary services or supplies from a *non-network* provider in a situation in which they have no control over provider selection (such as in the selection of an emergency room *physician*, an anesthesiologist, assistant surgeon, or a provider for *diagnostic services*), such *non-network* services or supplies will be covered at BlueCross BlueShield of Arizona *network* benefit levels up to the *maximum allowable charge*. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for notifying the *Third Party Administrator* for a review of any *claim* that meets this definition. This provision does not apply when *network physicians* refer *plan participants* to *non-network* providers.
3. **Certain Provider Specialties.** *Network* BlueCross BlueShield of Arizona anesthesiologists, assistant surgeons, hospitalists, rheumatologists, perinatologists, and pediatric specialists will be covered at the HonorHealth coverage level.
4. **Out of Area.** Services provided by PHCS *network* of *physicians* and *hospitals* are payable equivalent to *network* coverage levels in the following circumstances:
    a. if traveling, only for sick office visits, urgent care services, and emergency services
    b. if living outside the *network* service area, for purposes other than for receiving care

    For the Coordinated Care Plan Option, benefits are payable equivalent to the HonorHealth Providers and Innovation Care Partners benefit level shown in the Covered Services column of the applicable Schedule of Medical Benefits. PHCS specialists require approval by ICP Health.

    For the Standard Plan Option and Health Savings Account Plan (HDHP) Option, benefits are payable equivalent to the Blue Cross Blue Shield of Arizona benefit level shown in the Covered Services column of the applicable Schedule of Medical Benefits.

    Additional information about this option, as well as a list of *network* providers, will be given to *plan participants*, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology.
5. **Services Not Available at an HonorHealth and/or BCBSAZ Provider.** Covered charges not available at an HonorHealth and/or BCBSAZ provider will be considered at the *network* rate outlined in the applicable Schedule of Medical Benefits. This provision is also known as a gap benefit. Qualification of these services will be determined by the appropriate *Medical Management Administrator*.

Refer to the **Consolidated Appropriations Act of 2021** section for additional provisions pertaining to *balance billing/surprise billing*.

D. Network Information

All of the HonorHealth health plans utilize the services of three (3) networks: HonorHealth [which includes Innovation Care Partners (ICP)], Blue Cross Blue Shield of Arizona (BCBSAZ), and PHCS Network.

ICP is a growing network of primary care and specialty physicians that includes all HonorHealth providers. When you use one of these providers, your *co-payments* and *co-insurance* costs are lower than those of Blue Cross Blue Shield of Arizona *network* providers.

Blue Cross Blue Shield of Arizona (BCBSAZ) has an extensive network of physicians and facilities throughout Arizona. PHCS Network is your *network* provider for seeking care outside of Arizona if you are living outside the state. Coverage for *plan participants* traveling outside of Arizona is limited to coverage for urgent care, emergency services, and sick office visits.

Magellan Health (Magellan) refers to the contracted facilities and providers of Behavioral Health services only, as described in this plan document.

You may obtain more information about the providers in the *network* by contacting the *network* by phone or by visiting their website as listed in the Quick Reference Chart.

SECTION V—SCHEDULE OF BENEFITS

A. Verification of Eligibility: 1-602-231-8855

Call this number to verify eligibility for *Plan* benefits **before** charges are *incurred*. Please note that oral or written communications with the *Third Party Administrator* regarding a *plan participant's* or beneficiary's eligibility or coverage under the *Plan* are not *claims* for benefits, and the information provided by the *Third Party Administrator* or other *Plan* representative in such communications does not constitute a certification of benefits or a guarantee that any particular *claim* will be paid. Benefits are determined by the *Plan* at the time a formal *claim* for benefits is submitted according to the procedures outlined within the **Claims and Appeals** section of this plan document.

B. Schedule of Benefits

All benefits described in the Schedules of Benefits are subject to the exclusions and limitations described more fully herein, including, but not limited to, the *Plan Administrator's* determination that care and treatment is *medically necessary*; that charges are in accordance with the *maximum allowable charge*; and that services, supplies, and care are not *experimental/investigational*.

This document is intended to describe the benefits provided under the *Plan,* but due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all *covered charges* and/or exclusions with specificity. Please contact the *Plan Administrator* if you have questions about specific supplies, treatments, or procedures.

The *Plan Administrator* retains the right to audit *claims* to identify treatment(s) that are, or were, not *medically necessary*, *experimental*, *investigational*, or not in accordance with the *maximum allowable charges*.

Pre-Certification

The following services must be *pre-certified*, or reimbursement from the *Plan* will be reduced:

1. *inpatient* pre-admission certification and continued stay reviews (all ages, all diagnoses)
    a. surgical and non-surgical (excluding routine vaginal or cesarean deliveries)
    b. *inpatient* mental health/*substance use disorder* treatment (includes *residential treatment facility* services)

       Pre-certification for mental health/*substance use disorder* treatment will be administered by Magellan Health. Refer to the Quick Reference Chart.
    c. observation care after seventy-two (72) hours
2. maternity length of stay that is in excess of forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery
3. *inpatient* and *outpatient surgery* (excluding office *surgeries,* colonoscopies, and diagnostic scope procedures)

   NOTE: Opthalmology authorizations will be for surgical procedures only, not for place of service.
4. applied behavioral analysis (ABA) therapy

   Pre-certification for ABA therapy will be administered by Magellan Health. Refer to the Quick Reference Chart.
5. all potential cosmetic procedures
6. *durable medical equipment* purchases in excess of $1,000
7. breast pumps in excess of $1,000
8. corrective appliances (orthotics/prosthetics) purchases in excess of $2,000
9. gene therapy and adoptive cell therapy
10. insulin pumps in excess of $1,000 (purchase price or combined rental cost)
11. occupational and physical therapy in excess of twenty (20) visits combined per *calendar year*

12. *outpatient* advanced imaging – MRI/MRA and PET scans (excluding services rendered in an emergency room setting)
13. pain management treatment (epidurals, implantable infusion pumps, etc.)
14. surgical treatment of TMJ conditions
15. *home health care services and supplies*
16. home infusion therapy services
17. specialty infusion/injectable medications which are covered under the Medical Benefits and not obtained through the Prescription Drug Benefits
    a. blood-clotting factors
    b. Botulinum toxin type A and B: Botox®, Dysport® , and Myobloc
    c. C1 Inhibitors: Cinryze and Berinert
    d. blood cell deficiency/erythropoiesis stimulating agents (ESA): Epoetin, Darbepoetin, and Oprelvekin
    e. growth hormones
    f. growth hormone blocker: Mecasermin
    g. immunologic agents/immune modulators/biologics/monoclonal antibody agents : Abatacept (Orencia®), Adalimumab (Humira®), Amevive®, Anakinra (Kineret®), Belimumab, Certolizumab (Cimzia®), Etanercept (Enbrel®), Eculizumab (Soliris), Fingolimod (Gilenya), Glatiramer Acetate (Copaxone, Glatopa), Golimumab (Simponi®), Infliximab (Remicade®), Secukinumab (Cosentyx), Tofacitinib (Actemra®), Ustekinumab (Stelara®), and Vedolizumab (Entyvio®)
    h. Rituximab (Rituxan®) -except for chemotherapy
    i. immunoglobulins, includes any parenteral administration [intravenous (IV), subcutaneous (SubQ), and/or intramuscular (IM)]
    j. bone condition agents: Prolia®, Zometa, and/or Pamidronate (Aredia®)
    k. miscellaneous specialty medications, such as Spinraza (nusinersen), Exondys 51 (eteplirsen), Brineura (cerliponase alfa), and Zolgensma
    l. respiratory conditions: Omalizumab (Xolair) and Mepolizumab (Nucala)
    m. eye conditions: Afibercept (Eylea) and Ranibizumab (Lucentis)
    n. enzyme deficiency: Agalsidase Beta (Fabrazyme) and Pegloticase (Krystexxa),
    o. endocrine disorders: Octreotide (Sandostatin), Lanreotide (Somatuline Depot), and Pasireotide (Signifor LAR)
    p. gene therapy

    This list may be updated throughout the *calendar year*.
18. transplant, including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high-dose chemotherapy

    Includes pre-transplant workup tests.
19. experimental or investigational treatments or surgeries, including clinical trials conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition

    This *Plan* does not cover clinical trials related to other *diseases* or conditions. Refer to the **Medical Benefits** section of this document for a further description and limitations of this benefit.
20. genetic testing and related lab fees (excludes genetic counseling, amniocentesis, and mandated BRCA services)
21. medical foods administered orally, other than PKU
22. services at any post-acute facility, including the following:
    a. long term acute care facility (LTAC), not *custodial care*

b. *skilled nursing facility*/rehabilitation facility

c. partial hospitalization and intensive *outpatient* therapy

23. non-emergent ambulance services (such as *medically necessary* inter-facility transport)

    Pre-certification is not required for transport from an emergency room to a higher level of care.

24. hyperbaric oxygen testing
25. ventricular assistive devices (VAD), life vests, implantable cardiac defibrillators
26. proton beam therapy
27. speech therapy (other than speech evaluation and assessment)
28. testosterone hormone therapy (for males only)
29. *outpatient* dialysis

Please see the Health Care Management Program section in this document for details.

C. Deductible Amount

Deductibles are dollar amounts that the *plan participant* must pay before the *Plan* pays. Before benefits can be paid in a *calendar year,* a *plan participant* must meet the *deductible* shown in the applicable Schedule of Medical Benefits.

This amount will accrue toward the 100% maximum *out-of-pocket limit*.

D. Benefit Payment

Each *calendar year*, benefits will be paid for the *covered charges* of a *plan participant* that are in excess of the *deductible*, any *co-payments,* and any amounts paid for the same services. Payment will be made at the rate shown under the reimbursement rate in the applicable Schedule of Medical Benefits. No benefits will be paid in excess of the *maximum benefit* amount or any listed limit of the *Plan*.

E. Out-of-Pocket Limit

Covered charges are payable at the percentages shown each *calendar year* until the *out-of-pocket limit* shown in the applicable Schedule of Medical Benefits is reached. Then, *covered charges incurred* by a *plan participant* will be payable at 100% (except for the charges excluded) for the remainder of the *calendar year*.

The *out-of-pocket limit* includes applicable amounts paid for *deductibles*, *co-payments*, and *co-insurance*.

F. Diagnosis-Related Grouping (DRG)

Diagnosis related grouping (*DRG*) is a method for reimbursing *hospitals* for *inpatient* services. This is when a provider bills for services that go together in a group, or bundle, instead of the individual services that make up the group separately. The provider has agreed to a set *DRG* rate with the *network*. When a service is rendered, regardless of what the provider bills, the *DRG* amount has already been set for that specific group of services. A *DRG* amount can be higher or lower than the actual billed charge because it is based on an average cost for the services rendered.

In the case where the *DRG* amount on an eligible *claim* is higher than the actual billed charges, the following will determine how each party's cost sharing will be determined:

- the *Plan* will base their portion of the charge on the billed charges
- the *plan participant's* portion of the charge will be based on the billed charges
- the difference in the *network allowed amount* versus the actual billed charges will be the responsibility of the *Plan*

G. Co-Insurance

For *covered charges incurred* with a *network* provider, the *Plan* pays a specified percentage of the negotiated rate. This percentage varies, depending on the type of *covered charge*, and is specified in the applicable Schedule of Medical Benefits. You are responsible for the difference between the percentage the *Plan* pays and 100% of the negotiated rate.

For *covered charges incurred* with a *non-network* provider, the *Plan* pays a specified percentage of *covered charges* at the *maximum allowable charge*. In those circumstances, you are responsible for the difference between the percentage the *Plan* pays and 100% of the billed amount, unless your *claim* is a *surprise billing claim*.

These amounts for which you are responsible are known as *co-insurance*. Unless noted otherwise in the Special Comments column of the applicable Schedule of Medical Benefits, your *co-insurance* applies towards satisfaction of the *out-of-pocket limit*.

H. Co-Payments

In certain cases, instead of paying *co-insurance*, you must pay a specific dollar amount, as specified in the applicable Schedule of Medical Benefits. This amount for which you are responsible is known as a *co-payment* and is typically payable to the health care provider at the time services or supplies are rendered. Unless otherwise specified, medical *co-payments* are applied per provider per day.

Unless noted otherwise in the Special Comments column of the applicable Schedule of Medical Benefits, your *co-payments* apply toward satisfaction of the *out-of-pocket limit*.

I. Balance Bill

The *balance bill* refers to the amount you may be charged for the difference between a *non-network* provider's billed charges and the *allowable charge*.

Network providers will accept the *allowable charge* for *covered charges*. They will not charge you for the difference between their billed charges and the *allowable charge*.

Non-network providers have no obligation to accept the *allowable charge*. You are responsible to pay a *non-network* provider's billed charges, even though reimbursement is based on the *allowable charge*. Depending on what billing arrangements you make with a *non-network* provider, the provider may charge you for full billed charges at the time of service or seek to balance bill you for the difference between billed charges and the amount that is reimbursed on a claim.

Any amounts paid for balance bills do not count toward the *deductible*, *co-insurance*, or *out-of-pocket limit*.

Refer to the **Consolidated Appropriations Act of 2021** section for additional provisions pertaining to *balance billing/surprise billing*.

Refer to the **Prescription Drug Benefits** section of this plan document for additional information on prescription drug coverage.

J. Schedule of Medical Benefits – Coordinated Care Plan Option

	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS
Deductible, per Calendar Year The *network* and *non-network deductible* amounts do not accumulate towards each other. *Co-payments*, *prescription drugs,* and *co-insurance* do not apply to the *deductible*.			
Per *plan participant*	$500		Not Applicable
Per *family unit*	$1,000		Not Applicable
Family Unit - Embedded Deductible If you are enrolled in the family option, your plan contains two (2) components: an individual *deductible* and a *family unit deductible*. Having two (2) components to the *deductible* allows for each member of your *family unit* the opportunity to have your *Plan* cover medical expenses prior to the entire dollar amount of the *family unit deductible* being met. The individual *deductible* is embedded in the family *deductible*. **For example,** if you, your spouse, and child are on a family plan with a $1,000 *family unit* embedded *deductible*, and the individual *deductible* is $500, and your child *incurs* $500 in medical bills, their *deductible* is met, and your *Plan* will help pay subsequent medical bills for that child during the remainder of the *calendar year*, even though the *family unit deductible* of $1,000 has not been met yet.			
Maximum Out-of-Pocket Limit, per Calendar Year The *out-of-pocket limit* includes *co-payments, co-insurance, deductibles,* and covered *prescription drug* charges. The *network* and *non-network out-of-pocket limits* do not accumulate towards each other.			
Per *plan participant*	$5,000		Unlimited
Per *family unit*	$10,000		Unlimited
Family Unit - Embedded Out-of-Pocket Limit If you are enrolled in the *family unit* option, your *Plan* contains two (2) components: an individual *out-of-pocket limit* and a *family unit out-of-pocket limit*. Having two (2) components to the *out-of-pocket limit* allows for each member of your *family unit* the opportunity to have his/her *covered charges* be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the *family unit out-of-pocket limit* being met. The individual *out-of-pocket limit* is embedded in the *family unit out-of-pocket limit*.			
The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached, at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise. **NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the *Plan*:** 1. premiums 2. cost containment penalties 3. charges in excess of the *Plan's* maximum benefits 4. amounts over *the maximum allowable charges* 5. charges not covered under the *Plan* 6. *balanced billed* charges 7. expenses for medical services or supplies obtained from *non-network* providers or facilities, except as noted in the plan document			

Befits shown as *co-payments* are listed for what the *plan participant* will pay.

Benefits shown as *co-insurance* are listed for the percentage the *Plan* will pay.

Coordinated Care Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
General Percentage Payment Rule	80%, *deductible* waived	Not Covered	Not Covered	Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply. *Deductible* applies for *inpatient* services and *outpatient surgeries*.
FACILITY SERVICES				
Advanced Imaging (Outpatient Facility)	$150 *co-payment*, *deductible* waived	Not Covered	Not Covered	Includes: Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), discograms, myelograms, and PET scans, excluding services rendered in an emergency room setting. One *co-payment* per day per provider for all advanced imaging combined. ***Pre-certification* is required for MRI/MRA and PET scans.**
Blood Transfusions (Outpatient)	80%, *deductible* waived	Not Covered	Not Covered	
Diagnostic Testing (Outpatient Facility)	$20 *co-payment*, *deductible* waived	75%, *deductible* waived	Not Covered	Facility fees associated with *diagnostic testing* such as (but not limited to): • EKG/EEG • Stress Test • Peripheral Vascular Test
Emergency Room	$250 *co-payment*, *deductible* waived			Emergency room professional fees (for *physicians* licensed in emergency medicine) are included in the *co-payment*. *Co-payments* are applied per visit. *Non-network* emergency room care will apply toward the annual *out-of-pocket limit*. Emergency room *co-payment* will be waived if admitted for hospitalization or observation.

Coordinated Care Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
FACILITY SERVICES continued				
Inpatient Hospital				
Room and Board (Elective Admission)	80% after *deductible*	Not Covered	Not Covered	Limited to the semi-private room rate when such semi-private room rate is available (other than intensive care units and private rooms at HonorHealth facilities). **Calendar Year Maximum:** One hundred twenty (120) days per *plan participant* for *inpatient* rehabilitation services. ***Pre-certification* is required.** **For maternity stays:** refer to the **Healthcare Management Program** section for criteria. **Observation room stays: *pre-certification* is required after seventy-two (72) hours.**
Room and Board (Emergency Admission)	80% after *deductible*	80% after *deductible*	80% after *deductible*	
Laboratory Services (Outpatient Facility Fees)	$20 *co-payment*, *deductible* waived	$20 *co-payment*, *deductible* waived	Not Covered	*Co-payment* is per visit, not per service.
Outpatient Ambulatory Facility	80% after *deductible*	Not Covered	Not Covered	Includes facility fees for *outpatient* surgery at a hospital. ***Pre-certification* is required** for *outpatient* surgical procedures (excluding *outpatient* office surgical procedures and colonoscopies).
Outpatient Hospital	80% *deductible* waived	Not Covered	Not Covered	Includes facility fees for biopsies, catheterization lab procedures, chemotherapy, radiation therapy, and infusion. ***Pre-certification* is required** for certain services.
Pre-Admission Testing	100% after *deductible*	Not Covered	Not Covered	Includes laboratory tests and x-rays. Applies to facility and professional fees.
Skilled Nursing Facility/ Extended Care	80% after *deductible*	75% after *deductible*	Not Covered	**Calendar Year Maximum:** One hundred twenty (120) days per *plan participant*. Long-term acute care and rehabilitation hospital services apply toward this maximum. ***Pre-certification* is required.**
Sleep Study Facility Fees	80%, *deductible* waived	75%, *deductible* waived	Not Covered	

Coordinated Care Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
FACILITY SERVICES continued				
Urgent Care Facility	$35 *co-payment*, *deductible* waived	$60 *co-payment*, *deductible* waived	Not Covered	*Co-payments* are applied per visit. Coverage provided for hospital-based facilities, freestanding facilities, and walk-in clinics.
X-Rays and Ultrasounds (Outpatient Facility)	$20 *co-payment*, *deductible* waived	50%, *deductible* waived	Not Covered	
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES				
Acupuncture	75% up to $1,000, then *Plan* pays 10% All services combined *Deductible* waived			*Non-network coinsurance* applies to *in-network out-of-pocket*. $1,000 limit is combined for acupuncture and alternative care.
Allergy Services	80%, *deductible* waived	70%, *deductible* waived	Not Covered	
Alternative Care	75% up to $1,000, then *Plan* pays 10% All services combined *Deductible* waived			Alternative care includes chiropractic, biofeedback, and naturopathic services. Not all alternative healthcare services are covered. Refer to **Medical Benefits** section for more information. $1,000 limit is combined for acupuncture and alternative care.
Ambulance Service				
Initial Ambulance Transport	75%, *deductible* waived			
Inter-Facility Transport	100%, *deductible* waived			***Pre-certification* is required.**
Asthma Education Services	$20 *co-payment*, *deductible* waived	Not Covered	Not Covered	Education services for individuals and parents of children diagnosed with asthma, only when ordered by a *physician*.
Corrective Appliances (Orthotics/Prosthetics)	80%, *deductible* waived	70%, *deductible* waived	Not Covered	Only mastectomy items (i.e. breast prosthetics and bras) purchased at Tina's Treasures are available under the HonorHealth coverage level. ***Pre-certification* is required for orthotics/prosthetics in excess of $2,000 purchase price per device.**
Diabetic Education	$20 *co-payment*, *deductible* waived	Not Covered	Not Covered	
Diabetic Equipment	90%, *deductible* waived	90%, *deductible* waived	Not Covered	Includes continuous blood glucose monitor, insulin pump, and related supplies. Other coverage for diabetic equipment is provided by the **Prescription Drug Benefits**. ***Pre-certification* is required for insulin pumps in excess of $1,000.**

Coordinated Care Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES continued				
Durable Medical Equipment	75%, *deductible* waived	75%, *deductible* waived	Not Covered	***Pre-certification* is required for DME in excess of $1,000 purchase price.**
Genetic Testing and Counseling	75%, *deductible* waived	75%, *deductible* waived	Not Covered	***Pre-certification* is required for genetic testing.**
Hearing Aids	75% up to $2,000 per ear, then *Plan* pays 10%, *deductible* waived			**Benefit Maximum:** Maximum is per ear every three (3) years for hearing aids, hearing aid repairs, hearing aid batteries, and related supplies. *Non-network* hearing aid benefits accumulate to the *network out-of-pocket limit*.
Home Health Care	80%, *deductible* waived	75%, *deductible* waived	Not Covered	Therapy provided in the home will apply to the Rehabilitation *calendar year* maximum. Home hospice services are covered under the Hospice benefit. ***Pre-certification* is required.**
Home Infusion	80%, *deductible* waived	Not Covered	Not Covered	***Pre-certification* is required.**
Home Visits Rendered by Dispatch Health	Not Applicable	$60 *co-payment*, *deductible* waived	Not Applicable	
Hospice Care				
Hospice Care	75% after *deductible*	75% after *deductible*	Not Covered	
Bereavement Counseling	75% after *deductible*	75% after *deductible*	Not Covered	
Infertility				
Primary Care Provider (PCP)	$25 *co-payment*, *deductible* waived	Not Covered	Not Covered	*Co-payment* applies to the office visit only. Other charges will be considered at the applicable benefit level.
Specialist	$50 *co-payment*, *deductible* waived	Not Covered	Not Covered	
Treatment	80%, *deductible* waived	**Lab Fees ordered by a BCBSAZ provider:** 70%, *deductible* waived	Not Covered	**Calendar Year Maximum:** $1,500 for infertility treatment per *plan participant*, then *Plan* pays 10%. *Calendar year* maximum does not apply to office visits. *Outpatient* prescription drugs for the treatment of infertility are limited to $25,000 per *plan participant* per lifetime.

Coordinated Care Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES continued				
Maternity				
Pre-Natal and Post-Natal Care	100%, *deductible* waived	Not Covered	Not Covered	*Dependent* child *pregnancy* is covered. First ultrasound is covered at 100% under the Maternity benefit. Subsequent ultrasounds will be payable at the applicable medical benefit if *medically necessary*. *Co-insurance, deductibles,* and *co-payments* are waived for well newborns that are discharged with the mother.
Other Covered Physician and Healthcare Practitioner Services in an Office Setting	80%, *deductible* waived	Not Covered	Not Covered	
Labor and Delivery	80% after *deductible*	Not Covered	Not Covered	
Medical Foods	80%, *deductible* waived	70%, *deductible* waived	Not Covered	
Medical Supplies	75%, *deductible* waived	75%, *deductible* waived	Not Covered	Refer to **Medical Benefits** section, Medical Supplies provision for more information.
Office Visit				
Primary Care Physician (PCP)	$25 *co-payment*, *deductible* waived	Pediatrician: $25 *co-payment*, *deductible* waived Other PCP: Not Covered	Not Covered	The *co-payment* applies to the office visit and office consultations only, including when a *physician's* office is located within a *hospital*. If specialty is not included within HonorHealth/Innovation Care Partners, services rendered through BCBSAZ will pay at the HonorHealth benefit level.
Specialist	$50 *co-payment*, *deductible* waived	Office Setting: Not Covered Non-Office Setting: 70%, *deductible* waived	Not Covered	Includes virtual visits. *Plan participant* must have approval for BCBSAZ provider by the Medical Management Administrator, then apply the gap benefit: Services Not Available at an HonorHealth and/or BCBSAZ benefit. Refer to the **Medical Network Information** section, Special Reimbursement Provisions subsection, Certain Provider Specialties provision for information regarding which providers are covered at the HonorHealth coverage level.

Coordinated Care Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES continued				
Other Covered Physician and Healthcare Practitioner Services	80%, *deductible* waived	Not Covered in an office setting 70%, *deductible* waived in a non-office setting	Not Covered	Includes all other covered services rendered by a *physician* or healthcare practitioner not otherwise described in the **Schedule of Benefits**. Refer to the **Medical Network Information** section, Special Reimbursement Provisions subsection, Certain Provider Specialties provision for information regarding which providers are covered at the HonorHealth coverage level.
Professional Fees related to an Inpatient Hospital Stay	80% after *deductible*	80% after *deductible*	Not Covered	
Professional Fees related to Outpatient Surgery	80% after *deductible*	70% after *deductible*	Not Covered	Includes covered home births.
Pain Management	80%, *deductible* waived	70%, *deductible* waived	Not Covered	***Pre-certification* is required.**
Pre-Admission Testing	100% after *deductible*	Not Covered	Not Covered	Includes laboratory tests and x-rays.
Rehabilitation Therapy (Outpatient)				
Physical Therapy Occupational Therapy Speech Therapy	$20 *co-payment*, *deductible* waived	$20 *co-payment*, *deductible* waived	Not Covered	Multiple visits on the same day accumulate as one (1) visit toward the calendar year maximum. If visits occur with different providers on the same day, separate *co-payments* apply. ***Pre-certification* is required** for speech therapy. ***Pre-certification* is required** for physical and occupational therapy in excess of twenty (20) visits combined.
Cardiac Rehabilitation Pulmonary Rehabilitation	80%, *deductible* waived	50%, *deductible* waived	Not Covered	**Calendar Year Maximum:** Twelve (12) weeks per therapy type per *plan participant*.
Services Not Available at an HonorHealth and BCBSAZ Provider				
Surgical and Inpatient Services	Not Available	Not Available	Applicable *deductible* and HH/ICP *co-payment*, then *Plan* pays 70%	This provision is also known as a gap benefit. *Covered charges* not available at an HonorHealth and/or BCBSAZ provider will apply to the *out-of-pocket limit*. Services rendered by Medtronic/MiniMed when received from an HonorHealth facility will be considered under this benefit. PHCS *network* of *physicians* and *hospitals* is available when providers are outside of Arizona.
Other Outpatient Services	Not Available	Not Available	Applicable HH/ICP *co-payment*, then *Plan* pays 70%, *deductible* waived	

Coordinated Care Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES continued				
Wigs	80% up to $1,000, then *Plan* pays 10%, *deductible* waived	70% up to $1,000, then *Plan* pays 10%, *deductible* waived	Not Covered	Limited to the initial purchase of hair loss replacement toward a wig, toupee, or hairpiece if required as a result of an *illness* such as alopecia or cancer therapy. **Benefit Maximum:** Limited to one (1) wig per *plan participant* every three (3) years.

Coordinated Care Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, the IRS Safe Harbor preventive services list, or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by a *network* provider at a Routine Wellness Care visit. For more information about preventive services please refer to the following websites: **https://www.healthcare.gov/coverage/preventive-care-benefits/** **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/** **Safe Harbor Services:** **https://www.irs.gov/pub/irs-drop/n-04-23.pdf** **https://www.irs.gov/pub/irs-drop/n-19-45.pdf**				
Routine Wellness Care	100%, *deductible* waived	Lab fees ordered by a BCBSAZ provider: 100%, *deductible* waived Other preventive services: Not Covered	Not Covered	Services include routine physical exam, wellness labs and x-rays, immunizations, gynecological exam, pap smear, PSA test, 2D and 3D mammogram, colorectal cancer screening, blood work, bone density testing, and shingles vaccine. **Calendar Year Maximum:** One (1) routine exam per adult *plan participant*. This maximum does not include the well woman visit or colon cancer screening. Safe Harbor services and non-mandated diagnostic screenings performed at a wellness visit will be covered at the preventive level. Administrative, school, and sports physicals are also included in the preventive benefit. Please refer to the **Medical Benefits** section, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.
Well-Child Care	100%, *deductible* waived	Pediatricians only: 100%, *deductible* waived	Not Covered	Coverage is provided for newborn and well-child visits for health exams and related testing. Includes immunizations per CDC recommendations.
BRCA Genetic Counseling and Testing	100%, *deductible* waived	**Lab fees ordered by a *network* provider:** 100%, *deductible* waived **Other:** Not Covered	Not Covered	For BRCA testing and counseling not mandated under the Patient Protection and Affordable Care Act (PPACA), refer to Genetic Testing and Counseling Physician and Other Healthcare Practitioner Services row of this Schedule of Benefits.
Breastfeeding Counseling	100%, *deductible* waived	100%, *deductible* waived	Not Covered	Lactation support, counseling, and education.

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE continued				
Breastfeeding Pump and Supplies	100%, *deductible* waived	100%, *deductible* waived	Not Covered	**Benefit Maximum:** One (1) per pregnancy. ***Pre-certification* is required** for breast pumps in excess of $1,000. Includes hospital-grade breast pumps when ordered by a *physician*.
Cologuard	100%, *deductible* waived			
Contraceptive Services	100%, *deductible* waived	100%, *deductible* waived	Not Covered	Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion. When preventive and diagnostic services occur during the same visit, the diagnostic benefit cost will apply. **Benefit Limitations:** Sterilization services are available to male and female *plan participants;* other contraceptive services are available to all female *plan participants*.

Refer to the Medical Benefits section, Medical Plan Exclusions subsection for additional information relating to excluded services.

K. Schedule of Behavioral Benefits – Coordinated Care Plan Option

The *deductible* and *out-of-pocket limit* are combined with the medical and prescription drug plans.

	MAGELLAN HEALTH PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
MENTAL DISORDERS & SUBSTANCE USE DISORDERS			
Inpatient and Partial Hospitalization/Emergency Admissions	80% after *deductible*	Not Covered	***Pre-certification* is required.**
Intensive Outpatient	$20 *co-payment*, *deductible* waived	Not Covered	Includes Transcranial Magnetic Stimulation (TMS). ***Pre-certification* is required.**
Outpatient Therapy with PsyD, PhD, MD, Social Worker, or Mental Health/Substance Use Disorders Counselor	$20 *co-payment*, *deductible* waived	Not Covered	Includes group, individual, family, and medication evaluation counseling.
Residential Treatment	80% after *deductible*	Not Covered	***Pre-certification* is required.**
Applied Behavioral Analysis (ABA) Therapy	$20 *co-payment*, *deductible* waived	Not Covered	***Pre-certification* is required.**

L. Schedule of Dialysis Benefits – Coordinated Care Plan Option

COVERED SERVICES	ALL PROVIDERS	SPECIAL COMMENTS
DIALYSIS, OUTPATIENT		
Dialysis, Outpatient	75%, *deductible* waived	The following *outpatient dialysis* services will be considered at 125% of the *Medicare* rate, and then *Plan* benefits will apply: • facility and professional charges from *outpatient hospitals* and dialysis facilities • home dialysis charges Refer to the **Dialysis Services** section for a further description and limitations of this benefit. ***Pre-certification* is required.**

M. Schedule of Prescription Drug Benefits – Coordinated Care Plan Option

The prescription drug benefits are separate from the medical benefits and are administered by OptumRx. Refer to the **Prescription Drug Benefits** section of this plan document for additional information on prescription drug coverage.

Prescription drug charges do not apply to the medical *deductible*.

Prescription drug charges apply to the medical *out-of-pocket limit*.

Benefits shown reflect what the *plan participant* will pay.

Retail Pharmacy Option (30-Day Supply)	**Retail Pharmacy Option** (31-90 Day Supply)	**Mail Order Pharmacy Option** (90-Day Supply)	**Retail90 with Walgreens** (90-Day Supply)
Generic Drugs **Tier 1** $10 *co-payment* **Formulary Brand and Single Source Generic Drugs** **Tier 2** 30% *co-insurance* $30 minimum $80 maximum **Non-Formulary Brand** **Tier 3** 60% *co-insurance* $100 minimum No maximum	**Generic Drugs** **Tier 1** $25 *co-payment* **Formulary Brand and Single Source Generic Drugs** **Tier 2** 30% *co-insurance* $75 minimum $200 maximum **Non-Formulary Brand** **Tier 3** 100% *co-insurance*	**Generic Drugs** **Tier 1** $25 *co-payment* **Formulary Brand and Single Source Generic Drugs** **Tier 2** 30% *co-insurance* $75 minimum $200 maximum **Non-Formulary Brand** **Tier 3** Not Covered	**Generic Drugs** **Tier 1** $25 *co-payment* **Formulary Brand and Single Source Generic Drugs** **Tier 2** 30% *co-insurance* $75 minimum $200 maximum **Non-Formulary Brand** **Tier 3** 100% *co-insurance*

Specialty Drugs Obtained Through OptumRx Specialty Pharmacy or HonorHealth Specialty Pharmacy (30-Day Supply)	**Specialty Drugs NOT Obtained Through OptumRx Specialty Pharmacy or HonorHealth Specialty Pharmacy**
30% *co-insurance* $50 minimum $100 maximum	Not Covered

Certain *preventive care prescription drugs* received by a *network pharmacy* are covered at 100% and the *deductible*/*co-payment*/*co-insurance* (if applicable) is waived. Your pharmacy benefit plan includes special coverage for preventive medications. These medications help protect against or manage medical conditions such as diabetes, hypertension, asthma, and depression.

Please refer to the following websites for information on the types of payable *preventive care prescription drugs*: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**.

Walgreens Retail 90 Program: 90-day maintenance medications will only be covered when filled at Walgreens retail pharmacy or OptumRx Mail Order. Maintenance medications are those you take regularly.

High Cost Drug Utilization Program (HCDUP): The HCDUP is a program that allows Medical Management to identify high-cost drugs prescribed through the Plan so our care management team can review *medical necessity* of the medication to ensure *plan participants* are receiving appropriate, safe, and effective drugs at a lower cost. This program is set up for all *employees* and *dependents* of HonorHealth who use our insurance benefits for select high-cost medications.

The program has two (2) parts that need to be completed. First, your specialist will need to request a prior authorization review of your medication from the Medical Management team. Next, you will need to schedule a free video visit with the provider that works with the HonorHealth Specialty pharmacy. Once you complete the video visit and the prior authorization is approved, your prescription will be sent to HonorHealth Specialty pharmacy to be filled. The video visit is a face-to-face visit that is done on your cell phone, laptop, or computer. There is no cost involved for this face-to-face visit. Before the free video visit can take place, our staff at HonorHealth must obtain the office notes, prior authorization form, and lab work from your specialist.

If you have any questions or need additional clarification on what is required of you and your prescribing provider, call the Plan representative at 1-602-674-6222.

Claims for reimbursement of *prescription drugs* are to be submitted to OptumRx at:

OptumRx
Attn: Claims

P.O. Box 29044
Hot Springs, AR 71903

NOTE: For a complete list of covered drugs and supplies, and applicable limitations and exclusions, please refer to the OptumRx Drug Coverage List, which is incorporated by reference and is available from your *employer* or OptumRx at 1-844-368-9854 or **www.optumrx.com**.

N. Schedule of Medical Benefits – Standard Plan Option

	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS
Deductible, per Calendar Year The *network* and *non-network deductible* amounts do not accumulate towards each other. *Co-payments*, *prescription drugs,* and *co-insurance* do not apply to the *deductible*.			
Per *plan participant*	$500		Not Applicable
Per *family unit*	$1,000		Not Applicable
Family Unit - Embedded Deductible If you are enrolled in the family option, your plan contains two (2) components: an individual *deductible* and a *family unit deductible*. Having two (2) components to the *deductible* allows for each member of your *family unit* the opportunity to have your *Plan* cover medical expenses prior to the entire dollar amount of the *family unit deductible* being met. The individual *deductible* is embedded in the family *deductible*. **For example,** if you, your spouse, and child are on a family plan with a $1,000 *family unit* embedded *deductible*, and the individual *deductible* is $500, and your child *incurs* $500 in medical bills, their *deductible* is met, and your *Plan* will help pay subsequent medical bills for that child during the remainder of the *calendar year*, even though the *family unit deductible* of $1,000 has not been met yet.			
Maximum Out-of-Pocket Limit, per Calendar Year The *out-of-pocket limit* includes *co-payments, co-insurance, deductibles,* and covered *prescription drug* charges. The *network* and *non-network out-of-pocket limits* do not accumulate towards each other.			
Per *plan participant*	$6,450		Unlimited
Per *family unit*	$12,900		Unlimited
Family Unit - Embedded Out-of-Pocket Limit If you are enrolled in the *family unit* option, your *Plan* contains two (2) components: an individual *out-of-pocket limit* and a *family unit out-of-pocket limit*. Having two (2) components to the *out-of-pocket limit* allows for each member of your *family unit* the opportunity to have his/her *covered charges* be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the *family unit out-of-pocket limit* being met. The individual *out-of-pocket limit* is embedded in the *family unit out-of-pocket limit*.			
The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached, at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise. **NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the *Plan*:** 1. premiums 2. cost containment penalties 3. charges in excess of the *Plan's* maximum benefits 4. amounts over *the maximum allowable charges* 5. charges not covered under the *Plan* 6. *balanced billed* charges 7. expenses for medical services or supplies obtained from *non-network* providers or facilities, except as noted in the plan document			

Befits shown as *co-payments* are listed for what the *plan participant* will pay.

Benefits shown as *co-insurance* are listed for the percentage the *Plan* will pay.

Standard Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
General Percentage Payment Rule	85%, *deductible* waived	70%, *deductible* waived	Not Covered	Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply. *Deductible* applies for *inpatient* services and *outpatient surgeries*.
FACILITY SERVICES				
Advanced Imaging (Outpatient Facility)	$200 *co-payment*, *deductible* waived	$200 *co-payment*, then *Plan* pays 50%, *deductible* waived	Not Covered	Includes: Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), discograms, myelograms, and PET scans, excluding services rendered in an emergency room setting. One (1) *co-payment* per day per provider. ***Pre-certification* is required for MRI/MRA and PET scans.**
Blood Transfusions (Outpatient)	85%, *deductible* waived	70%, *deductible* waived	Not Covered	
Diagnostic Testing (Outpatient Facility)	$15 *co-payment*, *deductible* waived	75%, *deductible* waived	Not Covered	Facility fees associated with *diagnostic testing* such as (but not limited to): • EKG/EEG • Stress Test • Peripheral Vascular Test
Emergency Room	$300 *co-payment*, *deductible* waived			Emergency room professional fees (for *physicians* licensed in emergency medicine) are included in the *co-payment*. *Co-payments* are applied per visit. *Non-network* emergency room care will apply toward the annual *out-of-pocket limit*. Emergency room *co-payment* will be waived if admitted for hospitalization or observation.

Standard Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
FACILITY SERVICES continued				
Inpatient Hospital				
Room and Board (Elective Admission)	85% after *deductible*	50% after *deductible*	Not Covered	Limited to the semi-private room rate when such semi-private room rate is available (other than intensive care units and private rooms at HonorHealth facilities). **Calendar Year Maximum:** One hundred twenty (120) days per *plan participant* for *inpatient* rehabilitation services. ***Pre-certification* is required.** **For maternity stays:** refer to the **Healthcare Management Program** section for criteria. **Observation room stays: *pre-certification* is required after seventy-two (72) hours.**
Room and Board (Emergency Admission)	85% after *deductible*	85% after *deductible*	85% after *deductible*	
Laboratory Services (Outpatient Facility Fees)	$20 *co-payment*, *deductible* waived	$20 *co-payment*, *deductible* waived	Not Covered	*Co-payment* is per visit, not per service.
Outpatient Ambulatory Facility	85% after *deductible*	50% after *deductible*	Not Covered	Includes facility fees for *outpatient* surgery at a hospital. ***Pre-certification* is required** for *outpatient* surgical procedures (excluding *outpatient* office surgical procedures and colonoscopies).
Outpatient Hospital	85%, *deductible* waived	50%, *deductible* waived	Not Covered	Includes facility fees for biopsies, catheterization lab procedures, chemotherapy, radiation therapy, and infusion. ***Pre-certification* is required** for certain services.
Pre-Admission Testing	100% after *deductible*	50% after *deductible*	Not Covered	Includes laboratory tests and x-rays. Applies to facility and professional fees.
Skilled Nursing Facility/ Extended Care	85% after *deductible*	75% after *deductible*	Not Covered	**Calendar Year Maximum:** One hundred twenty (120) days per *plan participant*. Long-term acute care and rehabilitation hospital services apply toward this maximum. ***Pre-certification* is required.**
Sleep Study Facility Fees	85%, *deductible* waived	70%, *deductible* waived	Not Covered	

Standard Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Urgent Care Facility	$35 *co-payment*, *deductible* waived	$60 *co-payment*, *deductible* waived	Not Covered	*Co-payments* are applied per visit. Coverage provided for hospital-based facilities, freestanding facilities, and walk-in clinics.
X-Rays and Ultrasounds (Outpatient Facility)	$20 *co-payment*, *deductible* waived	75%, *deductible* waived	Not Covered	
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES				
Acupuncture	75% up to $1,000, then *Plan* pays 10% All services combined *Deductible* waived			*Non-network coinsurance* applies to *in-network out-of-pocket*. $1,000 limit is combined for acupuncture and alternative care.
Allergy Services	85%, *deductible* waived	70%, *deductible* waived	Not Covered	
Alternative Care	75% up to $1,000, then *Plan* pays 10% All services combined *Deductible* waived			Alternative care includes chiropractic, biofeedback, and naturopathic services. Not all alternative healthcare services are covered. Refer to **Medical Benefits** section for more information. $1,000 limit is combined for acupuncture and alternative care.
Ambulance Service				
Initial Ambulance Transport	75%, *deductible* waived			
Inter-Facility Transport	100%, *deductible* waived			***Pre-certification* is required.**
Asthma Education Services	$20 *co-payment*, *deductible* waived	Not Covered	Not Covered	Education services for individuals and parents of children diagnosed with asthma, only when ordered by a *physician*.
Corrective Appliances (Orthotics/Prosthetics)	85%, *deductible* waived	70%, *deductible* waived	Not Covered	Only mastectomy items (i.e. breast prosthetics and bras) purchased at Tina's Treasures are available under the HonorHealth coverage level. ***Pre-certification* is required for orthotics/prosthetics in excess of $2,000 purchase price per device.**
Diabetic Education	$20 *co-payment*, *deductible* waived	Not Covered	Not Covered	
Diabetic Equipment	90%, *deductible* waived	90%, *deductible* waived	Not Covered	Includes continuous blood glucose monitor, insulin pump, and related supplies. Other coverage for diabetic equipment is provided by the **Prescription Drug Benefits**. ***Pre-certification* is required for insulin pumps in excess of $1,000.**
Durable Medical Equipment	75%, *deductible* waived	75%, *deductible* waived	Not Covered	***Pre-certification* is required for DME in excess of $1,000 purchase price.**

Standard Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES continued				
Genetic Testing and Counseling	75%, *deductible* waived	75%, *deductible* waived	Not Covered	***Pre-certification* is required for genetic testing.**
Hearing Aids	75% up to $2,000 per ear, then *Plan* pays 10%, *deductible* waived			**Benefit Maximum:** Maximum is per ear every three (3) years for hearing aids, hearing aid repairs, hearing aid batteries, and related supplies. *Non-network* hearing aid benefits accumulate to the *network out-of-pocket limit*.
Home Health Care	85%, *deductible* waived	70%, *deductible* waived	Not Covered	Therapy provided in the home will apply to the Rehabilitation *calendar year* maximum. Home hospice services are covered under the Hospice benefit. ***Pre-certification* is required**.
Home Infusion	85%, *deductible* waived	70%, *deductible* waived	Not Covered	***Pre-certification* is required.**
Home Visits Rendered by Dispatch Health	Not Applicable	$60 *co-payment*, *deductible* waived	Not Applicable	
Hospice Care				
Hospice Care	75% after *deductible*	75% after *deductible*	Not Covered	
Bereavement Counseling	75% after *deductible*	75% after *deductible*	Not Covered	
Infertility				
Primary Care Provider (PCP)	$25 *co-payment*, *deductible* waived	$40 *co-payment*, *deductible* waived	Not Covered	*Co-payment* applies to the office visit only. Other charges will be considered at the applicable benefit level.
Specialist	$60 *co-payment*, *deductible* waived	**If specialty not included within HonorHealth:** $60 *co-payment*, *deductible* waived **If specialty is included within HonorHealth:** $125 *co-payment*, *deductible* waived	Not Covered	

Standard Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES continued				
Treatment	85%, *deductible* waived	70%, *deductible* waived	Not Covered	**Calendar Year Maximum:** $1,500 for infertility treatment per *plan participant*, then *Plan* pays 10%. *Calendar year* maximum does not apply to office visits. *Outpatient* prescription drugs for the treatment of infertility are limited to $25,000 per *plan participant* per lifetime.
Maternity				
Pre-Natal and Post-Natal Care	100%, *deductible* waived	100%, *deductible* waived	Not Covered	*Dependent* child *pregnancy* is covered. First ultrasound is covered at 100% under the Maternity benefit. Subsequent ultrasounds will be payable at the applicable medical benefit if *medically necessary*. *Co-insurance, deductibles,* and *co-payments* are waived for well newborns that are discharged with the mother.
Other Covered Physician and Healthcare Practitioner Services in an Office Setting	85%, *deductible* waived	70%, *deductible* waived	Not Covered	
Labor and Delivery	85% after *deductible*	70% after *deductible*	Not Covered	
Medical Foods	85%, *deductible* waived	70%, *deductible* waived	Not Covered	
Medical Supplies	75%, *deductible* waived	75%, *deductible* waived	Not Covered	Refer to **Medical Benefits** section, Medical Supplies provision for more information.
Office Visit				
Primary Care Physician (PCP)	$25 *co-payment*, *deductible* waived	$40 *co-payment*, *deductible* waived	Not Covered	The *co-payment* applies to the office visit and office consultations only, including when a *physician's* office is located within a *hospital*. Includes virtual visits. Refer to the **Medical Network Information** section, Special Reimbursement Provisions subsection, Certain Provider Specialties provision for information regarding which providers are covered at the HonorHealth coverage level.
Specialist	$60 *co-payment*, *deductible* waived	If specialty not included within HonorHealth: $60 *co-payment*, *deductible* waived If specialty is included within HonorHealth: $125 *co-payment*, *deductible* waived	Not Covered	

Standard Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES continued				
Other Covered Physician and Healthcare Practitioner Services	85%, *deductible* waived	70%, *deductible* waived	Not Covered	Includes all other covered services rendered by a *physician* or healthcare practitioner not otherwise described in the **Schedule of Benefits**. Refer to the **Medical Network Information** section, Special Reimbursement Provisions subsection, Certain Provider Specialties provision for information regarding which providers are covered at the HonorHealth coverage level.
Professional Fees related to an Inpatient Hospital Stay	85% after *deductible*	70% after *deductible*	Not Covered	
Professional Fees related to Outpatient Surgery	85% after *deductible*	70% after *deductible*	Not Covered	Includes covered home births.
Pain Management	85%, *deductible* waived	70%, *deductible* waived	Not Covered	***Pre-certification* is required.**
Pre-Admission Testing	100%, *deductible* waived	50%, after *deductible*	Not Covered	Includes laboratory tests and x-rays.
Rehabilitation Therapy (Outpatient)				
Physical Therapy Occupational Therapy Speech Therapy	$20 *co-payment*, *deductible* waived	$20 *co-payment*, *deductible* waived	Not Covered	Multiple visits on the same day accumulate as one (1) visit toward the calendar year maximum. If visits occur with different providers on the same day, separate *co-payments* apply. ***Pre-certification* is required** for speech therapy. ***Pre-certification* is required** for physical and occupational therapy in excess of twenty (20) visits combined.
Cardiac Rehabilitation Pulmonary Rehabilitation	85%, *deductible* waived	50%, *deductible* waived	Not Covered	**Calendar Year Maximum:** Twelve (12) weeks per therapy type per *plan participant*.

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES continued				
Services Not Available at an HonorHealth and/or BCBSAZ Provider				
Surgical and Inpatient Services	Not Available	Not Available	Applicable *deductible* and HH/ICP *co-payment*, then *Plan* pays 70%	This provision is also known as a gap benefit. *Covered charges* not available at an HonorHealth and/or BCBSAZ provider will apply to the *out-of-pocket limit*. Services rendered by Medtronic/MiniMed when received from an HonorHealth facility will be considered under this benefit. PHCS *network* of *physicians* and *hospitals* is available when providers are outside of Arizona.
Other Outpatient Services	Not Available	Not Available	Applicable HH/ICP *co-payment*, then *Plan* pays 70%, *deductible* waived	
Wigs	85% up to $1,000, then *Plan* pays 10%, *deductible* waived	70% up to $1,000, then *Plan* pays 10%, *deductible* waived	Not Covered	Limited to the initial purchase of hair loss replacement toward a wig, toupee, or hairpiece if required as a result of an *illness* such as alopecia cancer therapy. **Benefit Maximum:** Limited to one (1) wig per *plan participant* every three (3) years.

Standard Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by a *network* provider at a Routine Wellness Care visit. For more information about preventive services please refer to the following websites: **https://www.healthcare.gov/coverage/preventive-care-benefits/** **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/** **Safe Harbor Services:** **https://www.irs.gov/pub/irs-drop/n-04-23.pdf** **https://www.irs.gov/pub/irs-drop/n-19-45.pdf**				
Routine Wellness Care	100%, *deductible* waived	100%, *deductible* waived	Not Covered	Services include routine physical exam, wellness labs and x-rays, immunizations, gynecological exam, pap smear, PSA test, 2D and 3D mammogram, colorectal cancer screening, blood work, bone density testing, and shingles vaccine. **Calendar Year Maximum:** One (1) routine exam per adult *plan participant*. This maximum does not include the well woman visit or colon cancer screening. Safe Harbor services and non-mandated diagnostic screenings performed at a wellness visit will be covered at the preventive level. Administrative, school, and sports physicals are also included in the preventive benefit. Please refer to the **Medical Benefits** section, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.
Well-Child Care	100%, *deductible* waived	**Pediatricians only:** 100%, *deductible* waived	Not Covered	Coverage is provided for newborn and well-child visits for health exams and related testing. Includes immunizations per CDC recommendations.
BRCA Genetic Counseling and Testing	100%, *deductible* waived	100%, *deductible* waived	Not Covered	For BRCA testing and counseling not mandated under the Patient Protection and Affordable Care Act (PPACA), refer to Genetic Testing and Counseling Physician and Other Healthcare Practitioner Services row of this Schedule of Benefits.
Breastfeeding Counseling	100%, *deductible* waived	100%, *deductible* waived	Not Covered	Lactation support, counseling, and education.
Breastfeeding Pump and Supplies	100%, *deductible* waived	100%, *deductible* waived	Not Covered	**Benefit Maximum:** One (1) per pregnancy. ***Pre-certification* is required** for breast pumps in excess of $1,000. Includes hospital-grade breast pumps when ordered by a *physician*.

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE continued				
Cologuard	100%, *deductible* waived			
Contraceptive Services	100%, *deductible* waived	100%, *deductible* waived	Not Covered	Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion. When preventive and diagnostic services occur during the same visit, the diagnostic benefit cost will apply. **Benefit Limitations:** Sterilization services are available to male and female *plan participants;* other contraceptive services are available to all female *plan participants*.

Refer to the Medical Benefits section, Medical Plan Exclusions subsection for additional information relating to excluded services.

O. Schedule of Behavioral Benefits – Standard Plan Option

The *deductible* and *out-of-pocket limit* are combined with the medical and prescription drug plans.

	MAGELLAN HEALTH PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
MENTAL DISORDERS & SUBSTANCE USE DISORDERS			
Inpatient and Partial Hospitalization/Emergency Admissions	85% after *deductible*	Not Covered	***Pre-certification* is required.**
Intensive Outpatient	$20 *co-payment*, *deductible* waived	Not Covered	Includes Transcranial Magnetic Stimulation (TMS). ***Pre-certification* is required.**
Outpatient Therapy with PsyD, PhD, MD, Social Worker, or Mental Health/Substance Use DisordersCounselor	$20 *co-payment*, *deductible* waived	Not Covered	Includes group, individual, family, and medication evaluation counseling.
Residential Treatment	85% after *deductible*	Not Covered	***Pre-certification* is required.**
Applied Behavioral Analysis (ABA) Therapy	$20 co-payment, *deductible* waived	Not Covered	***Pre-certification* is required.**

P. Schedule of Dialysis Benefits – Standard Plan Option

COVERED SERVICES	ALL PROVIDERS	SPECIAL COMMENTS
DIALYSIS, OUTPATIENT		
Dialysis, Outpatient	75%, *deductible* waived	The following *outpatient dialysis* services will be considered at 125% of the *Medicare* rate, and then *Plan* benefits will apply: • facility and professional charges from *outpatient hospitals* and dialysis facilities • home dialysis charges Refer to the **Dialysis Services** section for a further description and limitations of this benefit. ***Pre-certification* is required.**

Q. Schedule of Prescription Drug Benefits – Standard Plan Option

The prescription drug benefits are separate from the medical benefits and are administered by OptumRx. Refer to the **Prescription Drug Benefits** section of this plan document for additional information on prescription drug coverage.

Prescription drug charges do not apply to the medical *deductible*.

Prescription drug charges apply to the medical *out-of-pocket limit*.

Benefits shown reflect what the *plan participant* will pay.

Retail Pharmacy Option (30-Day Supply)	**Retail Pharmacy Option** (31-90 Day Supply)	**Mail Order Pharmacy Option** (90-Day Supply)	**Retail90 with Walgreens** (90-Day Supply)
Generic Drugs **Tier 1** $15 *co-payment* **Formulary Brand and Single Source Generic Drugs** **Tier 2** 35% *co-insurance* $40 minimum $100 maximum **Non-Formulary Brand** **Tier 3** 60% *co-insurance* $125 minimum No maximum	**Generic Drugs** **Tier 1** $37.50 *co-payment* **Formulary Brand and Single Source Generic Drugs** **Tier 2** 35% *co-insurance* $100 minimum $250 maximum **Non-Formulary Brand** **Tier 3** 100% *co-insurance*	**Generic Drugs** **Tier 1** $37.50 *co-payment* **Formulary Brand and Single Source Generic Drugs** **Tier 2** 35% *co-insurance* $100 minimum $250 maximum **Non-Formulary Brand** **Tier 3** Not Covered	**Generic Drugs** **Tier 1** $37.50 *co-payment* **Formulary Brand and Single Source Generic Drugs** **Tier 2** 35% *co-insurance* $100 minimum $250 maximum **Non-Formulary Brand** **Tier 3** 100% *co-insurance*

Specialty Drugs Obtained Through OptumRx Specialty Pharmacy or HonorHealth Specialty Pharmacy (30-Day Supply)	**Specialty Drugs NOT Obtained Through OptumRx Specialty Pharmacy or HonorHealth Specialty Pharmacy**
30% *co-insurance* $60 minimum $150 maximum	Not Covered

Certain *preventive care prescription drugs* received by a *network pharmacy* are covered at 100% and the *deductible*/*co-payment*/*co-insurance* (if applicable) is waived. Your pharmacy benefit plan includes special coverage for preventive medications. These medications help protect against or manage medical conditions such as diabetes, hypertension, asthma, and depression.

Please refer to the following websites for information on the types of payable *preventive care prescription drugs*:
https://www.healthcare.gov/coverage/preventive-care-benefits/ or
http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

Walgreens Retail 90 Program: 90-day maintenance medications will only be covered when filled at Walgreens retail pharmacy or OptumRx Mail Order. Maintenance medications are those you take regularly.

High Cost Drug Utilization Program (HCDUP): The HCDUP is a program that allows Medical Management to identify high-cost drugs prescribed through the plan so our care management team can review *medical necessity* of the medication to ensure *plan participants* are receiving appropriate, safe, and effective drugs at a lower cost. This program is set up for all *employees* and *dependents* of HonorHealth who use our insurance benefits for select high-cost medications.

The program has two (2) parts that need to be completed. First, your specialist will need to request a prior authorization review of your medication from the Medical Management team. Next, you will need to schedule a free video visit with the provider that works with the HonorHealth Specialty pharmacy. Once you complete the video visit and the prior authorization is approved, your prescription will be sent to HonorHealth Specialty pharmacy to be filled. The video visit is a face-to-face visit that is done on your cell phone, laptop, or computer. There is no cost involved for this face-to-face visit. Before the free video visit can take place, our staff at HonorHealth must obtain the office notes, prior authorization form, and lab work from your specialist.

If you have any questions or need additional clarification on what is required of you and your prescribing provider, call the Plan representative at 1-602-674-6222.

Claims for reimbursement of *prescription drugs* are to be submitted to OptumRx at:

OptumRx
Attn: Claims

P.O. Box 29044
Hot Springs, AR 71903

NOTE: For a complete list of covered drugs and supplies, and applicable limitations and exclusions, please refer to the OptumRx Drug Coverage List, which is incorporated by reference and is available from your *employer* or OptumRx at 1-844-368-9854 or **www.optumrx.com**.

R. High Deductible Health Plan (HDHP)

A qualified *high deductible health plan (HDHP)* with a *health savings account (HSA)* provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help build savings for future medical expenses. The *Plan* gives you greater control over how health care benefits are used. An *HDHP* satisfies certain statutory requirements with respect to minimum *deductibles* and *out-of-pocket limits* for both individual and family coverage. These minimum *deductibles* and maximum *out-of-pocket limits* are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

How This Plan Works

This *Plan* features higher annual *deductibles* and *out-of-pocket limits* than other traditional health plans. With the exception *of preventive care*, you must meet the annual *deductible* before the *Plan* pays benefits. It is called a *high deductible health plan* or *HDHP*.

It is paired with a *health savings account (HSA)*. You may elect to make pre-tax contributions from your paycheck to your *HSA* each pay period. The *HDHP* provides medical and *prescription drug* coverage, and the *HSA* provides a tax-free way to help you save for health expenses in retirement. The *HDHP* gives you flexibility and discretion to determine how to use your health care benefits.

You can pay your *deductible* with funds from your *HSA*, or you can choose to pay your *deductible* out-of-pocket, allowing your *health savings account* to grow. **Preventive care services are not subject to the deductible. These benefits are paid at 100%.**

Applying Expenses to the Deductible

If you have not met your *deductible*, you will be responsible for 100% of the *allowed amount* for your health care expenses. If you use a *network* provider, the provider will submit the *claim* to the *Third Party Administrator* on your behalf. If you use a *non-network* provider, your *physician* may ask you to pay for the services provided before you leave the office. In that case, you must submit your *claim* to the *Third Party Administrator* to ensure your expenses are applied to the *deductible*. You will subsequently receive an *Explanation of Benefits* from the *Third Party Administrator* stating how much the negotiated payment amount is and the amount you are responsible for.

S. Requirements for a Health Savings Account (HSA)

To be eligible for enrollment in a *health saving account*, you must:

1. be enrolled in a qualified *HDHP*
2. in general,not have any other non-HDHP medical coverage including coverage under a health flexible spending account or health reimbursement account

   You are allowed to have auto, dental, vision, disability, and long-term care insurance at the same time as an *HDHP*.
3. not be enrolled in a general purpose health care flexible spending account (and your *spouse* may not be enrolled in a general purpose flexible spending account)
4. not be enrolled in *Medicare*
5. not be claimed as a *dependent* on someone else's tax return

Qualified Medical Expenses

A partial list is provided in IRS Publication 502, available at **www.irs.gov**.

T. Schedule of Medical Benefits – Health Savings Account Plan (HDHP) Option

	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS
Deductible, per Calendar Year The *network* and *non-network deductible* amounts do not accumulate towards each other. Behavioral services and *outpatient* prescription drug expenses apply to the *deductible*. Non-covered charges do not apply to the *deductible*.			
Per *plan participant*	$2,800		$3,600
Per *family unit*	$5,600		$7,200
Family Unit - Embedded Deductible If you are enrolled in the family option, your plan contains two (2) components: an individual *deductible* and a *family unit deductible*. Having two (2) components to the *deductible* allows for each member of your *family unit* the opportunity to have your *Plan* cover medical expenses prior to the entire dollar amount of the *family unit deductible* being met. The individual *deductible* is embedded in the family *deductible*. When enrolled in family coverage, each individual must meet $2,800 of their own deductible expenses as required by the IRS before benefits will apply for that *plan participant* (unless the combined total deductible expenses paid by all family members has satisfied the overall family deductible). **For example,** if you, your spouse, and child are on a family plan with a $5,200 *family unit* embedded *deductible*, and the individual *deductible* is $2,800, and your child *incurs* $2,800 in medical bills, his/her *deductible* is met, and your *Plan* will help pay subsequent medical bills for that child during the remainder of the *calendar year*, even though the *family unit deductible* of $5,200 has not been met yet.			
Maximum Out-of-Pocket Limit, per Calendar Year The *out-of-pocket limit* includes *co-payments, co-insurance, deductibles,* and covered *prescription drug* charges. The *network* and *non-network out-of-pocket limits* do not accumulate towards each other.			
Per *plan participant*	$6,450		Unlimited
Per *family unit*	$12,900		Unlimited
Family Unit - Embedded Out-of-Pocket Limit If you are enrolled in the *family unit* option, your *Plan* contains two (2) components: an individual *out-of-pocket limit* and a *family unit out-of-pocket limit*. Having two (2) components to the *out-of-pocket limit* allows for each member of your *family unit* the opportunity to have his/her *covered charges* be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the *family unit out-of-pocket limit* being met. The individual *out-of-pocket limit* is embedded in the *family unit out-of-pocket limit*.			
The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached, at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise. **NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the *Plan*:** 1. premiums 2. cost containment penalties 3. charges in excess of the *Plan's* maximum benefits 4. amounts over *the maximum allowable charges* 5. charges not covered under the *Plan* 6. *balanced billed* charges 7. expenses for medical services or supplies obtained from *non-network* providers or facilities, except as noted in the plan document			

Health Savings Account (HSA)

The *Plan* will match your per pay period contributions up to $54.17 for individual coverage and $108.33 for *family unit* coverage into your HSA on your behalf if you are making contributions and enrolled in the HDHP option.

The per pay period contribution will be prorated to newly eligible participants, not to exceed the annual contribution amount set by IRS.

Contributions will cease once you no longer are enrolled in the HDHP option.

Benefits shown as *co-insurance* are listed for the percentage the *Plan* will pay.

Health Savings Account Plan (HDHP) Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
General Percentage Payment Rule	80% after *deductible*	70% after *deductible*	Not Covered	Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply.
FACILITY SERVICES				
Advanced Imaging (Outpatient Facility)	80% after *deductible*	50% after *deductible*	Not Covered	Includes: Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), discograms, myelograms, and PET scans, excluding services rendered in an emergency room setting. ***Pre-certification* is required for MRI/MRA and PET scans.**
Blood Transfusions (Outpatient)	80% after *deductible*	70% after *deductible*	Not Covered	
Diagnostic Testing (Outpatient Facility)	80% after *deductible*	80% after *deductible*	Not Covered	Facility fees associated with *diagnostic testing* such as (but not limited to): • EKG/EEG • Stress Test • Peripheral Vascular Test
Emergency Room	80% after *deductible*			*Non-network* emergency room care will apply toward the annual *out-of-pocket limit*.
Inpatient Hospital				
Room and Board (Elective Admission)	80% after *deductible*	50% after *deductible*	Not Covered	Limited to the semi-private room rate when such semi-private room rate is available (other than intensive care units and private rooms at HonorHealth facilities). **Calendar Year Maximum:** One hundred twenty (120) days per *plan participant* for *inpatient* rehabilitation services. ***Pre-certification* is required.** **For maternity stays:** refer to the **Healthcare Management** section for criteria. **Observation room stays: *pre-certification* is required after seventy-two (72) hours.**
Room and Board (Emergency Admission)	80% after *deductible*	70% after *deductible*	70% after *deductible*	

Health Savings Account Plan (HDHP) Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
FACILITY SERVICES continued				
Laboratory Services (Outpatient Facility Fees)	80% after *deductible*	80% after *deductible*	Not Covered	
Maternity Facility Fees	80% after *deductible*	50% after *deductible*	Not Covered	
Outpatient Ambulatory Facility	80% after *deductible*	50% after *deductible*	Not Covered	Includes facility fees for *outpatient* surgery at a hospital. ***Pre-certification* is required** for *outpatient* surgical procedures (excluding *outpatient* office surgical procedures and colonoscopies).
Outpatient Hospital	80% after *deductible*	50% after *deductible*	Not Covered	Includes facility fees for biopsies, catheterization lab procedures, chemotherapy, radiation therapy, and infusion. ***Pre-certification* is required** for certain services.
Skilled Nursing Facility/ Extended Care	80% after *deductible*	70% after *deductible*	Not Covered	**Calendar Year Maximum:** One hundred twenty (120) days per *plan participant*. Long-term acute care and rehabilitation hospital services apply toward this maximum. ***Pre-certification* is required.**
Pre-Admission Testing	100% after *deductible*	50% after *deductible*	Not Covered	Includes laboratory tests and x-rays. Applies to facility and professional fees.
Sleep Study Facility Fees	80% after *deductible*	70% after *deductible*	Not Covered	
Urgent Care Facility	80% after *deductible*	80% after *deductible*	Not Covered	Coverage provided for hospital-based facilities, freestanding facilities, and walk-in clinics.
X-Rays and Ultrasounds (Outpatient Facility)	80% after *deductible*	80% after *deductible*	Not Covered	

Health Savings Account Plan (HDHP) Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES				
Acupuncture	75% after *deductible* up to $1,000, then *Plan* pays 10% All services combined			*Non-network deductible* and *coinsurance* applies to *in-network deductible* and *out-of-pocket*. $1,000 limit is combined for acupuncture and alternative care.
Allergy Services	80% after *deductible*	70% after *deductible*	Not Covered	
Alternative Care	75% after *deductible* up to $1,000, then *Plan* pays 10% All services combined			Alternative care includes chiropractic, biofeedback, and naturopathic services. Not all alternative healthcare services are covered. Refer to **Medical Benefits** section for more information. $1,000 limit is combined for acupuncture and alternative care.
Ambulance Service				
Initial Ambulance Transport	75% after *deductible*			
Inter-Facility Transport	100% after *deductible*			***Pre-certification* is required.**
Asthma Education Services	80% after *deductible*	Not Covered	Not Covered	Education services for individuals and parents of children diagnosed with asthma, only when ordered by a *physician*.
Corrective Appliances (Orthotics/Prosthetics)	80% after *deductible*	70% after *deductible*	Not Covered	Only mastectomy items (i.e. breast prosthetics and bras) purchased at Tina's Treasures are available under the HonorHealth coverage level. ***Pre-certification* is required for orthotics/prosthetics in excess of $2,000 purchase price per device.**
Diabetic Education	80% after *deductible*	Not Covered	Not Covered	
Diabetic Equipment	80% after *deductible*	80% after *deductible*	Not Covered	Includes continuous blood glucose monitor, insulin pump, and related supplies. Other coverage for diabetic equipment is provided by the **Prescription Drug Benefits**. ***Pre-certification* is required for insulin pumps in excess of $1,000.**
Durable Medical Equipment	75% after *deductible*	75% after *deductible*	Not Covered	***Pre-certification* is required for DME in excess of $1,000 purchase price.**
Genetic Testing and Counseling	75% after *deductible*	75% after *deductible*	Not Covered	***Pre-certification* is required for genetic testing.**
Hearing Aids	75% after *deductible* up to $2,000 per ear, then *Plan* pays 10%			**Benefit Maximum:** Maximum is per ear every three (3) years for hearing aids, hearing aid repairs, hearing aid batteries, and related supplies. *Non-network* hearing aid benefits accumulate to the *network out-of-pocket limit*.

Health Savings Account Plan (HDHP) Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES continued				
Home Health Care	80% after *deductible*	70% after *deductible*	Not Covered	Therapy provided in the home will apply to the Rehabilitation *calendar year* maximum. Home hospice services are covered under the Hospice benefit. ***Pre-certification* is required.**
Home Infusion	80% after *deductible*	70% after *deductible*	Not Covered	***Pre-certification* is required.**
Home Visits Rendered by Dispatch Health	Not Applicable	80% after *deductible*	Not Applicable	
Hospice Care				
Hospice Care	80% after *deductible*	80% after *deductible*	Not Covered	
Bereavement Counseling	80% after *deductible*	80% after *deductible*	Not Covered	
Infertility				
Primary Care Provider (PCP)	80% after *deductible*	70% after *deductible*	Not Covered	
Specialist	80% after *deductible*	70% after *deductible*	Not Covered	
Treatment	80% after *deductible*	70% after *deductible*	Not Covered	**Calendar Year Maximum:** $1,500 for infertility treatment per *plan participant*, then *Plan* pays 10%. *Calendar year* maximum does not apply to office visits. *Outpatient* prescription drugs for the treatment of infertility are limited to $25,000 per *plan participant* per lifetime.
Male Sterilization	100% after *deductible*	100% after *deductible*	Not Covered	
Maternity				
Pre-Natal and Post-Natal Care	100% after *deductible*	100% after *deductible*	Not Covered	*Dependent* child *pregnancy* is covered. First ultrasound is covered at 100% under the Maternity benefit. Subsequent ultrasounds will be payable at the applicable medical benefit if *medically necessary*.
Other Covered Physician and Healthcare Practitioner Services in an Office Setting	80%, after *deductible*	70%, after *deductible*	Not Covered	
Labor and Delivery	80% after *deductible*	70% after *deductible*	Not Covered	

Health Savings Account Plan (HDHP) Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES continued				
Medical Foods	80% after *deductible*	70% after *deductible*	Not Covered	
Medical Supplies	75% after *deductible*	75% after *deductible*	Not Covered	Refer to **Medical Benefits** section, Medical Supplies provision for more information.
Office Visit				
Primary Care Physician (PCP)	80% after *deductible*	70% after *deductible*	Not Covered	Includes virtual visits. Refer to the **Medical Network Information** section, Special Reimbursement Provisions subsection, Certain Provider Specialties provision for information regarding which providers are covered at the HonorHealth coverage level.
Specialist	80% after *deductible*	70% after *deductible*	Not Covered	
Other Covered Physician and Healthcare Practitioner Services	80% after *deductible*	70% after *deductible*	Not Covered	Includes all other covered services rendered by a *physician* or healthcare practitioner not otherwise described in the **Schedule of Benefits**. Refer to the **Medical Network Information** section, Special Reimbursement Provisions subsection, Certain Provider Specialties provision for information regarding which providers are covered at the HonorHealth coverage level.
Pain Management	80% after *deductible*	70% after *deductible*	Not Covered	***Pre-certification* is required.**
Pre-Admission Testing	80% after *deductible*	70% after deductible	Not Covered	Includes laboratory tests and x-rays.
Rehabilitation Therapy (Outpatient)				
Physical Therapy Occupational Therapy Speech Therapy	80% after *deductible*	80% after *deductible*	Not Covered	Multiple visits on the same day accumulate as one (1) visit toward the calendar year maximum. ***Pre-certification* is required** for speech therapy. ***Pre-certification* is required** for physical and occupational therapy in excess of twenty (20) visits combined.
Cardiac Rehabilitation Pulmonary Rehabilitation	80% after *deductible*	70% after *deductible*	Not Covered	**Calendar Year Maximum:** Twelve (12) weeks per therapy type per *plan participant*.

Health Savings Account Plan (HDHP) Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES continued				
Services Not Available at an HonorHealth and/or BCBSAZ Provider	Not Available	Not Available	70% after *deductible*	This provision is also known as a gap benefit. *Covered charges* not available at an HonorHealth and/or BCBSAZ provider will apply to the *out-of-pocket limit*. Services rendered by Medtronic/MiniMed when received from an HonorHealth facility will be considered under this benefit. PHCS *network* of *physicians* and *hospitals* is available when providers are outside of Arizona.
Wigs	80% after *deductible* up to $1,000, then *Plan* pays 10%	70% after *deductible* up to $1,000, then *Plan* pays 10%	Not Covered	Limited to the initial purchase of hair loss replacement toward a wig, toupee, or hairpiece if required as a result of an *illness* such as alopecia or cancer therapy. **Benefit Maximum:** Limited to one (1) wig per *plan participant* every three (3) years.

Health Savings Account Plan (HDHP) Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by a *network* provider at a Routine Wellness Care visit. For more information about preventive services please refer to the following websites: **https://www.healthcare.gov/coverage/preventive-care-benefits/** **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/** **Safe Harbor Services:** **https://www.irs.gov/pub/irs-drop/n-04-23.pdf** **https://www.irs.gov/pub/irs-drop/n-19-45.pdf**				
Routine Wellness Care	100%, *deductible* waived	100%, *deductible* waived	Not Covered	Services include routine physical exam, wellness labs and x-rays, immunizations, gynecological exam, pap smear, PSA test, 2D and 3D mammogram, colorectal cancer screening, blood work, bone density testing, and shingles vaccine. **Calendar Year Maximum:** One (1) routine exam per adult *plan participant*. This maximum does not include the well woman visit or colon cancer screening. Safe Harbor services performed at a wellness visit will be covered at the preventive level. Non-mandated diagnostic screenings performed at a wellness visit will first apply to the deductible. Administrative, school, and sports physicals are also included in the preventive benefit. Please refer to the **Medical Benefits** section, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.
Well-Child Care	100%, *deductible* waived	Pediatricians only: 100%, *deductible* waived	Not Covered	Coverage is provided for newborn and well-child visits for health exams and related testing. Includes immunizations per CDC recommendations.

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE continued				
BRCA Genetic Counseling and Testing	100%, *deductible* waived	100%, *deductible* waived	Not Covered	For BRCA testing and counseling not mandated under the Patient Protection and Affordable Care Act (PPACA), refer to Genetic Testing and Counseling Physician and Other Healthcare Practitioner Services row of this Schedule of Benefits.
Breastfeeding Counseling	100%, *deductible* waived	100%, *deductible* waived	Not Covered	Lactation support, counseling, and education.
Breastfeeding Pump and Supplies	100%, *deductible* waived	100%, *deductible* waived	Not Covered	**Benefit Maximum:** One (1) per pregnancy. ***Pre-certification* is required** for breast pumps in excess of $1,000. Includes hospital-grade breast pumps when ordered by a *physician*.
Cologuard	100%, *deductible* waived			
Contraceptive Services	100%, *deductible* waived	100%, *deductible* waived	Not Covered	Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion. When preventive and diagnostic services occur during the same visit, the diagnostic benefit cost will apply. **Benefit Limitations:** Contraceptive services are available to all female *plan participants*.

Refer to the Medical Benefits section, Medical Plan Exclusions subsection for additional information relating to excluded services.

U. Schedule of Behavioral Benefits – Health Savings Account Plan (HDHP) Option

The *deductible* and *out-of-pocket limit* are combined with the medical and prescription drug plans.

	MAGELLAN HEALTH PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
MENTAL DISORDERS & SUBSTANCE USE DISORDERS			
Inpatient and Partial Hospitalization/Emergency Admissions	80% after *deductible*	Not Covered	***Pre-certification* is required.**
Intensive Outpatient	80% after *deductible*	Not Covered	Includes Transcranial Magnetic Stimulation (TMS). ***Pre-certification* is required.**
Outpatient Therapy with PsyD, Social Worker, or Mental Health/Substance Use Disorders Counselor	80% after *deductible*	Not Covered	Includes group, individual, family, and medication evaluation counseling.
Outpatient Therapy with PhD or MD	80% after *deductible*	Not Covered	Includes group, individual, family, and medication evaluation counseling.
Residential Treatment	80% after *deductible*	Not Covered	***Pre-certification* is required.**
Applied Behavioral Analysis (ABA) Therapy	80% after *deductible*	Not Covered	***Pre-certification* is required.**

V. Schedule of Dialysis Benefits – Health Savings Account (HDHP) Plan Option

COVERED SERVICES	ALL PROVIDERS	SPECIAL COMMENTS
DIALYSIS, OUTPATIENT		
Dialysis, Outpatient	75% after *deductible*	The following *outpatient dialysis* services will be considered at 125% of the *Medicare* rate, and then *Plan* benefits will apply: • facility and professional charges from *outpatient hospitals* and dialysis facilities • home dialysis charges Refer to the **Dialysis Services** section for a further description and limitations of this benefit. ***Pre-certification* is required.**

W. Schedule of Prescription Drug Benefits – Health Savings Account Plan (HDHP) Option

The prescription drug benefits are separate from the medical benefits and are administered by OptumRx. Refer to the **Prescription Drug Benefits** section of this plan document for additional information on prescription drug coverage.

The *deductible* and *out-of-pocket limit* are combined with the medical and behavioral health plans.

Benefits shown reflect what the *plan participant* will pay.

Retail Pharmacy Option (30-Day Supply)	**Retail Pharmacy Option** (31-90 Day Supply)	**Mail Order Pharmacy Option** (90-Day Supply)	**Retail90 with Walgreens** (90-Day Supply)
Generic Drugs **Tier 1** $15 *co-payment* after *deductible* **Formulary Brand and Single Source Generic Drugs** **Tier 2** 35% *co-insurance* after *deductible* $40 minimum $100 maximum **Non-Formulary Brand** **Tier 3** 60% *co-insurance* after *deductible* $125 minimum No maximum	**Generic Drugs** **Tier 1** $37.50 *co-payment* after *deductible* **Formulary Brand and Single Source Generic Drugs** **Tier 2** 35% *co-insurance* after *deductible* $100 minimum $250 maximum **Non-Formulary Brand** **Tier 3** 100% *co-insurance* after *deductible*	**Generic Drugs** **Tier 1** $37.50 *co-payment* after *deductible* **Formulary Brand and Single Source Generic Drugs** **Tier 2** 35% *co-insurance* after *deductible* $100 minimum $250 maximum **Non-Formulary Brand** **Tier 3** Not Covered	**Generic Drugs** **Tier 1** $37.50 *co-payment* after *deductible* **Formulary Brand and Single Source Generic Drugs** **Tier 2** 35% *co-insurance* after *deductible* $100 minimum $250 maximum **Non-Formulary Brand** **Tier 3** 100% *co-insurance* after *deductible*

Specialty Drugs Obtained Through OptumRx Specialty Pharmacy or HonorHealth Specialty Pharmacy (30-Day Supply)	**Specialty Drugs NOT Obtained Through OptumRx Specialty Pharmacy or HonorHealth Specialty Pharmacy**
30% *co-insurance* after *deductible* $60 minimum $150 maximum	Not Covered

Certain *preventive care prescription drugs* received by a *network pharmacy* are covered at 100% and the *deductible*/*co-payment*/*co-insurance* (if applicable) is waived. Your pharmacy benefit plan includes special coverage for preventive medications. These medications help protect against or manage medical conditions such as diabetes, hypertension, asthma, and depression.

Please refer to the following websites for information on the types of payable *preventive care prescription drugs*: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**.

Walgreens Retail 90 Program: 90-day maintenance medications will only be covered when filled at Walgreens retail pharmacy or OptumRx Mail Order. Maintenance medications are those you take regularly.

High Cost Drug Utilization Program (HCDUP): The HCDUP is a program that allows Medical Management to identify high-cost drugs prescribed through the Plan so our care management team can review *medical necessity* of the medication to ensure *plan participants* are receiving appropriate, safe, and effective drugs at a lower cost. This program is set up for all *employees* and *dependents* of HonorHealth who use our insurance benefits for select high-cost medications.

The program has two (2) parts that need to be completed. First, your specialist will need to request a prior authorization review of your medication from the Medical Management team. Next, you will need to schedule a free video visit with the provider that works with the HonorHealth Specialty pharmacy. Once you complete the video visit and the prior authorization is approved, your prescription will be sent to HonorHealth Specialty pharmacy to be filled. The video visit is a face-to-face visit that is done on your cell phone, laptop, or computer. There is no cost involved for this face-to-face visit. Before the free video visit can take place, our staff at HonorHealth must obtain the office notes, prior authorization form, and lab work from your specialist.

If you have any questions or need additional clarification on what is required of you and your prescribing provider, call the Plan representative at 1-602-674-6222.

Claims for reimbursement of *prescription drugs* are to be submitted to OptumRx at:

OptumRx
Attn: Claims

P.O. Box 29044
Hot Springs, AR 71903

NOTE: For a complete list of covered drugs and supplies, and applicable limitations and exclusions, please refer to the OptumRx Drug Coverage List, which is incorporated by reference and is available from your *employer* or OptumRx at 1-844-368-9854 or **www.optumrx.com**.

SECTION VI—MEDICAL BENEFITS

Medical Benefits apply when *covered charges* are *incurred* for care of an *injury* or *illness* while a *plan participant* is covered for these benefits under the *Plan*.

A. Covered Medical Charges

Covered charges are the *maximum allowable charges* that are *incurred* for the following items of service and supply. These charges are subject to the benefit limits, exclusions, and other provisions of this *Plan*. A charge is *incurred* on the date that the service or supply is performed or furnished.

1. **3D Mammograms.**
2. **Acupuncture.** Expenses incurred for acupuncture, including coverage for acupuncture in lieu of anesthetic, and related office visit. *Covered charges* will be payable as shown in the Schedule of Medical Benefits.
3. **Adoptive Cell Therapy. *Pre-certification* is required.** Travel expenses are not covered.
4. **Advanced Imaging.** Charges for advanced imaging including: Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans. Charges include the readings of these medical tests/scans. ***Pre-certification* is required for MRI/MRA and PET scans.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
5. **Allergy Services.** Charges for allergy testing and the cost of the resultant serum preparation (antigen) and its administration, when ordered and rendered by a *physician*, or in the *physician's* office. Includes skin patch or blood tests such as Rast or Mast, rapid desensitization, and hyposensitization.
6. **Ambulance.** Benefits will be provided only for licensed ground, air, and water ambulance services used to transport you in the case of a *medical emergency* from the place where you are *injured* or stricken by *illness,* or for inter-facility transport to the nearest accredited general *hospital* with adequate facilities for treatment after the *plan participant* has been stabilized at a *non-network* emergency facility. Charges for services requested for a licensed ground, air, or water ambulance service, when the patient is not transported, will not be covered by the *Plan*. Services for chartered flights will not be covered by the *Plan*. ***Pre-certification* is required for non-emergency ambulance services.**
7. **Anesthetics.** Includes anesthetic, oxygen, intravenous injections/solutions, and the administration of these items.
8. **Autism Spectrum Disorder and Applied Behavior Analysis.** Benefits will be paid the same as any other *illness* for covered charges related to the assessment, diagnosis, and treatment, including *applied behavior analysis* of autism spectrum disorders. Treatment for autism spectrum disorders must be prescribed or ordered by a licensed physician or licensed psychologist.

   'Applied behavior analysis' means the use of behavior analytic methods and research findings to change socially important behaviors in meaningful ways.

   Autism spectrum disorders include the following neurobiological disorders: autistic disorder, Asperger's disorder, and atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time of diagnosis.

   Treatment for autism spectrum disorders shall be for treatments that are *medically necessary*, appropriate, effective, or efficient. Treatment for autism spectrum disorders shall include:

   a. evaluation and assessment services
   b. behavior training and behavior management and applied behavior analysis, including but not limited to, consultations, direct care, supervision, or treatment, or any combination thereof, provided by autism services providers
   c. habilitative or rehabilitative care, including but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies
   d. psychiatric care
   e. psychological care, including family counseling

f. therapeutic care

g. prescription drugs under the Prescription Drug Benefits

Benefits shall be subject to all *deductible*, *co-payment*, *co-insurance*, limitations, or any other provisions of the policy.

9. **Blood.** Non-replaced blood, blood plasma, blood derivatives, and their administration and processing. Blood transfusions and blood products and equipment for its administration. Expenses related to autologous blood donation are covered.
10. **Cardiac Rehabilitation.** Cardiac rehabilitation as deemed *medically necessary,* provided services are rendered in a *medical care facility* as defined by this *Plan.* Subject to the limitations stated in the applicable **Schedule of Benefits**.
11. **Cataract Surgery.** Services and supplies associated with cataract *surgery*. The initial purchase of eyeglasses or contact lenses following each *surgery* will be covered under the corrective appliances benefit. ***Pre-certification*** **is required for surgical procedures.**
12. **Chemotherapy/Radiation.** Radiation or chemotherapy and treatment with radioactive substances, including materials and services of technicians.
13. **Chiropractic**. Chiropractic services may also be performed by a D.O. or M.D. and apply to the alternative benefit level.
14. **Circumcision.** Circumcision for newborns from birth to twenty-eight (28) days. After twenty-eight (28) days, only *medically necessary* circumcisions will be covered.
15. **Clinical Trials.** This *Plan* will cover routine patient costs for a *qualified individual* participating in an *approved clinical trial* that is conducted in connection with the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is federally funded through a variety of entities or departments of the federal government, is conducted in connection with an *investigational* new drug application reviewed by the Food and Drug Administration, or is exempt from *investigational* new drug application requirements. Refer to the Medical Plan Exclusions subsection for a further description and limitations of this benefit. ***Pre-certification*** **is required.**
16. **Contraceptives.** All federally-approved contraceptive methods including injections, implants, devices, and associated *physician* charges are covered under the Preventive Care provision of this *Plan*. Self-administered contraceptives are covered under the **Prescription Drug Benefits** section of this *Plan*.
17. **Corrective Appliances (Orthotics/Prosthetics).** The initial purchase, fitting, and repair of standard model orthotic appliances such as braces, splints, or other appliances which required for support for an *injured* or deformed part of the body as a result of a disabling congenital condition or an *injury* or *illness*. The initial purchase of temporary and permanent artificial limbs, eyes, and breast prostheses, including service and repair of an artificial limb, eye, or breast prosthesis when the attending *physician* indicates *medical necessity* due to a change in the body condition, and the artificial limb or eye cannot be repaired or made serviceable.

    The following items will also be considered under the Corrective Appliances benefit:

    a. **Cochlear Implants.** Implantable hearing devices, including Cochlear implants and related surgical procedures. Benefits include aural therapy in connection with covered implantable hearing devices. Aural therapy applies to the Speech Therapy benefit level. See the Speech Therapy benefit in the Schedule of Benefits sub-section for any applicable benefit maximum.

    b. **Colostomy and Ostomy Supplies.** Includes urostomy supplies.

    c. **Cranial Helmets.** Initial purchase of cranial helmets.

    d. **Foot Orthotics.** Includes prescribed diabetic shoes and custom molded foot orthotics limited to one (1) pair of each per *calendar year* for adults and two (2) pairs per *calendar year* for children under age nineteen (19) when replacement is due to growth. Non-custom molded foot orthotics are not covered.

    e. **Glasses or Contacts.** The initial purchase of eyeglasses or contact lenses following cataract *surgery*.

    f. **Mastectomy Bras and Camisoles.** Limited to six (6) per *plan participant* per *calendar year*.

    g. **Temporomandibular Joint Syndrome (TMJ) Oral Devices.**

h. **Vascular Support Garments.** Anti-embolism or vascular support garments (jobst/compression stockings). Limited to four (4) units, or two (2) pair, per *plan participant* per *calendar year*.

The total rental fee will not exceed the purchase price of the corrective appliances. Benefits for repair or replacement of a corrective appliance due to normal use, adolescent growth, or pathological changes will be provided. Duplicate services are not covered. ***Pre-certification*** **is required when the purchase price is expected to exceed $2,000 per device.**

18. **Dental Injuries.** *Injury* to or care of the mouth, teeth, gums, and alveolar processes will be covered charges under this *Plan* only if that care is initiated within twelve (12) months following the injury and is for the following oral *surgical procedures*:

    a. *emergency* repair or replacement due to *injury* to teeth or jaw

    b. restoration of the jaw if damaged by an external object

    c. *surgery* needed to correct *accidental injuries* to the jaws, cheeks, lips, tongue, floor, and roof of the mouth

    NOTE: For the purposes of coverage under this *Plan*, an accident does not include any *injury* caused by biting or chewing. No charge will be covered under this *Plan* for dental and oral *surgical procedures* involving orthodontic care of teeth, periodontal *disease*, and preparing the mouth for fitting of or continued use of dentures.

19. **Developmental Delay.** Only covered as a direct result of an *injury*, *surgery*, or covered treatment (i.e. covered treatment for Down syndrome or autism spectrum disorder).

20. **Diabetic Education.** Services and supplies used in *outpatient* diabetes and pre-diabetes self-management programs are covered under this *Plan* when they are provided by a *physician*.

21. **Diabetic Equipment.** Diabetic equipment will be covered when *medically necessary*, including:

    a. continuous blood glucose monitor

    b. insulin pump and related supplies

    Pre-certification **is required for insulin pumps in excess of $1,000.**

    Glucometers are covered under the **Prescription Drugs Benefits**.

    Refer to the *Preventive Care* provision or visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of diabetic equipment and supplies related *preventive care* benefits.

22. **Diagnostic Testing.**

23. **Durable Medical Equipment.** Rental of standard model *durable medical equipment (DME)* if deemed *medically necessary*. The total rental fee for *durable medical equipment* will not exceed the purchase price of the equipment, based on the *maximum allowable charge*. If the purchase price is not available, rental is allowed for the *lifetime* of the equipment. Coverage is provided for delivery and set-up charges associated with the covered *durable medical equipment*. Education pertaining to use of *DME* is covered.

    Pre-certification **is required when the purchase price is expected to exceed $1,000.**

    Repair or replacement of purchased equipment if either:

    a. the replacement is needed because of a change in your physical condition

    b. it is likely to cost less to replace the item than to repair the existing item or rent a similar item

    Temporary rental equipment may be covered up to three (3) months while durable medical equipment is repaired. Maintenance and repairs needed due to misuse or abuse are not covered.

    The following item will be considered under the *DME* benefit:

    a. **Oxygen.** Oxygen and its administration, including oxygen concentrators. Oxygen concentrators are not subject to purchase price requirements.

    b. **Sleep Apnea Oral Devices.**

24. **Family History.** Charges related to services provided with a diagnosis of family history, including colonoscopies for *plan participants* with a family history of colon cancer.

25. **Foot Care.** Treatment for metabolic or peripheral-vascular *disease,* plantar fasciitis, neuromas, nail bed removal, or cutting/surgical procedures when *medically necessary* and not otherwise excluded.
26. **Gender.** Services will be considered under the applicable benefit level and limited as any other service outlined in the plan document. Services will not be limited based on an individual's documented gender.
27. **Gene Therapy.** Therapy that seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use. ***Pre-certification* is required.** Travel expenses are not covered.
28. **Genetic/Genomic Testing.** Genetic testing to identify the potential for, or existence of, a medical condition, as mandated by *PPACA*. Genomic testing to examine abnormalities in groups of genes to aid in designing specific treatment options for an individual's condition, such as cancer. Genetic testing and counseling is also covered in the following instances:
    a. for mutations associated with multifactorial diseases
    b. for fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis in covered pregnant women
    c. when provided to discuss the test results and implications of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis as described above

    ***Pre-certification* is required for genetic testing and related lab fees.** Refer to the **Federal Notices** section for the statements of rights under the Genetic Information Nondiscrimination Act of 2008 (GINA).
29. **Growth Hormones. *Pre-certification* is required.**
30. **Hearing Aids.** Charges for services or supplies in connection with hearing aids, including exams for their fitting, batteries, and related supplies. Hearing exams and implantable hearing devices do not accumulate under this benefit. Refer to the Corrective Appliances provisions for implantable hearing devices and Cochlear implants.
31. **Hearing Exams.**
32. **Home Health Care.** Charges for *home health care services and supplies* are covered only for care and treatment of an *illness* or *injury* when *hospital* or *skilled nursing facility* confinement would otherwise be required. The diagnosis, care, and treatment must be certified by the attending *physician* and be contained in a *home health care plan*. A home health care visit will be considered a periodic visit by a *physician*.

    ***Pre-certification* is required**. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
33. **Home Infusion Therapy. *Pre-certification* is required.**
34. **Home Visits.** When a provider visits the home for covered services, commonly known as a 'house call.' This is separate from home health care and therapy done in the home.
35. **Hospice Care.** Services must be rendered by a state-licensed *hospice care agency* and included in a written *hospice care plan* established and periodically reviewed by the attending *physician*. The *physician* must certify the *plan participant* is terminally *ill* and that *hospital* confinement would be required in the absence of the hospice care. The *hospice care plan* shall also describe the services and supplies for palliative care and *medically necessary* treatment to be provided to the *plan participant* by the *hospice care agency*. Benefits are provided for:
    a. medical supplies
    b. visits by a *physician*
    c. bereavement counseling services

        Services by a licensed social worker or a licensed pastoral counselor for the hospice patient's immediate family (covered spouse and/or other covered *dependents*).

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.
36. **Hospital Care.** The medical services and supplies furnished by a *hospital*, *ambulatory surgical facility*, or a *birthing center*. *Covered charges* for *room and board* will be payable as shown in the applicable

Schedule of Medical Benefits. ***Pre-certification*** **is required for inpatient admissions and observation stays after seventy-two (72) hours.**

a. *Room and board* charges made by an HonorHealth facility or a *hospital* having only private rooms will not be limited to the semi-private room rate when such semi-private room rate is available.

b. *Medically necessary* private rooms will not apply to the semi-private room rate.

c. Charges for *intensive care unit* or HonorHealth facility stays do not apply to the semi-private room rate.

d. Services for general anesthesia and related *hospital* or *ambulatory surgical center* services are covered for dental procedures if *medically necessary* and if any of the following conditions apply:

i. The *plan participant* is under age seven (7).

ii. The *plan participant* is disabled physically or developmentally and has a dental condition that cannot be safely and effectively treated in a dental office.

iii. The *plan participant* has a medical condition besides the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment were not done in a *hospital* or *ambulatory surgical center*.

This benefit does not cover the *dentist's* services.

37. **Impotence.** Care, treatment, services, supplies, and medication in connection with treatment for impotence or erectile dysfunction. Penile implants are only covered when performed at an HonorHealth facility and necessitated by an individual's cancer or *injury*.

38. **Infertility.** Evaluation, *diagnostic testing*, and treatment associated with infertility for the *employee*, spouse, or domestic partner, subject to the limitations shown in the **Schedule of Benefits**.

39. **Laboratory Studies.** *Covered charges* for diagnostic lab testing and services.

40. **Maternity.** *Pregnancy* and complications of *pregnancy* shall be covered as any other *illness* for the *employee* or spouse. *Dependent* child pregnancy is covered. Benefits include pre-and post-natal care, obstetrical delivery, caesarean section, miscarriage, and complications resulting from the *pregnancy*. Charges for a planned home birth will be considered a covered benefit.

When a provider submits a bill to the Plan with a global CPT code for the combination of pre/postnatal visits and delivery expenses, the Plan's Claims Administrator will process the claim applying no cost-sharing to 40% of the charges representing prenatal/postnatal expenses, and normal cost-sharing to 60% of the charges representing the delivery expenses.

NOTE: Breastfeeding support, supplies, and counseling are also available without cost sharing when services are received from a *network* provider. Any breast pump purchased at Essential Touch at the HonorHealth Shea location will be considered for reimbursement based on the billed charges, including sales tax. ***Pre-certification*** **is required for breast pumps in excess of $1,000.**

Refer to the Preventive Care provision or visit **https://www.healthcare.gov/coverage /preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/** for a current listing of required *pregnancy* related *preventive care* benefits. *Pregnancy* tests are not considered *preventive care* even when performed in conjunction with covered birth control services.

Delivery and hospitalization stay may be subject to *pre-certification* if over the standards set forth in the Newborns' and Mothers' Health Protection Act. Refer to the **Federal Notices** section for the statement of rights under the Newborns' and Mothers' Health Protection Act for certain protections mothers and newborns have regarding *hospital* stays.

41. **Medical Foods.** Medical foods are considered a *covered charge* if intravenous therapy (IV) or tube feedings are *medically necessary.* Enteral nutritional therapy is payable after meeting all of the following criteria:

a. The formula is the primary source of nutrition (60% or more of caloric nutritional intake)

b. Without enteral feedings, the individual would be unable to obtain sufficient nutrients to maintain an appropriate weight by dietary adjustment and/or oral supplements

c. The individual has one (1) of the following conditions that is expected to be permanent or of indefinite duration:

i. an anatomical or motility disorder of the gastrointestinal tract that prevents food from reaching the small bowel; disease of the small bowel that impairs absorption of an oral diet

ii. a central nervous or system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition

Coverage for a home enteral infusion pump and associated supplies are considered payable when the use of the pump is *medically necessary* because the individual cannot tolerate gravity or syringe feedings or requires a controlled rate of infusion of the enteral formula.

***Pre-certification* is required for medical foods administered orally, other than PKU.**

42. **Medical Supplies.** Charges for surgical dressings, splints, casts, and other devices used in the reduction of fractures and dislocations. Syringes and needles are covered for non-diabetic medical conditions. Also included are supplies and dressings when *medically necessary* for surgical wounds, cancer, burns, diabetic ulcers, catheters, and surgical and orthopedic braces, unless covered under the **Prescription Drug Benefits** section.

Refer to the *Preventive Care* provision or visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of medical supplies related *preventive care* benefits.

43. **Mental Disorders and Substance Use Disorders.** Coverage for mental health treatments are considered the same as benefits provided for other medical conditions. *Inpatient* and *outpatient* treatment for *mental disorders* will be eligible when rendered by a *physician*, licensed psychiatrist, or licensed psychologist, or when rendered by *behavioral health practitioner*. Includes bereavement counseling beyond that which is included as part of the *Plan's* hospice benefit. Coverage is provided for family counseling, marital counseling, and group counseling. Includes partial hospitalization. *Covered charges* will be payable as shown in the applicable Schedule of Behavioral Benefits.

***Pre-certification* is required for inpatient admissions.**

Note: Professional fees for behavioral services performed in an emergency room will process through the medical benefits rather than the behavioral health benefits.

Refer to the **Federal Notices** section for the statement of rights under the *Mental Health Parity and Addiction Equity Act of 2008*.

44. **Midwife Services.** Benefits for midwife services performed by a certified nurse midwife (CNM) who is licensed as such and acting within the scope of his/her license. This *Plan* will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries. Please see Maternity benefit for home birth coverage.

45. **National Health Emergency.** In the event of a declared National Health Emergency, the *Plan* will offer coverage as mandated for the condition(s) as outlined in the National Health Emergency, as required by federal regulation. This provision shall override any potentially conflicting, specific exclusions, defined terms, or other *Plan* provisions as necessary to provide, and limited to, any mandated services as outlined in the public health emergency, and corresponding regulation(s). Such coverage shall remain in effect until the public health emergency, as declared by the governing federal agency, has ended.

46. **Neuropsychological Testing.** Tests used to evaluate patients who have experienced a traumatic brain injury, brain damage, or organic neurological problems (e.g., dementia). May also be used to evaluate the progress of a patient who has undergone treatment or rehabilitation for a neurological *injury* or *illness*.

47. **Oral Surgery.** Care of the mouth, teeth, gums, and alveolar processes will be covered as any other *illness* under this *Plan* only if that care is for the following oral *surgical procedures*:

a. excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth

b. excision of benign bony growths of the jaw and hard palate

c. incision of sensory sinuses, salivary glands, or ducts

d. removal of bony impacted teeth

e. reduction of dislocations and excision of temporomandibular joints (TMJ)

f. external incision and drainage of cellulitis

g. removal of all teeth at an inpatient or outpatient hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the *plan participant* can undergo radiation therapy for a covered medical condition

h. organ transplant preparation

NOTE: No charge will be covered under this *Plan* for dental and oral *surgical procedures* involving orthodontic care of teeth, periodontal *disease,* and preparing the mouth for fitting of or continued use of dentures.

***Pre-certification* is required for surgical procedures.**

48. **Orthognathic Surgery/LeFort Procedures.** Expenses for *medically necessary* orthognathic services/surgery for the 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.

49. **Physician Care.** The professional services of a *physician* for medical services. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's *maximum allowable charge*. Certified surgical assistants are covered if the use of an assistant surgeon was *medically necessary* to a max of 20% of the eligible expenses covered to the primary surgeon.

    Charges for **multiple surgical procedures** will be a *covered charge* subject to the following provisions:

    a. If bilateral or multiple *surgical procedures* are performed by one (1) surgeon, benefits will be determined based on the *maximum allowable charge* that is allowed for the primary procedures; 50% of the *maximum allowable charge* will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered incidental, and no benefits will be provided for such procedures.

    b. If multiple unrelated *surgical procedures* are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the *maximum allowable charge* for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the *maximum allowable charge* allowed for that procedure.

    c. If a co-surgeon is required, meaning skills of both surgeons are necessary to perform distinct parts of a specific operative procedure, payment is based for each physician on the lower of the billed amount or 125% of the global fee, dividing the payment equally between the two (2) surgeons. *Surgeries* performed by co-surgeons that have the same specialty are not covered under the *Plan,* unless *medically necessary*.

    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.

50. **Pre-Admission Testing.** Includes diagnostic labs, x-rays, and EKGs that you obtain on an *outpatient* basis prior to your scheduled admission to the *hospital*. However, you should make sure your *hospital* will accept the results of these tests and not simply repeat them.

51. **Preventive Care.** Benefits will be provided for *preventive care,* including, but not limited to:

    a. **Immunizations.** Pediatric and adult preventive vaccinations, inoculations, and immunizations, per Centers for Disease Control and Prevention (CDC) guidelines, including, but not limited to:

        i. **HPV Vaccine.** For male and female *plan participants* ages nine (9) through forty-five (45).

        ii. **Influenza Vaccine.**

        iii. **Shingles Vaccine.**

        The *Plan* contributes to at least one (1) state-funded vaccination program, which covers the provider's costs associated with immunization serum for eligible, minor children up to the age of nineteen (19). Should a provider bill a vaccine charge for a child who is covered by that state's immunization program, regardless of their eligibility under the *Plan*, the *Plan* will consider its financial obligation of that *claim* satisfied through its contribution to the state

funded immunization program and will not remit payment for that *claim*, except as may be required by applicable federal law. The administration of immunizations is covered.

b. **Adult Physical Examination, Well-Baby, and Well-Child Examinations.**

c. **Preventive Lab and X-Ray.** Laboratory and x-ray services related to routine examinations.

d. **Gynecological Exam.** Coverage is provided for one (1) annual gynecological exam and cervical cancer screening Pap smear lab test and related diagnostic cultures and blood work for *plan participants* ages twenty-one (21) through sixty-five (65).

e. **Prostate Specific Antigen Test.** Annual Prostatic Specific Antigen (PSA) prostate cancer screening blood test and exam.

f. **Colonoscopy or Cologuard Test.** Coverage is provided for one (1) screening colonoscopy, including related pre-operative exam, or Cologuard test, every five (5) years for individuals age forty-five (45) and up. *Plan participants* must contact OptumRx for a list of covered bowel preparation products that are covered under this provision.

g. **Mammogram.** Coverage is provided for one (1) baseline breast cancer screening mammogram and interpretation of it, for *plan participants* up to age thirty-nine (39), then one (1) annually for *plan participants* age forty (40) or older. Additional mammograms that are *medically necessary* because of the patient's condition are covered subject to the *Plan's deductibles*, *co-insurance*, or *co-payments* and all other *Plan* provisions.

h. **Contraceptives.** Injections, implants, devices, and associated *physician* charges are covered under the Medical Benefits of this *Plan*. Self-administered contraceptives are covered under the Prescription Drug Benefits.

i. **Bone Density Screening.** Annual screening for *plan participants* age sixty (60) or older.

j. **Breast Cancer Screening.** BRCA1 or BRCA2 genetic test and counseling for routine breast cancer susceptibility gene. BRCA1 or BRCA2 is covered for women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes. Must be prescribed by a *physician* or genetic counselor. BRCA counseling is limited to an HonorHealth facility.

k. **Sterilization.** Services for vasectomy, tubal ligation, or other voluntary sterilization procedures for *plan participants* are covered. Vasectomy is subject to the *deductible* under the *HDHP*.

NOTE: Additional *preventive care* shall be covered as required by applicable law if provided by a *network* provider. A current listing of required *preventive care* can be accessed at the following websites:

a. **https://www.healthcare.gov/coverage/preventive-care-benefits/**

b. **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**

c. **https://www.irs.gov/pub/irs-drop/n-04-23.pdf**

d. **https://www.irs.gov/pub/irs-drop/n-19-45.pdf**

52. **Pulmonary Rehabilitation.** Pulmonary rehabilitation is available to *plan participants* with a chronic respiratory disorder, such as asthma or emphysema, 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.

53. **Reconstructive Surgery.** Reconstructive *surgery* expenses are covered in the following circumstances:

    a. when needed to correct functional damage caused by a birth defect resulting in the malformation or absence of a body part

    b. to correct damage caused by an *accidental injury*

    c. for breast reconstruction following a total or partial *mastectomy*, as follows:

        i. reconstruction of the breast on which the *mastectomy* has been performed

        ii. *surgery* and reconstruction of the other breast to produce a symmetrical appearance

        iii. prosthesis and treatment of physical complications of all stages of *mastectomy*, including lymphedemas

All other reconstructive *surgeries* will be covered under the *Plan* when *medically necessary*.

***Pre-certification* is required.**

Refer to the **Federal Notices** section for the statement of rights to *surgery* and prostheses following a covered *mastectomy* under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

Removal or replacement of a ruptured breast implant is not covered if the original purpose of the implant was for cosmetic purposes, not post-mastectomy purposes.

54. **Rehabilitation Services.** Services include physical therapy, occupational therapy, and speech therapy rendered on an *inpatient* or *outpatient* basis. Maintenance rehabilitation is not covered. Therapy in the home applies to the *outpatient* rehabilitation therapy maximum. Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.
    a. **Occupational Therapy**. Therapy must result from an *injury* or *illness* and improve a body function. *Covered charges* do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.
    b. **Physical Therapy**. The therapy must be for conditions which are subject to significant improvement through short-term therapy. Services include aquatic therapy. Physical therapy services from a network chiropractor do not require a *physician* order and apply to the rehabilitation therapy benefit. Wound debridement services do not apply toward the Rehabilitation Therapy maximum.
    c. **Speech Therapy**. Therapy must follow either:
        i. *surgery* for correction of a congenital condition of the oral cavity, throat, or nasal complex (other than a frenectomy) of a person
        ii. an *injury*
        iii. an *illness* that is other than a learning or *mental disorder*
        iv. *surgery* for a covered implantable hearing device
        v. diagnosis of Down syndrome and/or autism spectrum disorders

    ***Pre-certification* is required for speech therapy. *Pre-certification* is required for occupational and physical therapy in excess of twenty (20) combined visits per calendar year.**
55. **Residential Treatment Facilities. *Pre-certification* is required.**
56. **Routine Newborn Care.** Routine well-baby care is care while the newborn is hospital-confined after birth and includes *room and board* and other normal care for which a *hospital* makes a charge
    a. This coverage is only provided if the newborn child is an eligible *dependent* and a parent either:
        i. is a *plan participant* who was covered under the *Plan* at the time of the birth
        ii. enrolls himself/herself (as well as the newborn child if required) in accordance with the Special Enrollment Period provisions with coverage effective as of the date of birth
    b. The benefit is limited to *allowable charges* for well-baby care after birth while the newborn child is *hospital* confined as a result of the child's birth.
    c. Charges for covered routine newborn care will be applied toward the *Plan* of the mother.
57. **Second Surgical Opinion.** If your doctor recommends *surgery* or other medical treatment, it is often in your best interest to obtain a second opinion with a specialist regarding the necessity of the procedure. In many cases an alternative method of treatment is available that would save yourself the discomfort of *surgery* or other medical treatment as well as the time and extra expenses.
58. **Skilled Nursing Facility.** The *room and board* and nursing care furnished by a *skilled nursing facility* will be payable if and when:
    a. The patient is confined as a bed patient in the facility.
    b. The attending *physician* certifies that the confinement is needed for further care of the condition that caused the *hospital* confinement.

c. The attending *physician* completes a treatment plan which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the *skilled nursing facility*.

***Pre-certification* is required for inpatient admissions.** *Covered charges* will be payable as shown in the Schedule of Medical Benefits.

59. **Sleep Disorders/Sleep Studies.** Care and treatment for sleep disorders, including sleep studies performed in the home.

60. **Surgery.** Benefits for the treatment of *illnesses* and *injuries,* including fractures and dislocations, are covered for the surgeon, assistant surgeon, anesthesiologist, and surgical supplies. Prophylactic surgery is also covered. ***Pre-certification* is required for outpatient surgical procedures (excluding outpatient office surgical procedures and colonoscopies).**

61. **Temporomandibular Joint Syndrome (TMJ).** Benefits for medical or dental services for treatment of temporomandibular joint disorders will be covered as any other illness.

62. **Testosterone Treatment.** Testosterone treatment for males. Testosterone treatment for women will also be covered for menopause. ***Pre-certification* is required.**

63. **Transplants.** The Transplant Program provides access to a *network* of transplant centers that perform many transplants each year and have historically high success rates. They are often affiliated with renowned teaching and research facilities with access to experienced surgeons and advanced medical techniques. Using a *hospital* with transplant experience can result in shorter *hospital* stays, fewer complications, and fewer repeat transplants.

    Under the Transplant Program, the *Plan* reimburses you for covered services and supplies arising out of, and specifically limited to, the following human organ and tissue transplants for a *plan participant* recipient:

    a. bone marrow*
    b. cornea
    c. double lung
    d. heart
    e. heart/lung
    f. intestine
    g. kidney
    h. kidney/liver
    i. kidney/pancreas
    j. liver
    k. pancreas

    *NOTE: Bone marrow transplants must be performed at an HonorHealth facility. All other transplants are considered under the Services Not Available at HonorHealth benefit.

    When the donor of an organ or tissue who is covered by this *Plan* and donates to an individual whose transplant is covered under this *Plan*, donor expenses are covered without any *deductibles*, *co-payments*, or *co-insurance* applicable to those expenses. These donor expenses apply toward the transplant recipient's annual *out-of-pocket limit*. When the donor of an organ or tissue is not a *plan participant*, the donor's *hospital*, surgical, and medical expenses will be eligible on the basis of a *claim* made by the *plan participant,* without *deductibles, co-payments*, or *co-insurance*, but only to the extent the donor is not covered by his or her own insurance or healthcare plan. For the *HDHP* option, donor expenses (both when the donor is a *plan* participant and when the donor is not a *plan participant*) are covered without any *co-payments* or *co-insurance* only after the *deductible* has been met.

    Medical and surgical treatment or devices related to transplantation that are *experimental*, *investigational,* or unproven are those not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use, subject to review and approval by any institutional Review Board for the proposed use; or non-demonstrative through prevailing peer-reviewed medical literature to be efficacious for the treatment of the *disease* state at the time of the request. The *Plan* reserves the right to make final judgment regarding coverage of *experimental*, *investigational,* and unproven

procedures and treatments. *Medically necessary* means those transplant-related services which are determined by the *Plan* to be medically appropriate for the diagnosis and clinical status of the *plan participants* and their *dependents*, rendered in an appropriate setting, and of demonstrated medical value. The fact that a *physician* has performed or prescribed a transplant-related service, or the fact that it may be the only treatment for a *disease* does not mean that is *medically necessary*.

Transplant-related services and supplies are covered when they are related to transplantation when recommended by a *physician*, provided at or arranged by a transplant *hospital*, and determined to be *medically necessary*. Such services and supplies include but are not limited to *hospital* charges, *physician* charges, organ acquisition charges, tissue typing donor search charges, and ancillary services.

The Transplant Program provides the following benefits:

a. access to a transplant network, BlueCross BlueShield of Arizona facilities, Mayo Clinics, or *network* providers

b. services of a transplant case manager, who will coordinate services and savings

c. organ or tissue testing, procurement, and acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor

Transplant benefits under the *Plan* are only available when a *plan participant* fully utilizes a Transplant Network, BlueCross BlueShield of Arizona facility, Mayo Clinic, or *network* provider and meets all of the following requirements:

a. Pre-notification of the upcoming transplant **must** be given by the *plan participant* or the *plan participant's physician* as soon as the *plan participant* is identified as a potential transplant candidate.

b. *Pre-certification* **must** be obtained as outlined in the **Health Care Management Program** section.

c. All transplant services must be rendered at a transplant center facility.

If these requirements are not met, transplant benefits are not available under the Plan.

***Pre-certification* is required** for transplants and pre-transplant workup tests. Refer to the Medical Plan Exclusions subsection for exclusions pertaining to transplant services.

64. **Virtual Visits.** When performed for an otherwise covered service.
65. **Vision Refraction Exam.** Covered only in conjunction with a medical diagnosis.
66. **Vitamin B12 Injections.** Covered for the following reasons or as *medically necessary*:
    a. vitamin B12 deficiency anemia due to intrinsic factor deficiency
    b. vitamin B12 deficiency anemia due to selective vitamin B12 malabsorption with proteinuria
    c. transcobalamin II deficiency
    d. other vitamin B12 deficiency anemias
    e. Vitamin B12 deficiency anemia, unspecified
67. **Weight Management.** Coverage is limited to employees and their spouse/partner only. The benefit includes bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery for the treatment of obesity/morbid obesity along with physician office visits, psychiatric testing, hospital services, and lab tests. Services and procedures are limited to one (1) per lifetime and must be performed in the HonorHealth Bariatric Center. Charges for adjustment procedures do not apply toward this maximum. Non-surgical services and counseling required prior to surgery are also covered. ***Pre-certification* is required for surgical services.**
68. **Wigs.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
69. **X-Rays.** Diagnostic x-rays.

B. Medical Plan Exclusions

The following list is intended to give you a general description of expenses for services and supplies that are not covered by the *Plan*. Items that are not listed as excluded may be considered based on *medical necessity*, standard of care, and medical appropriateness. This list is not exhaustive.

NOTE: All exclusions related to prescription drugs are shown in the Prescription Drug Benefits section.

1. **Abortion.** Services, supplies, care, or treatment in connection with an abortion unless the life of the mother is endangered by the continued *pregnancy* or the *pregnancy* is the result of rape or incest.
2. **Alcohol.** Services, supplies, care, or treatment to a *plan participant* for an *injury* or *illness* arising from taking part in any activity made illegal due to the use of alcohol. Expenses will be covered for *injured plan participants* other than the person partaking in any activity made illegal due to the use of alcohol, and expenses may be covered for *substance use disorders* treatment as specified in this *Plan*, if applicable.
3. **Alternative Medicine.** Hypnotherapy, hypnosis, electro-hypnosis, and thermography, including drugs. Expenses for prayer, religious healing, or spiritual healing, including services provided by a Christian Science Practitioner.
4. **Armed Forces.** Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any *plan participant* in the armed forces of a government.
5. **Athletic Training.**
6. **Autopsy.** Expenses for an autopsy and any related expenses, except as required by the *Plan Administrator* or its designee.
7. **Behavioral Modification.** Diagnosis and treatment of behavioral problems, learning disabilities, dyslexia, and vocational disabilities; behavior modification, sensitivity training; special education, behavioral counseling, therapy, or care for learning deficiencies or behavioral problems, whether or not associated with a manifest *mental disorder* or other disturbances.
8. **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.
9. **Clinical Trials.** The following items are excluded from *approved clinical trial* coverage under this *Plan*:
    a. the *investigational* item, device, or service, itself
    b. items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the patient
    c. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

    If one (1) or more participating providers do participate in the *approved clinical trial,* the qualified *plan participant* must participate in the *approved clinical trial* through a participating, *network* provider, if the provider will accept the *plan participant* into the trial.

    The *Plan* does not cover routine patient care services that are provided outside of this *Plan's* health care provider *network* unless *non-network* benefits are otherwise provided under this *Plan*.
10. **Complications from a Non-Covered Service.** Care, services, or treatment required as a result of complications from a treatment not covered under the *Plan*, including complications arising from bariatric surgery, unless the original surgery took place at HonorHealth Bariatric Center after January 1, 2011.
11. **Cord Blood.** Harvesting and storage of umbilical cord blood.
12. **Cosmetic.** Cosmetic or reconstructive procedures and attendant hospitalization, except for newborn children or due to trauma or *disease*, done for aesthetic purposes and not to restore an impaired function of the body. Cosmetic procedures will not be covered regardless of the fact that the lack of correction causes emotional or psychological effects. Complications or subsequent *surgery* related in any way to any previous cosmetic procedure shall not be covered, regardless of *medical necessity*.
13. **Counseling.** Benefits for counseling in the absence of *illness* or *injury*, including, but not limited to, premarital or marital counseling; education, social, behavioral, or recreational therapy; sex or interpersonal relationship counseling; or counseling with *plan participant's* friends, *employer*, school counselor, or school teacher.

14. **Court-Ordered Treatment.** Any treatment of a *plan participant* in a public or private institution as the result of a court order. This exclusion does not apply to *mental health or substance use disorder holds*, as they are not court-ordered treatments.
15. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, or *custodial care*, regardless of where they are provided, except as part of a covered hospice program or during covered hospitalization. Expenses for occupational therapy (orthotic) supplies and devices needed to assist a person in performing activities of daily living including self-help devices such as feeding utensils, reaching tools, and devices to assist in dressing and undressing.
16. **Dental Care.** Normal dental care benefits, including any dental, or gum treatments, except as otherwise specifically provided herein. Expenses for dental prosthetics, dental implants, gingivectomy, treatment of dental abscess, root canal (endodontic) therapy 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.
17. **Developmental Delay.** Testing, office visits, habilitation therapy, and consultations for developmental delay, unless specifically covered herein.
18. **Dialysis, Outpatient .** Refer to the **Outpatient Dialysis Services** section for coverage.
19. **Educational or Vocational Testing.** Except as may otherwise be expressly provided in the **Schedule of Benefits** for certain educational services, the following expenses are not covered by the *Plan*, even if they are required because of an injury, illness, or disability of a *plan participant*: educational or vocational services, supplies, testing, or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aids, vision therapy, auditory aides, speech aids, devices/programs for behavioral intervention or *developmental delays* or to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education, and associated costs in conjunction with sign language education for a patient or family members. Educational services such as nutrition therapy, asthma self-management education, and Lamaze, except as listed herein.
20. **Employer-Provided Services.** Expenses for services rendered through a medical department, clinic, or similar facility provided or maintained by HonorHealth or if benefits are otherwise provided under this Plan or any other plan that contributes to or otherwise sponsors, such as HMOs.
21. **Enteral Therapy.** Enteral nutritional formula is not payable by the *Plan* if it includes any of the following:
    a. standardized or specialized infant formula (e.g., Alimentum, Elecare, Neocate, and Nutramigen), or baby food for conditions other than inborn errors of metabolism or inherited metabolic diseases, including, but not limited to: food allergies; multiple protein intolerances; lactose intolerance; gluten-free formula for gluten-sensitivity, or formula for protein, soy or fat digestive problems
    b. food thickeners, dietary and food supplements, including, but not limited to, puddings, powders, mixes, vitamins and minerals, lactose-free products or products to aid in lactose digestion, gluten-free food products, high protein or high carbohydrate products, and the like
    c. weight-loss or weight-gain foods, formulas, or products; normal grocery items; low carbohydrate foods; or nutritional supplement puddings powders, mixes, vitamins, and minerals
22. **Error.** Any charge for care, supplies, treatment, and/or services that are required to treat *injuries* that are sustained, or an *illness* that is contracted, including infections and complications, while the *plan participant* was under, and due to, the care of a provider wherein such *illness*, *injury*, infection, or complication is not reasonably expected to occur. Any charge for care, supplies, treatment, and/or services that are required as a result of unreasonable provider error. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the *Plan Administrator*, in its sole discretion, unreasonably gave rise to the expense.
23. **Examinations.** Any health examination required by any law of a government to secure insurance or school admissions (including sports physicals) or professional or other licenses, except as required under applicable federal law. Such exams are covered if they fall within the *Plan's* preventive care benefits.
24. **Excess Charges.** Any charge for care, supplies, treatment, and/or services that are not payable under the *Plan* due to application of any *Plan* maximum or charges which are in excess of the *maximum*

allowable charge, or services not deemed to be *reasonable* or *medically necessary*, based upon the *Plan Administrator's* determination as set forth by and within the terms of this document.

25. **Exercise Programs.** Exercise programs or equipment for treatment of any condition, except for *physician* supervised cardiac rehabilitation, occupational, or physical therapy, if covered by this *Plan*.
26. **Experimental/Investigational.** Care and treatment that is *experimental/investigational*. This exclusion shall not apply if the charge is for routine patient care for costs *incurred* by a *qualified individual* who is a participant in an *approved clinical trial*. Charges will be covered only to the extent specifically set forth in this plan document.
27. **Foot Care.** Services for routine, palliative, or cosmetic foot care including flat foot conditions, treatment of subluxation of the foot, care of corns, bunions (except capsular or bone *surgery*), callouses, toe nails, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet, except as otherwise specifically provided herein.
28. **Foreign Travel.** Expenses for planned and/or routine services received or supplies purchased outside the United States, including those rendered on a cruise ship, are excluded under this *Plan*. Services in the case of a *medical emergency* are a *covered charge*.
29. **Genetic/Genomic Testing and Counseling.** Genetic/genomic testing and counseling services are excluded under this *Plan* except amniocentesis or as required under applicable federal law and as otherwise specified herein. Genetic counseling may be covered if it is performed by a qualified genetic counselor and performed in conjunction with a genetic test that is payable by this *Plan*.
30. **Government Coverage.** Care, treatment, or supplies furnished by a program or agency funded by any government, including those received in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related *illness* or *injury*. This exclusion does not apply to Medicaid, other services at a Veteran's Administration facility, or when otherwise prohibited by applicable law. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of any other condition that is not a military service-related *illness* or *injury*, benefits are covered by the *Plan* to the extent those services are *medically necessary* and the charges are within this *Plan's maximum allowable charge*.
31. **Habilitation Services.** Habilitation services are excluded except for in conjunction with *ABA therapy*.
32. **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a *physician*, except as shown in the applicable **Schedule of Medical Benefits**.
33. **Hazardous Activity.** Care and treatment of an *injury* or *illness* that results from engaging in a hazardous activity on a professional or semi-professional basis. An activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous activities are skydiving, auto racing, hang gliding, or bungee jumping.
34. **Hospice Care.** Services for pastoral or spiritual counseling; services performed by a family member or volunteer workers, homemaker, or housekeeping services; respite care; food services (such as Meals on Wheels); legal and financial counseling services; and services or supplies not included in the *hospice care plan* or not specifically set forth as a hospice benefit.
35. **Hospital Employees.** Professional services billed by a *physician* or nurse who is an *employee* of a *hospital* or *skilled nursing facility* and paid by the *hospital* or facility for the service.
36. **Hospital Services.** *Hospital* services when hospitalization is primarily for *diagnostic testing*/studies or physical therapy when such procedures could have been done adequately and safely on an *outpatient* basis.
37. **Illegal Acts.** Any charge for care, supplies, treatment, and/or services for any *injury* or *illness* which is *incurred* while taking part or attempting to take part in an illegal activity, including, but not limited to, misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act.
38. **Illegal Drugs or Medications.** Services, supplies, care, or treatment to a *plan participant* for *injury* or *illness* resulting from that *plan participant's* voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a *physician*. Expenses will be covered for *injured plan participants* other than the person using controlled substances.

39. **Immunizations.** Immunizations and vaccinations for the purpose of travel outside of the United States.
40. **Infertility.** Expenses associated with a surrogate, donor egg/semen, cryostorage of egg or sperm, ovarian transplant, infertility donor expenses, and reversal of sterilization procedures.
41. **Long Term Care.**
42. **Massage Therapy.** Expenses for massage therapy or rolfing provided by a masseur, physical culturist, physical education instructor, or personal trainer. Massage therapy may be covered when provided as part of physical therapy or chiropractic care.
43. **Maternity.** Expenses for childbirth education and Lamaze classes. Charges for services related to surrogate *pregnancy*.
44. **Medical Students and Interns.** Expenses for the services of a medical student or intern.
45. **Medicare.** Any charge for benefits that are provided, or which would have been provided had the *plan participant* enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (*Medicare*), including any amendments thereto, or under any federal law or regulation, except as provided in the sections entitled **Coordination of Benefits** and **Medicare**.
46. **Methadone Clinic.**
47. **Milieu Therapy.** A treatment program based on manipulation of the *plan participant's* environment for their benefit.
48. **Modifications of Homes or Vehicles.** Expenses for construction or modification to a home, residence, stairs, or vehicle required as a result of an *injury*, *illness,* or disability of a *plan participant*, including, without limitation, construction or modification of ramps, elevators, chair lifts, swimming pools, spas/hot tubs, air purifiers, motorized modes of transportation, asbestos removal, hand rails, emergency alert system, etc.
49. **Negligence.** Care and treatment of an *injury* or *illness* that results from activity where the *plan participant* is found by a court of competent jurisdiction and/or a jury of his/her peers to have been negligent in his/her actions, as negligence is defined by the jurisdiction where the activity occurred.
50. **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
51. **No Legal Obligation.** Any charge for care, supplies, treatment, and/or services that are provided to a *plan participant* for which the provider of a service customarily makes no direct charge, for which the *plan participant* is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including, but not limited to, fees, care, supplies, or services for which a person, company, or any other entity except the *plan participant* or this benefit *Plan*, may be liable for necessitating the fees, care, supplies, or services.
52. **No Physician Recommendation.** Care, treatment, services, or supplies not ordered by or recommended and approved by a *physician*, other than those described in the Preventive Care provisions. Treatment, services, or supplies when the *plan participant* is not under the regular care of a *physician*. Regular care means ongoing medical supervision or treatment which is appropriate care for the *injury* or *illness*.
53. **Non-Compliance.** All additional charges in connection with treatments or medications which were directly caused by, and attributed to, the patient's non-compliance with or discharge from a *hospital* or *skilled nursing facility* against medical advice. Expenses incurred by any *plan participant* during travel if a *physician* or other healthcare provider has specifically advised against such travel because of the health condition of the *plan participant*.
54. **Non-Durable 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. Hypodermic needles, syringes, and similar devices are excluded except when used for administration of a covered drug when prescribed in accordance with the terms of this plan document. Only those nondurable supplies identified in the Schedule of Medical Benefits or Covered Medical Charges are covered by this *Plan*. All others are not.
55. **Non-Emergency Hospital Admissions.** Care and treatment billed by a *hospital* for *medical non-emergency care* admissions on a Friday or a Saturday. This does not apply if *surgery* is performed within twenty-four (24) hours of admission.

56. **Non-Medical Expenses.** Expenses including, but not limited to, those for preparing medical reports, itemized bills, completion of claim forms or medical records unless otherwise required by law, calling a patient to provide their test results, sales tax, shipping and handling, benefit request forms, or claim forms; mailing, shipping, or handling expenses; interest charges; late fees; mileage costs; provider administration or photocopying fees; or expenses for failure to keep a scheduled visit or appointment, *physician* or *hospital* stand-by services, holiday or overtime rates, membership or access fees, educational brochures, or reports prepared in connection with litigation.

57. **Non-Prescription Medication.** Drugs and supplies not requiring a prescription order (unless required under applicable federal law), including, but not limited to, antacid, benzyl peroxide preparations, cosmetics, medicated soaps, food or nutritional supplements, syringes, bandages, special foods or diets, vitamins, minerals, dietary and nutritional supplements, nutritional therapy, *experimental* drugs, including those labeled "Caution: Federal law prohibits dispensing without prescription," and prescription medications related to health care services which are not covered under this *Plan*. This exclusion does not apply to foods and nutritional supplements provided during covered *inpatient* hospitalization, and prescription prenatal vitamins or minerals and enteral therapy.

58. **Not Actually Rendered.** Any charge for care, supplies, treatment, and/or services that are not actually rendered. Expenses for any *physician* or other healthcare provider who did not directly provide or supervise medical services to the *plan participant*, even if the *physician* or healthcare practitioner was available on a stand-by basis.

59. **Not Medically Necessary.** Any charge for care, supplies, treatment, and/or services that are not *medically necessary*, unless specifically stated as covered herein.

60. **Nutritional Counseling.** Dietary counseling/instructions from any provider, except for dietary counseling services received through diabetes education benefits or as required by law.

61. **Obesity/Morbid Obesity.** Screening and counseling for obesity will be covered to the extent required under the Preventive Care provision. Other care or treatment of obesity, weight loss, or dietary control whether or not it is, in any case, a part of the treatment plan for another *illness*, is not covered under the *Plan*, except as covered under the Weight Management benefit in the Covered Medical Charges subsection. Treatment of any skin reduction procedure or bariatric surgery reversal is excluded.

62. **Occupational or Workers' Compensation.** Charges for care, supplies, treatment, and/or services for any condition, *illness*, *injury*, or complication thereof arising out of or in the course of employment (including self-employment), or an activity for wage or profit. If you are covered as a *dependent* under this *Plan* and you are self-employed or employed by an *employer* that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. Benefits may be considered under the *Plan* for related services after the Workers' Compensation benefits have been exhausted.

63. **Other than Attending Physician.** Any charge for care, supplies, treatment, and/or services by a *provider* who did not render an actual service to the *participant*. *Covered charges* are limited to those certified by a *physician* who is attending the *plan participant* as required for the treatment of *injury* or *disease*, and performed by an appropriate provider. This exclusion does not apply to interdisciplinary team conferences to coordinate patient care.

64. **Outside Scope of License.** Expenses for healthcare practitioners providing services not within the scope of their license.

65. **Personal Comfort or Convenience Items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-medical grade stockings, non-prescription drugs and medicines, first-aid supplies, television, CD/DVD, telephone, seat risers, and non-hospital adjustable beds. Also excludes expenses for patient convenience, including, but not limited to, care of family members while the *plan participant* is confined to a *hospital* or other healthcare facility or to bed at home, guest meals, barber or beautician services, house cleaning or maintenance, shopping.

66. **Personal Injury Insurance.** Expenses in connection with an automobile *accident* for which benefits payable hereunder are, or would be otherwise covered by, mandatory *no-fault automobile insurance* or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the *plan participant* actually had such mandatory coverage. This exclusion does not apply if the *injured* person is a passenger in a non-family owned vehicle or a pedestrian.

67. **Prescription Drugs.** Prescription drugs charges covered under the Prescription Drug Benefits, other than those covered in a *physician's* office or *inpatient* admission.
68. **Prior to or After Coverage.** Any charge for care, supplies, treatment, and/or services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.
69. **Private Duty Nursing.** Charges in connection with care, treatment, or services of a private duty nurse, unless *medically necessary* as determined by the *Plan*.
70. **Private Room in a Hospital or Healthcare Facility.** The use of a private room in a *hospital* or other healthcare facility, unless the facility has only private room accommodations or unless the use of a private room is certified as *medically necessary* by the *Plan Administrator* or its designee. This exclusion does not apply for HonorHealth facilities.
71. **Prohibited by Law.** Any charge for care, supplies, treatment, and/or services to the extent that payment under this *Plan* is prohibited by law.
72. **Rehabilitation.** Maintenance or passive rehabilitation. Expenses incurred at an *inpatient* rehabilitation facility for any *inpatient* rehabilitation therapy services provided to an individual who is unconscious, comatose, or in the judgment of the *Plan Administrator* or its designee, is otherwise incapable of 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.
73. **Repair of Purchased Equipment.** Maintenance and repairs needed due to misuse or abuse are not covered.
74. **Replacement Devices.** Replacement of orthotics or prosthetics such as braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the *plan participant's* physical condition to make the original device no longer functional. Expenses for replacement of lost, missing, or stolen duplicate or personalized corrective appliances, orthotic devices, prosthetic appliances, or *durable medical equipment*.
75. **Smoking Cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under the Preventive Care provision. Tobacco cessation care and treatment, including hypnotherapy, is otherwise excluded under the Medical Benefits. Refer to the **Prescription Drug Benefits** section for details on coverage of certain tobacco cessation medications.
76. **Speech Therapy.** 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 and disorders are excluded from coverage. This exclusion does not apply to treatment for Down syndrome.
77. **Sterilization Reversal.** Care and treatment for reversal of surgical sterilization, including related follow-up care.
78. **Subrogation, Reimbursement, and/or Third Party Responsibility.** Any charges for care, supplies, treatment, and/or services of an *injury* or *illness* not payable by virtue of the *Plan's* subrogation, reimbursement, and/or third party responsibility provisions. Refer to the **Reimbursement and Recovery Provisions** section.
79. **Surgery Suite Fees.** Charges made by a *physician* or healthcare practitioner for use of a specific room within the *physician* or healthcare practitioner's office.
80. **Transplants.** The following transplant-related expenses are not covered by the *Plan*:
    a. when the recipient is not an eligible *plan participant*
    b. when the organ or tissue is sold rather than donated to the recipient
    c. charges that are covered or funded by governmental, foundation, or charitable grants or programs
    d. expenses for human organ and/or tissue transplants that are *experimental and/or investigational* and all complications thereof
    e. charges for any artificial or mechanical organ

    This exclusion does not apply to cardiac assist devices such as LVADs or other devices being used as a bridge to a covered transplant.

f. expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except heart valves

g. expenses for travel or lodging

81. **Travel or Accommodations.** Charges for travel accommodations (including lodging, meals, and related expenses) of a healthcare provider or *plan participant*, whether or not recommended by a *physician*, except for ambulance charges defined as a *covered charge*.

82. **Vision Care Exclusions.** Expenses for the following:

    a. surgical correction of refractive errors and refractive keratoplasty procedures, including, but not limited to, Radial Keratotomy (RK) and Automated Lamellar Keratoplasty (ALK), or Laser In-Situ Keratomileusis (LASIK)

    b. diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting, and repair of eyeglasses or lenses and associated supplies, except one (1) pair of eyeglasses or contact lenses is payable as following ocular surgery when the lens of the eye has been removed such as with a cataract extraction

    c. orthoptics (eye muscle exercises), orthoptic therapy, vision training, or subnormal vision aids

    d. specialty lenses

    e. orthokeratology lenses for reshaping the cornea of the eye to improve vision

83. **War.** Any loss that is due to a declared or undeclared act of a war, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

SECTION VII—OUTPATIENT DIALYSIS SERVICES

The following *outpatient dialysis* services are not included under the *network* arrangement of this *Plan:*

1. facility and professional charges from:
    a. *outpatient hospitals*
    b. dialysis facilities
2. home dialysis charges

A. Coordination with Medicare

If you are diagnosed with a condition requiring dialysis, you may be able to enroll in *Medicare*. Upon beginning dialysis treatments, *Medicare*, if applicable, will coordinate benefits with the *Plan* as the secondary payer for months four (4) through thirty-three (33) of the coordination period while you are receiving dialysis treatments. Your *outpatient* dialysis medical *claims* as described in this section will be considered at 125% of *Medicare's* reimbursement level.

The *Plan* will not enroll you in *Medicare*; it is your decision and your responsibility to enroll in *Medicare*, if applicable.

If you are eligible but do not enroll for both Part A and Part B of *Medicare*, the *Plan* will pay benefits as if you have enrolled. Your *claims* will be reduced as secondary under this *Plan* regardless of enrollment status under *Medicare*.

Refer to the **Coordination of Benefits** and **Medicare** sections of this document for more information.

B. Medical Management

All dialysis services require *pre-certification*. To begin the *pre-certification* process, call ICP Health at 1-800-250-6647.

C. ID Cards

Plan participants requiring dialysis services will be issued a separate Dialysis Identification Card. This card will be sent to you by ICP Health upon your initial *pre-certification* call.

D. Submitting Outpatient Dialysis Claims

All *outpatient* dialysis medical *claims* will be submitted to:

AmeriBen
P.O. Box 7186
Boise, ID 83707

Please refer to the **Claims and Appeals** section for information regarding filing *claims*.

SECTION VIII—HEALTH CARE MANAGEMENT PROGRAM

Health Care Management Program Phone Number

ICP Health (Medical)	Magellan Health (Behavioral)
1-800-250-6647	1-800-424-4138

The Health Care Management Program consists of several components to assist *plan participants* in staying well: providing optimal management of chronic conditions, provisions of support, and service coordination during times of acute or new onset of a medical condition.

The scope of the Health Care Management Program consists of the following components (each of which will be further discussed in this section):

- Utilization Review
- Concurrent Review and Discharge Planning
- Case Management
- Health Management

A. Utilization Review

The utilization review program is designed to help ensure all *plan participants* receive *medically necessary* and appropriate health care while avoiding unnecessary expenses.

The purpose of the program is to determine what services are *medically necessary* and eligible for payment by the *Plan*. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending *physician* or other health care provider. The *Plan*, *Claims Administrator*, and *Medical Management Administrators* are not engaged in the practice of medicine, and none of them take responsibility either for the quality of healthcare services actually provided, even if they have been certified by as medically necessary, or for the results if the *plan participant* chooses not to receive healthcare services that have not been certified as *medically necessary*.

If a particular course of treatment or medical service is not *pre-certified*, it means that either the *Plan* will not pay for the charges, or the *Plan* will not consider that course of treatment as *medically necessary* and appropriate for the maximum reimbursement under the *Plan*. The patient is urged to review why there is a discrepancy between what was requested and what was certified before *incurring* charges.

Your *employer* has contracted with ICP Health and Magellan Health in order to assist you in determining whether or not proposed services are appropriate for reimbursement under the *Plan*. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility.

Elements of the Utilization Review Program

The program consists of:

1. **Pre-Certification.** Review of the *medical necessity* for non-emergency services before medical and/or surgical services are provided.
2. **Retrospective Review.** Review of the *medical necessity* of the health care services provided on an *emergency* basis, after they have been provided.
3. **Concurrent Review.** Ongoing assessment of the health care as it is being provided, especially, but not limited to, *inpatient* confinement in a *hospital* or covered *medical care facility* (based on the admitting diagnosis, of the listed services requested by the attending *physician*).
4. **Discharge Planning.** Certification of services and planning for discharge from a *medical care facility* or cessation of medical treatment.

What Services Must Be Pre-Certified (Approved Before they are Provided)

The provider, patient, or family member must call the *Medical Management Administrator* to receive certification of certain health care management services. This call must be made at least forty-eight (48) hours in advance of services being rendered or within forty-eight (48) hours after an *emergency*.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the *out-of-pocket limit*.

The following services must be *pre-certified* before the services are provided:

1. *inpatient* pre-admission certification and continued stay reviews (all ages, all diagnoses)
    a. surgical and non-surgical (excluding routine vaginal or cesarean deliveries)
    b. *inpatient* mental health/*substance use disorder* treatment (includes *residential treatment facility* services)

       Pre-certification for mental health/*substance use disorder* treatment will be administered by Magellan Health. Refer to the Quick Reference Chart.
2. maternity length of stay that is in excess of forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery
3. *inpatient* and *outpatient surgery* (excluding office *surgeries*, colonoscopies, and diagnostic scope procedures)

   NOTE: Opthamology authorizations will be for surgical procedures only, not for place of service.
4. applied behavioral analysis (ABA) therapy

   Pre-certification for ABA therapy will be administered by Magellan Health. Refer to the Quick Reference Chart.
5. all potential cosmetic procedures
6. *durable medical equipment* purchases in excess of $1,000
7. breast pumps in excess of $1,000
8. corrective appliances (orthotics/prosthetics) purchases in excess of $2,000
9. gene therapy and adoptive cell therapy
10. insulin pumps in excess of $1,000 (purchase price or combined rental cost)
11. occupational and physical therapy in excess of twenty (20) visits combined per *calendar year*
12. *outpatient* advanced imaging – MRI/MRA and PET scans (excluding services rendered in an emergency room setting)
13. pain management treatment (epidurals, implantable infusion pumps, etc.)
14. surgical treatment of TMJ conditions
15. *home health care services and supplies*
16. home infusion therapy services
17. specialty infusion/injectable medications which are covered under the Medical Benefits and not obtained through the Prescription Drug Benefits
    a. blood-clotting factors
    b. botulinum toxin type A and B: Botox®, Dysport® , and Myobloc
    c. C1 Inhibitors: Cinryze and Berinert
    d. blood cell deficiency/erythropoiesis stimulating agents (ESA): Epoetin, Darbepoetin, and Oprelvekin
    e. growth hormones
    f. growth hormone blocker: Mecasermin
    g. immunologic agents/immune modulators/biologics/monoclonal antibody agents : Abatacept (Orencia®), Adalimumab (Humira®), Amevive®, Anakinra (Kineret®), Belimumab, Certolizumab

(Cimzia®), Etanercept (Enbrel®), Eculizumab (Soliris), Fingolimod (Gilenya), Glatiramer Acetate (Copaxone, Glatopa), Golimumab (Simponi®), Infliximab (Remicade®), Secukinumab (Cosentyx), Tofacitinib (Actemra®), Ustekinumab (Stelara®), and Vedolizumab (Entyvio®)

h. Rituximab (Rituxan®) -except for chemotherapy

i. immunoglobulins, includes any parenteral administration [intravenous (IV), subcutaneous (SubQ), and/or intramuscular (IM)]

j. bone condition agents: Prolia®, Zometa, and/or Pamidronate (Aredia®)

k. miscellaneous specialty medications, such as Spinraza (nusinersen), Exondys 51 (eteplirsen), Brineura (cerliponase alfa), and Zolgensma

l. respiratory conditions: Omalizumab (Xolair) and Mepolizumab (Nucala)

m. eye conditions: Afibercept (Eylea) and Ranibizumab (Lucentis)

n. enzyme deficiency: Agalsidase Beta (Fabrazyme) and Pegloticase (Krystexxa),

o. endocrine disorders: Octreotide (Sandostatin), Lanreotide (Somatuline Depot), and Pasireotide (Signifor LAR)

p. gene therapy

This list may be updated throughout the *calendar year*.

18. transplant, including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high-dose chemotherapy

    Includes pre-transplant workup tests.

19. experimental or investigational treatments or surgeries, including clinical trials conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition

    This *Plan* does not cover clinical trials related to other *diseases* or conditions. Refer to the **Medical Benefits** section of this document for a further description and limitations of this benefit.

20. genetic testing and related lab fees (excludes genetic counseling, amniocentesis, and mandated BRCA services)
21. medical foods administered orally, other than PKU
22. services at any post-acute facility, including the following:
    a. long term acute care facility (LTAC), not *custodial care*
    b. *skilled nursing facility*/rehabilitation facility
    c. partial hospitalization and intensive *outpatient* therapy
23. non-emergent ambulance services (such as *medically necessary* inter-facility transport)

    Pre-certification is not required for transport from an emergency room to a higher level of care.

24. hyperbaric oxygen testing
25. ventricular assistive devices (VAD), life vests, implantable cardiac defibrillators
26. proton beam therapy
27. speech therapy (other than speech evaluation and assessment)
28. testosterone hormone therapy (for males only)
29. *outpatient* dialysis

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

How to Request Pre-Certification

Before a *plan participant* enters a *medical care facility* on a non-emergency basis or receives other listed medical services, the *Medical Management Administrator* will, in conjunction with the attending *physician*, certify the care as *medically necessary* for *Plan* reimbursement. A non-emergency stay in a *medical care facility* is one that can be scheduled in advance.

The medical management program is set in motion by a telephone call from, or on behalf of, the *plan participant*. Contact the appropriate *Medical Management Administrator* **at least seven (7) days before** services are scheduled to be rendered with the following information:

1. the name of the *plan participant* and relationship to the covered *employee*
2. the name, *employee* identification number, and address of the covered *employee*
3. the name of the *employer*
4. the name and telephone number of the attending *physician*
5. the name of the *medical care facility*
6. the proposed medical services
7. the proposed date(s) of services
8. the proposed length of stay

If there is an *emergency* admission to the *medical care facility,* the patient, patient's family member, *medical care facility,* or attending *physician* must contact the *Medical Management Administrator* within **twenty-four (24) hours** of the first business day after the admission.

The *Medical Management Administrator* will determine the number of days of *medical care facility* confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

Warning: Obtaining *pre-certification* of particular services does not guarantee that they will be reimbursed by the *Plan*. Benefits are determined by the *Plan* at the time a formal *claim* for benefits is submitted according to the procedures outlined within the **Claims and Appeals** section of this plan document.

Note: If your admission or service is determined to **not** be *medically necessary*, you may pursue an *appeal* by following the provisions described in the **Claims and Appeals** section (First Level Appeal of a Pre-Service Claim subsection) of this document. The *plan participant* and provider will be informed of any denial or non-certification in writing.

Penalty for Failure to Pre-Certify

When the required *pre-certification* procedures are followed, your benefits will be unaffected. However, if you do not follow the *pre-certification* requirements outlined above, **you will be subject to a financial penalty or denial of payment for any resulting claims**. Penalty charges will be applied to the facility charge, if applicable. Amounts assessed under this penalty will not go towards satisfaction of your *out-of-pocket limit*.

The *Plan* may also coordinate a retrospective review to determine if the services performed or medications received were *medically necessary*. If it is determined that services were not *medically necessary*, no *Plan* benefits will be provided for those services. Retrospective requests are accepted up to twelve (12) months from the date of service.

If it is determined that services were *medically necessary*, and services received were subject to the *pre-certification* review requirements set forth in this chapter that you did not follow, you must pay an additional penalty as outlined below:

1. $500 for each failure to pre-certify an admission or *outpatient* surgery
2. $250 for each failure to pre-certify any other services that required *pre-certification*

Appeals of a Denial of Pre-Certification from the Medical Management Administrator

Pre-certification decisions are considered *claims* decisions that are subject to *appeal*. Refer to the **Claims and Appeals** section (Other Pre-Service Claims subsection) for details on how to *appeal* and the timeframes for *appealing* a *pre-service claim* decision.

B. Concurrent Review and Discharge Planning

How Concurrent Review Works

Concurrent review of a course of treatment and discharge planning from a *medical care facility* are part of the medical management program. The *Medical Management Administrator* will monitor the *plan participant's*

medical care facility stay or use of other medical services and coordinate with the attending *physician*, *medical care facilities*, and *plan participant* either the scheduled release or an extension of the *medical care facility* stay or extension or cessation of the use of other medical services.

If the attending *physician* feels that it is *medically necessary* for a *plan participant* to receive additional services or to stay in the *medical care facility* for a greater length of time than has been *pre-certified*, the attending *physician* must request the additional services or days.

How to File a Concurrent Claim for Benefits under this Plan

Refer to the **Claims and Appeals** section (Concurrent Care Claims subsection) for details on how to *appeal* a denial of a concurrent review. No benefits will be paid for any charges related to days of confinement to a *hospital* or other *health care facility* that have not been determined to be *medically necessary* by the *Medical Management Administrator*.

C. Case Management

Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a *plan participant's* health needs, using communication and available resources to promote quality, cost-effective outcomes. The primary objective of Case Management is to identify and coordinate cost-effective medical care, which meets accepted standards of medical practice. Case Management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients, and others.

Cases are identified for possible Case Management involvement based on a request for review or the presence of a number of parameters, such as, but not limited to:

1. admissions that exceed the recommended or approved length of stay
2. utilization of health care services that generates ongoing and/or excessively high costs
3. conditions that are known to require extensive and/or long-term follow-up care and/or treatment

Benefits under Case Management may be provided if the *Medical Management Administrator* determines that the services are *medically necessary*, appropriate, cost effective, and feasible. All decisions made by Case Management are based on the individual circumstances of that *plan participant's* case. Each case is reviewed on its own merits, and any benefits provided are under individual consideration.

Case Management is designed to help manage the care of patients who have special or extended care *illnesses* or *injuries*.

The *Plan* may elect, at its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the *Plan*. The alternative benefits shall be determined on a case-by-case basis, and the *Plan's* determination to provide the benefits in one (1) instance shall not obligate the *Plan* to provide the same or similar alternative benefits for the same or any other *plan participant*, nor shall it be deemed to waive the right of the *Plan* to strictly enforce the provisions of the *Plan*.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The *Plan Administrator*, attending *physician*, patient, and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the *Plan Administrator* will direct the *Plan* to reimburse for *medically necessary* expenses as stated in the treatment plan, even if these expenses normally would not be paid by the *Plan*. Unless specifically provided to the contrary in the *Plan Administrator's* instructions, reimbursement for expenses *incurred* in connection with the treatment plan shall be subject to all *Plan* limits and cost sharing provisions.

Benefits under Case Management may be provided if the *Medical Management Administrator* determines that the services are *medically necessary*, appropriate, cost-effective, and feasible. All decisions made by Case Management are based on the individual circumstances of that *plan participant's* case. Each case is reviewed on its own merits, and any benefits provided are under individual consideration.

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

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

D. Courtesy Reviews

AmeriBen Medical Management may perform *courtesy reviews*. *Courtesy reviews* are a pre-service assessment of *medical necessity* only and are not a guarantee of benefits. *Courtesy reviews* will be made as soon as possible after the request has been submitted, but no later than thirty (30) days. Completion of a *courtesy review* is not a requirement of the *Plan* and should not be a cause for delay in treatment of *medically necessary* care. Contact AmeriBen Medical Management with any questions at 1-602-231-8855. Refer to the **Claims and Appeals** section for timeframes and other information regarding filing *claims*.

E. Health Management Program

Your *employer* has contracted with ICP Health to provide the Health Management Program. The Health Management Program is designed to assist individuals who are suffering from chronic conditions, or who have been identified as at risk for a chronic condition. The Health Management Program assists *plan participants* with managing those conditions by providing *plan participants* with access to education and personal engagement. This service provides programs for patients to gain education on the care and management of chronic *diseases* (such as diabetes, asthma, high blood pressure, coronary heart *disease*, etc.) and is designed to improve patient knowledge of the *disease* and techniques for self-management and compliance with proper health care procedures required for the patient's well-being.

How the Health Management Program Works

This program is designed to educate *plan participants* and eligible family members with chronic *diseases* and help *plan participants* better understand and take control of their condition, proactively participate in care and treatment, and reduce the risk of complications. Participation in the program is voluntary and confidential.

Program Benefits:

1. It is a benefit of your health care plan at no extra cost to you.
2. It provides personal contact between you and a specially trained registered nurse (R.N.), who will be your Health Coach.
3. The program supports your *physicians* as well as helping you follow your doctor's plan of care.

This program does not replace *physician*-patient relationships. It is designed to complement the relationship and reinforce the treatment plan of care established by you and your *physician*. All Protected Health Information (PHI) is highly confidential, will be kept confidential as required by law, and shall not be improperly used or disclosed.

Managing Chronic Conditions

Chronic health management is a proactive approach that addresses chronic *diseases* early in the *disease* cycle to prevent *disease* progression and reduce potential health complications. Multiple strategies are used to improve the health of all *plan participants* diagnosed with specific conditions, not only those who visit the provider's office. This approach allows *plan participants* to maintain their independence and remain healthy for as long as possible.

AmeriBen's dedicated team of Health Management nurses accomplish this by reinforcing proper treatment plans and educating *plan participants* about their conditions. This typically incudes information about:

1. the early signs and symptoms of trouble
2. medications and the proper way to take them
3. following a healthy diet
4. managing and maintaining scheduled doctor visits
5. preventing *hospital* admissions

While the specific list of conditions and programs will vary, the Health Management Program's main goal is to empower the *plan participant* to take control and remain healthy.

How to Enroll

Your *physician* may refer you to the Health Management Program, or you may refer yourself or a covered *dependent* into the program by calling ICP Health directly. *Plan participants* may also be identified through the Predictive Modeling tool. Once you are identified as having a chronic condition, your R.N. Health Coach will contact you to discuss the next steps of the program.

F. Pregnancy Notification

Pregnant women should notify the appropriate *Medical Management Administrator* as soon as possible once they know they are pregnant. This helps to assure that the pregnant woman will receive adequate prenatal care, allow for planning for the upcoming delivery, and enable the *Plan* to provide adequate educational material regarding pregnancy. It also enables the *Medical Management Administrator* to work with the treating physician to monitor for high-risk pregnancy factors and to assist the pregnant woman in completing the steps to assure that plan benefits will be available for the newborn child. There is no penalty for failure to notify the *Medical Management Administrator* about the pregnancy.

SECTION IX—PRESCRIPTION DRUG BENEFITS

A. About Your Prescription Benefits

The Prescription Drug Benefits are separate from the Medical Benefits and are administered by OptumRx. This program allows you to use your OptumRx *prescription drug* card at a nationwide *network* of participating *pharmacies* to purchase your prescriptions. When purchasing *prescription drugs* at retail *pharmacies* or through mail-order, using your *prescription drug* card at participating *pharmacies* provides you with the best economic benefit.

Claims for reimbursement of *prescription drugs* are to be submitted to OptumRx at:

OptumRx
Attn: Claims
P.O. Box 29044
Hot Springs, AR 71903

B. Out-of-Pocket Limit

Specialty drug *covered charges* are payable at the amounts shown each *calendar year* until the *out-of-pocket maximum* shown in the applicable Schedule of Prescription Drug Benefits is reached. Then, specialty drug *covered charges incurred* by a *plan participant* will be payable at 100% (except for the excluded charges) for the rest of the *calendar year*.

When a *family unit* reaches the specialty drug *out-of-pocket limit*, covered *prescription drug* charges for that *family unit* will be payable at 100% (except for the charges excluded) for the rest of the *calendar year*.

The specialty drug *out-of-pocket limit* includes *prescription drug co-payments*.

C. Co-Payments

The *co-payment* is applied to each covered *pharmacy* drug or mail order drug charge and is shown in the applicable Schedule of Prescription Drug Benefits. The *co-payment* amount is not a *covered charge* under the Medical Plan. Any one (1) retail prescription is limited to a thirty (30) day supply or a ninety (90) day supply. Any one (1) mail order prescription is limited to a ninety (90) day supply.

D. Co-Insurance

Once you have met the Medical Plan's *calendar year deductible*, your *co-insurance* is applied to each covered *pharmacy* drug or mail order drug charge and is shown in the applicable Schedule of Prescription Drug Benefits. Any one (1) *pharmacy* prescription is limited to a thirty (30) day supply or a ninety (90) day supply. Any one (1) mail order prescription is limited to a ninety (90) day supply.

E. Manufacturer Coupons

Any amounts in the form of manufacturer coupons or drug savings discount cards used for brand name drugs when there is a generic equivalent available, unless the brand name is *medically necessary*, apply to the *out-of-pocket limit*.

Any amounts in the form of manufacturer coupons or drug savings discount cards used for brand name drugs, even when there is a generic equivalent available, apply to the *out-of-pocket limit*.

F. Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart *disease*, high blood pressure, asthma, etc.). Because of volume buying, Orchard Pharmaceutical Services, the mail order *pharmacy*, may be able to offer *plan participants* significant savings on their prescriptions.

To use the mail order service have your doctor write the prescription for a ninety (90) day supply, with the appropriate refills. Mail your prescription and the mail order form to the Mail Order Services of the Prescription Drug Program whose address is listed in the Quick Reference Chart. Mail order forms may be obtained from the

Prescription Drug Program. Allow up to fourteen (14) days to receive your order. Excludes non-formulary and specialty drugs with the exception of covered drugs that come packaged in multiple quantities.

G. OptumRx Walgreens90 Program

How the HonorHealth OptumRx Walgreens90 program works

If you are taking a long-term medication on a regular basis, your pharmacy benefit plan requires you to use an HonorHealth specialty pharmacy, Walgreens retail pharmacy, or OptumRx home delivery.

You must choose to fill a ninety (90) day supply of your prescription through a Walgreens retail pharmacy or OptumRx home delivery or your medication will not be covered by your *Plan*.

H. Specialty Pharmacy Program

Optum Specialty Pharmacy is a Specialty Pharmacy Program offered through a partnership with a specialty *pharmacy* experience in handling specialty drugs. The Specialty Pharmacy Program covers some limited drugs, such as specialty injectables, cancer drugs, and certain respiratory therapies used to treat various chronic conditions. Optum Specialty Pharmacy also provides personalized support, education, a proactive refill process, and free delivery, as well as information about health care needs related to the chronic *disease*.

To start using Optum Specialty Pharmacy, call toll free at 1-855-427-4682 or visit **www.specialty.optumrx.com**.

I. Prior Authorization

Prescriptions for certain medications or circumstances require clinical approval before they can be filled, even with a valid prescription. Prescriptions may be limited to quantity, frequency, dosage, or may have age restrictions. The authorization process may be initiated by the *plan participant*, the local *pharmacy*, or the *physician* by calling OptumRx at 1-844-368-9854.

J. Step Therapy Program

Step therapy is a program where you first try a proven, cost-effective medication (called a 'prerequisite drug' in this document) before moving to a more costly drug treatment option. With this program, trying one (1) or more prerequisite drugs is required before a certain prescription medication will be covered under your *pharmacy* benefits plan. Prerequisite drugs are FDA-approved and treat the same condition as the corresponding step therapy drugs. Step therapy promotes the appropriate use of equally effective but lower-cost drugs first. You, your *physician*, or the person you appoint to manage your care can ask for an exception if it is *medically necessary* for you to use a more expensive drug on the step therapy list. If the request is approved, OptumRx will *notify* you or your *physician*. The medication will then be covered at the applicable *co-insurance/co-payment* under your *Plan*. You will also be notified of approvals where states require it. If the request is denied, OptumRx will *notify* you and your *physician*. For information on which drugs are part of the step therapy program under your *Plan* call the OptumRx Customer Service number on your ID card.

K. Medicare Part D Prescription Drug Plans for Medicare Eligible Participants

Plan participants enrolled in either Part A or Part B of *Medicare* are also eligible for *Medicare* Part D Prescription Drug benefits. It has been determined that the *prescription drug* coverage provided in this *Plan* is generally better than the standard *Medicare* Part D Prescription Drug benefits. Because this *Plan's prescription drug* coverage is considered *creditable coverage*, you do not need to enroll in *Medicare* Part D to avoid a late penalty under *Medicare*. If you enroll in *Medicare* Part D while covered under this *Plan*, payment under this *Plan* may coordinate benefit payment with *Medicare*. Refer to the **Coordination of Benefits** section of the *Plan* for information on how this *Plan* will coordinate benefit payment.

For more information about Medicare prescription drug coverage visit **www.medicare.gov**, call 1-800-MEDICARE (1-800-633-4227), or call your State Health Insurance Assistance Program for personalized help. TTY users should call 1-877-486-2048.

L. Covered Prescription Drug Charges

1. **Compounded Prescription Drugs.** All compounded *prescription drugs* containing at least one (1) prescription ingredient in a therapeutic quantity.
2. **Diabetic.** Insulin and glucometers when prescribed by a *physician.* Includes continuous glucose monitor disposable sensor strips such as DexCom or similar device.
3. **Impotence.** A charge for impotence medication. Quantity limitations may apply.
4. **Infertility Drugs.** *Outpatient prescription drugs* for the treatment of infertility are limited to $25,000 per *plan participant* per lifetime.
5. **Injectable Drugs.** Injectable drugs or any prescription directing administration by injection. Prior authorization may be required.
6. **Prescribed by Physician.** All drugs prescribed by a *physician* that require a prescription either by federal or state law.

   This excludes any drugs stated as not covered under this *Plan*.
7. **Prescription Drugs mandated under PPACA.** Certain preventive medications (including contraceptives) received by a *network pharmacy* are covered and subject to the following limitations:
   a. generic preventive *prescription drugs* are covered at 100%, and the *deductible/co-payment* (if applicable) is waived
   b. if no *generic drug* is available, then the *formulary brand* will be covered at 100%, and the *deductible/co-payment/co-insurance* (if applicable) is waived

   This provision includes, but is not limited to, the following categories of drugs (In order for these medications to be covered at 100%, a prescription is required from your *physician*, including over-the-counter drugs.):
   a. **Aspirin.** For men between the ages of 45-79 to reduce the chance of heart attack and for women between the ages of 55-79 to reduce the chance of stroke.
   b. **Breast Cancer Risk-Reducing Medications.** Medications such as tamoxifen or raloxifene for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
   c. **Contraceptives**. Women's contraceptives including, but not limited to, oral contraceptives, transdermal contraceptives (i.e., Ortho-Evra), vaginal rings (i.e., Nuvaring), implantable contraceptive devices, injectable contraceptives, and emergency contraception. FDA-approved over-the-counter female birth control products.
   d. **Folic Acid**. For female *plan participants*.
   e. **Fluoride Supplements**. For children age six (6) months to five (5) years.
   f. **Immunizations.** Certain vaccinations are available without cost sharing including vaccines for influenza, pneumonia, tetanus, hepatitis, shingles, measles, mumps, HPV (human papillomavirus), pertussis, varicella, and meningitis.

      The shingles vaccine is covered without cost sharing under the Prescription Drug Benefits when administered by the pharmacy for *plan participants* age sixty (60) and over.
   g. **Tobacco Cessation Products**. Such as nicotine gum, smoking deterrent patches, or generic tobacco cessation medications. These drugs are payable without cost sharing up to two (2) cycles of treatment per *calendar year*, which applies to all products, including over-the-counter, with the maximum daily dose applying to each active ingredient. Thereafter, tobacco cessation products are not covered under the *Plan*. Vaping is not considered under the smoking cessation benefit.
   h. **Preparation 'Prep' Products for a Colon Cancer Screening Test.** The *Plan* covers the over-the-counter or prescription strength products prescribed as preparation for a payable preventive colon cancer screening test, such as a colonoscopy. *Plan participants* must contact OptumRx for a list of covered bowel preparation products that are covered under this provision.

Please refer to the following website for information on the types of payable preventive medications: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**.

M. Limits to This Benefit

This benefit applies only when a *plan participant incurs* a covered *prescription drug* charge. The covered drug charge for any one (1) prescription will be limited to:

1. refills only up to the number of times specified by a *physician*
2. refills up to one (1) year from the date of order by a *physician*

If the cost of the drug is less than the *co-payment* or *co-insurance*, the *plan participant* pays the drug cost. Reimbursement for covered prescription drugs at a *network* pharmacy are at the negotiated price and not the full cost of the drug. When a generic version of a formulary drug becomes available, the drug will be moved to the non-formulary coverage.

N. Dispense As Written (DAW) Program

The *Plan* requires that retail *pharmacies* dispense *generic drugs* when available. Should a *plan participant* choose a *formulary* brand or non-preferred *formulary* drug rather than the generic equivalent, the *plan participant* will be responsible for the cost difference between the generic and *formulary* brand or non-preferred *formulary* in addition to the *formulary* brand or non-preferred *formulary* drug *co-payment*, even if a DAW (Dispense As Written) is written by the prescribing *physician*. The *plan participant's* share of this *prescription drug* cost difference does not apply toward the *Plan's out-of-pocket limit*.

O. Prescription Drug Plan Exclusions

This benefit will not cover a charge for any of the following:

1. **Administration.** Any charge for the administration of a covered *prescription drug*.
2. **Appetite Suppressants/Dietary Supplements.** A charge for appetite suppressants, naturopathic substances, dietary supplements, or vitamin supplements, except as otherwise covered under the *Plan* such as prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
3. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
4. **Drugs Used for Cosmetic Purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A, or medications for hair growth or removal.
5. **Experimental/Investigational.** E*xperimental/investigational* drugs and medicines, even though a charge is made to the *plan participant*. A drug or medicine labeled: "Caution: Federal law prohibits dispensing without prescription."
6. **FDA.** Any drug not approved by the Food and Drug Administration.
7. **Growth Hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance, unless preauthorized through OptumRx.
8. **Immunization.** Immunization agents or biological sera unless permitted under healthcare reform.
9. **Inpatient Medication.** A drug or medicine that is to be taken by the *plan participant*, in whole or in part, while *hospital* confined. This includes being confined in any *institution* that has a facility for the dispensing of drugs and medicines on its premises.
10. **Medical Exclusions.** A charge excluded under the Medical Plan Exclusions subsection, unless specifically covered in this **Prescription Drug Benefits** section.
11. **Medical Marijuana.**
12. **No Charge.** A charge for *prescription drugs* which may be properly received without charge under local, state, or federal programs.

13. **Non-Legend Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
14. **Non-Network.** Prescriptions filled at a *non-network* retail pharmacy.
15. **Over-the-Counter.** Non-prescription or over-the-counter drugs or medicines (except insulin and certain over-the-counter medication required by law); prescriptions dispensed in a doctor's office or other healthcare facility; non-prescription contraceptives for males; and abortive medications.
16. **Refills.** Any refill that is requested more than one (1) year after the prescription was written or any refill that is more than the number of refills ordered by the *physician*.
17. **Tobacco/Smoking Cessation.** A charge for *prescription drugs*, such as nicotine gum or smoking deterrent patches, for smoking cessation, except as required by law.

SECTION X—CLAIMS AND APPEALS

This section contains the *claims* and *appeals* procedures and requirements for the HonorHealth Employee Health Plan.

TIME LIMIT FOR FILING CLAIMS

All *claims* must be received by the *Plan* within twelve (12) months from the date of *incurring* the expense, or in accordance with applicable federal government regulations. The *Plan* will accept *network* adjustments of *claims* that are within the *network's* established guidelines.

The *Plan's* representatives will follow administrative processes and safeguards designed to ensure and to verify that benefit *claim* determinations are made in accordance with governing plan documents and that where appropriate the *Plan* provisions have been applied consistently with respect to similarly situated *claimants*.

The following types of claims are covered by the procedures in this section:

1. **Pre-Service Claim.** Some *Plan* benefits are payable without a financial penalty only if the *Plan* approves services **before** services are rendered. These benefits are referred to as *pre-service claims* (also known as *pre-certification* or prior authorization). The services that require *pre-certification* are listed in the **Health Care Management Program** section of this document.
2. **Urgent Care Claim.** An *urgent care claim* is a *claim* (request) for medical care or treatment in which:
    a. applying the time periods for *pre-certification* could seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function
    b. 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*
    c. the *claim* involves urgent care
3. **Concurrent Care Claim.** A *concurrent care claim* refers to a *Plan* decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A *concurrent care claim* also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.
4. **Post-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 *claim* and an electronic bill, submitted for payment after services have been provided, are examples of *post-service claims*. A *claim* regarding rescission of coverage will be treated as *post-service claim*.

Following is a description of how the *Plan* processes *claims* for benefits and reviews the *appeal* of any *claim* that is denied.

If a *claim* is denied, in whole or in part, or if *Plan* coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an *adverse benefit determination*.

A *claimant* has the right to request a review of an *adverse benefit determination*. This request is an *appeal*. If the *claim* is denied at the end of the *appeal* process, as described later in this section, the *Plan's* final decision is known as a *final internal adverse benefit determination*. If the *claimant* receives *notice* of a *final internal adverse benefit determination*, or if the *Plan* does not follow the *appeal* procedures properly, the *claimant* then has the right to request an independent *external review*. The *external review* procedures are also described later in this section.

Both the *claims* and the *appeal* procedures are intended to provide a full and fair review. This means, among other things, that *claims* and *appeals* will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A *claimant* must follow all *claims* and *appeals* procedures, both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the *Plan Administrator* has not complied with the procedures described in this section. If a lawsuit is brought, it must be filed within two (2) years after the final determination of an *appeal*.

Any of the authority and responsibilities of the *Plan Administrator* under the *claims* and *appeals* procedures or the *external review* process, including the discretionary authority to interpret the terms of the *Plan*, may be

delegated to a third party. If you have any questions regarding these procedures, please contact the *Plan Administrator* or its designee.

Review of Issues That Are Not a Claim

A *plan participant* may request review of an issue (that is not a *claim*) by writing to the *Plan Administrator* whose address is listed on the Quick Reference Chart in the front of this document. The request will be reviewed and the *participant* will be advised of the decision within sixty (60) days of the receipt of the request.

A. Timeframes for Claim and Appeal Processes

	Post-Service Claims	Pre-Service Claim Types		
		Urgent Care Claim	Concurrent Care Claim	Other Pre-Service Claim
From the date of the expense, *claimant* must submit *claim* for benefit determination within:	twelve (12) months	twenty-four (24) hours	N/A	N/A
After receipt of the *claim*, *Plan* must make initial *benefit determination* as soon as possible but no later than:	thirty (30) days	seventy-two (72) hours	Before the benefit is reduced or treatment terminated	fifteen (15) days
Extension permitted during initial *benefit determination*:	fifteen (15) days	No	No	Fifteen (15) days
After receiving notification of adverse benefit determination, first-level *appeal* review must be submitted to the *Plan* within:	one hundred eighty (180) days	one hundred eighty (180) days	one hundred eighty (180) days	one hundred eighty (180) days
After the *Plan Administrator* or its designee receives the *appeal*, *Plan* must make first *appeal benefit determination* as soon as possible but no later than:	thirty (30) days per benefit *appeal*	thirty-six (36) hours	Before the benefit is reduced or treatment terminated	fifteen (15) days for each level of *appeal*
Extension permitted during *appeal* review:	No	No	No	No
After receiving notification of original appeal decision, second-level appeal must be submitted in writing within:	sixty (60) days	sixty (60) days	sixty (60) days	sixty (60) days
After the *Plan Administrator* or its designee receives the *appeal*, *Plan* must make second *appeal benefit determination* as soon as possible but no later than:	thirty (30) days	36 hours	thirty (30) days	thirty (30) days
Appeal for external review must be submitted after a final adverse benefit determination within:	four (4) months	four (4) months	four (4) months	four (4) months
After receipt of an *external review* request, *Plan* will complete preliminary review of *IRO* request within:	five (5) business days	five (5) business days	five (5) business days	five (5) business days
If request is ineligible for *external review*, *Plan* will notify *claimant* of preliminary review within:	one (1) business day	one (1) business day	one (1) business day	one (1) business day
IRO determination and notice within:	forty-five (45) days	seventy-two (72) hours	seventy-two (72) hours	forty-five (45) days

B. Appropriate Claim Administrator

The chart below outlines the companies acting as the appropriate *Claim Administrator* and types of *claims* managed.

Appropriate Claim Administrator	Types of Claims Processed
Claims Administrator	Medical *post-service claims*
Medical Management Administrator	Medical urgent care, *concurrent care*, and other *pre-service claims*
Prescription Drug Benefits Administrator	*Outpatient prescription drug pre-service* and *post-service claims*
Behavioral Health Services Administrator	Urgent, *pre-service*, *concurrent*, and *post-service claims* related to *inpatient* behavioral health service claims

Dental Plan Administrator (refer to dental plan document)	Dental pre-service and post-service claims
Vision Plan Administrator (refer to vision plan document)	Vision post-service claims

C. Types of Claims Managed by the Medical Management Administrator

The following types of *claims* are managed by the *Medical Management Administrator*:

1. *urgent care claims*
2. *concurrent care claims*
3. other *pre-service claims*

The process and procedures for each *pre-service claim* type are listed below.

D. Urgent Care Claims

Any *pre-service claim* for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health, or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*. Whether a *claim* is an *urgent care claim* will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any *claim* that a *physician,* with knowledge of the *claimant's* medical condition, determines is an *urgent care claim* (as described herein) shall be treated as an *urgent care claim* under the *Plan. Urgent care claims* are a subset of *pre-service claims*.

How to File Urgent Care Claims

In order to file an *urgent care claim*, you or your *authorized representative* must call the appropriate *Medical Management Administrator* and provide the following:

1. information sufficient to determine whether, or to what extent, benefits are covered under the *Plan*
2. a description of the medical circumstances that give rise to the need for expedited review

If you or your *authorized representative* fail to provide the *Plan* with the above information, the *Plan* will provide *notice* as soon as reasonably possible, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection . You will be afforded a reasonable amount of time under the circumstance, but no less than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection, to provide the specified information.

Notification of Benefit Determination of Urgent Care Claims

Notice of a *benefit determination* (whether adverse or not) will be provided as soon as possible, taking into account the medical circumstances, but no later than the deadline shown in the Timeframes for Claim and Appeal Processes subsection. However, if the *Plan* gives you *notice* of an incomplete *claim*, the *notice* will include a time period of no less than forty-eight (48) hours for you to respond with the requested specified information. The *Plan* will then provide you with the *notice* of *benefit determination* within forty-eight (48) hours after the earlier of:

1. receipt of the specified information
2. the end of the period of time given you to provide the information

If the *benefit determination* is provided orally, it will be followed in writing no later than three (3) days after the oral *notice*.

If the *urgent care claim* involves a concurrent care decision, a *notice* of the *benefit determination* (whether adverse or not) will be provided as soon as possible, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection for extension of treatment or care, as long as the *claim* is made within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection before the prescribed period of time expires or the prescribed number of treatments ends.

Notification of Adverse Benefit Determination of Urgent Care Claims

If an *urgent care claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Plan Administrator's notification* of an *adverse benefit determination* may be oral, followed by written or electronic *notification* within three (3) days of the oral *notification*. The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based
4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination,* either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request
6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request
7. a description of the expedited review process applicable to the *claim*
8. a description of the *Plan's* review or *appeal* procedures, including applicable time limits, and a statement of your right to bring suit under ERISA §502(a) with respect to any *claim* denied after an *appeal*
9. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

How to File an Appeal of an Urgent Care Claim

You may *appeal* any *adverse benefit determination* to the *Plan Administrator*. The *Plan Administrator* is the sole *fiduciary* of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes subsection for when a *claimant* may file a written request for an *appeal* to the decision upon *notification* of an *adverse benefit determination*. However, for *concurrent care claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Plan Administrator* or its designee will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *Plan Administrator* or its designee will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

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

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*

3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *Plan Administrator* or its designee issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of Appeals of Denied Urgent Care Claims

You or your *authorized representative* must file an *appeal* of an *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection .

Requests for *appeal* which do not comply with the above requirement will not be considered.

You may *appeal* an *adverse benefit determination* of an *urgent care claim* on an expedited basis, either orally or in writing. You may *appeal* orally by calling the appropriate *Medical Management Administrator*. All necessary information, including the *Medical Management Administrator's benefit determination* on review, will be transmitted between the *Medical Management Administrator* and you by telephone, facsimile, or other available similarly expeditious method.

Time Period for Deciding Appeals of Urgent Care Claims

Appeals of *urgent care claims* will be decided by the *Plan Administrator* or its designee as soon as possible, taking into account the *medical emergencies*, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection . A decision communicated orally will be followed-up in writing.

Notification of Appeal Denials of Urgent Care Claims

The *Plan Administrator* or its designee shall provide *notification* of the decision on an *urgent care claim* orally, but a follow-up written *notification* will be provided no later than three (3) days after the oral *notice*. The *notice* will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One (1) way to find out what may be available is to contact your local U. S. Department of Labor Office.

5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational,* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request
7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary
8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures
9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures, and a statement of your right to bring suit under ERISA §502(a)
10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

E. Concurrent Care Claims

Your *claim* for medical care or treatment is a *concurrent care claim* if your *claim* has been approved to provide an ongoing course of treatment over a period of time, which either involves a reduction or termination by the *Plan* of such course of treatment (other than by *Plan* amendment or termination), or a request by you or on your behalf to extend or expand your treatment.

If your request involves concurrent care (the continuation/reduction of an ongoing course of treatment), you may file the *claim* by writing (orally for an expedited review) to the *Medical Management Administrator*.

1. If a decision is made to reduce or terminate an approved course of treatment, you will be provided *notification* of the termination or reduction sufficiently in advance of the reduction or termination to allow you to *appeal* and obtain a determination of that *adverse benefit determination* before the benefit is reduced or terminated.
2. The *Plan* will provide you free of charge with any new or additional evidence considered, relied upon, or generated by the *Plan* (or at the direction of the *Plan*) in connection with the denied *claim*. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the *notice* of *adverse benefit determination* on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the *Plan* issues an *adverse benefit determination* or review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the *notice* of *adverse benefit determination* on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
3. A *concurrent care claim* that involves urgent care will be processed according to the initial review and *appeals* procedures and timeframes noted under the Urgent Care Claims subsection (above).
4. If a *concurrent care claim* does not involve urgent care, the request may be treated as a new benefit *claim* and decided within the timeframe appropriate to the type of *claim* (i.e., as a *pre-service claim* or a *post-service claim*). Such *claims* will be processed according to the initial review and *appeals* procedures and timeframes applicable to the claim-type, as noted under the Other Pre-Service Claims subsection (below) or the Post-Service Claims subsection listed later in this section.
5. If the *concurrent care claim* is approved, you will be *notified* orally followed by written (or electronic, as applicable) *notice* provided no later than three (3) calendar days after the oral *notice*

F. Other Pre-Service Claims

Claims that require *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan* are considered *other pre-service claims* (e.g. a request for *pre-certification* under the Health Care Management Program). Refer to the **Heath Care Management Program** section to review the list of services that require *pre-certification.*

How to File Other Pre-Service Claims

Typically, *other pre-service claims* are made on a *claimant's* behalf by the treating *physician*. However, it is the *claimant's* responsibility to ensure that the *other pre-service claim* has been filed. The *claimant* can accomplish this by having his or her *health care provider* contact the *Medical Management Administrator* to file the *other pre-service claim* on behalf of the *claimant*.

Other pre-service claims must *include* the following information:

1. the name of this *Plan*
2. the identity of the *claimant* (name, address, and date of birth)
3. the proposed date(s) of service
4. the name and credentials of the *health care provider*
5. an order or request from the *health care provider* for the requested service
6. the proposed place of service
7. a specific diagnosis
8. a specific proposed service code for which approval or payment is requested [current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format]
9. clinical information for this *Plan* to make a *medical necessity* determination

Under certain circumstances provided by federal law, if you or your *authorized representative* fail to follow the *Plan's* procedures for filing *other pre-service claims*, the *Plan* will provide *notice* of the failure and the proper procedures to be followed. This *notification* will be provided as soon as reasonably possible, but no later than five (5) days after receipt of the *claim*. You will then have up to forty-five (45) days from receipt of the *notice* to follow the proper procedures.

Notification of Benefit Determination of Other Pre-Service Claims

Notice of a *benefit determination* (whether adverse or not) will be provided in writing within a reasonable period appropriate to the medical circumstances, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection . However, this period may be extended one (1) time by the *Plan* for up to an additional fifteen (15) days if the *Plan* both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original the timeframe shown in the Timeframes for Claim and Appeal Processes subsection, of the circumstances requiring the extension and the date by which the *Plan* expects to render a decision. Refer to the Incomplete Claims subsection, if such an extension is necessary due to your failure to submit the information necessary to decide the *claim*.

Notification of Adverse Benefit Determination of Other Pre-Service Claims

If the *other pre-service claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Plan Administrator* or its designee shall provide written or electronic *notification* of the *adverse benefit determination*. This *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based
4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination,* either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the

adverse benefit determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request

6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request
7. a description of the *Plan's* review or *appeal* procedures, including applicable time limits, and a statement of your right to bring suit under ERISA §502(a) with respect to any *claim* denied after an *appeal*
8. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

How to File an Appeal of Other Pre-Service Claims

You may *appeal* any *adverse benefit determination* to the *Plan Administrator*. The *Plan Administrator* is the sole *fiduciary* of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes subsection in which a *claimant* may file a written request for an *appeal* of the decision after receiving *notification* of an *adverse benefit determination*. However, for *concurrent care claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within thirty (30) days. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Plan Administrator* or its designee will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s), and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *Plan Administrator* or its designee will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

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

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *Plan Administrator* or its designee issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of Appeals of Denied Other-Pre-Service Claims

You or your *authorized representative* must file an *appeal* of an *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection.

Requests for *appeal* which do not comply with the above requirement will not be considered.

All requests for a review of a denied *pre-service claim* (other than *urgent care claim*) must be in writing and should include a copy of the *adverse benefit determination*, if applicable, and any other pertinent information that you wish the *Medical Management Administrator* to review in conjunction with your *appeal*. Send all information to the mailing address of the applicable *Medical Management Administrator* as listed in the Quick Reference Chart.

Time Period for Deciding Appeals of Other Pre-Service Claims

Appeals of other *pre-service claims* will be decided by the *Plan Administrator* or its designee within a reasonable period of time appropriate to the medical circumstances, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. The *Plan Administrator's* decision will be provided to you in writing.

Notification of Appeal Denials of Other Pre-Service Claims

If your *appeal* is denied, in whole or in part, the *Plan Administrator* or its designee will provide written *notification* of the *adverse benefit determination* on *appeal*. The *notice* will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office.
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational,* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request
7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary
8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures
9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures, and a statement of your right to bring suit under ERISA §502(a)
10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

G. Second Level Appeals Process for Urgent Care, Concurrent Care, and Other Pre-Service Claims

If your *appeal* of a *claim* is denied, you or your *authorized representative* may request further review by the *Plan Administrator*. This request for a second-level *appeal* must be made in writing within sixty (60) days of the date you are *notified* of the original *appeal* decision. For *claims*, this second-level review is mandatory; i.e., you are required to undertake this second-level *appeal* before you may pursue civil action under Section 502(a) of ERISA.

The *Plan Administrator* or its designee will promptly conduct a full and fair review of your *appeal*, independently from the individual(s) who considered your first-level *appeal* or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was consulted neither in connection with the *adverse benefit determination* nor the initial *appeal* denial and who is not a subordinate of any such individuals.

Second-level *appeals* of *claims* will be decided by the *Plan Administrator* or its designee within a reasonable period of time, but no later than the deadline shown in the Timeframes for Claim and Appeal Processes subsection. The *Plan Administrator's* decision will be provided to you in writing, and if the decision is a second denial, the *notification* will include all of the information described in the subsection entitled Notification of Appeal Denials above.

H. External Review of Pre-Service Claims

Refer to the **External Review of Claims** section for the full description of the external review process under the *Plan*.

I. Incomplete Claims

Incomplete *pre-service claims* and/or *post-service claims* can be addressed through the extension of time described herein. (Refer to *Claim* in the **Defined Terms** section.) If the reason for the extension is the failure to provide necessary information and the *claimant* is appropriately *notified*, this *Plan's* period of time to make a decision is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the *claimant* responds or should have responded.

The *notification* will include a timeframe of at least forty-five (45) days in which the necessary information must be provided. Once the necessary information has been provided, this *Plan* will decide the *claim* within the extension described herein.

However, if the time period for the *benefit determination* is extended due to your failure to submit information necessary to decide a *claim*, the time period for making the *benefit determination* will be suspended from the date the *notice* of extension is sent to you until the earlier of:

1. the date on which you respond to the request for additional information
2. the date established by the *Plan* for the furnishing of the requested information [at least forty-five (45) days]

If the requested information is not provided within the time specified, the *claim* may be denied. If your *claim* is denied based on your failure to submit information necessary to decide the *claim*, the *Plan* may, in its sole discretion, renew its consideration of the denied *claim* if the *Plan* receives the additional information within one hundred eighty (180) days after original receipt of the *claim*. In such circumstances, you will be *notified* of the *Plan's* reconsideration and subsequent *benefit determination*.

J. Post-Service Claims

The *Claims Administrator* manages the *claims* and *appeal* process of *post-service claims*.

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 *claim* and an electronic bill, submitted for payment after services have been

provided, are examples of *post-service claims*. A *claim* regarding rescission of coverage will be treated as *post-service claim*.

How to File Post-Service Claims

In order to file a *post-service claim*, you or your *authorized representative* must submit the *claim* in writing on a form pre-approved by the *Plan*. Pre-approved *claim* forms are available from **www.MyAmeriBen.com**.

All *claims* must be received by the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection and must include the following information:

1. the *plan participant's* name and address
2. the covered *employee's* name, employee number, and address if different from the *plan participant's*
3. the provider's name, tax identification number, address, degree, and signature
4. date(s) of service
5. diagnosis
6. procedure codes (describes the treatment or services rendered)
7. *assignment of benefits*, signed (if payment is to be made to the provider)
8. release of information statement, signed
9. coordination of benefits (COB) information if another plan is the primary payer
10. sufficient medical information to determine whether and to what extent the expense is a covered benefit under the *Plan*

Send complete information to:

AmeriBen
P.O. Box 7186
Boise, ID 83707

BlueCross BlueShield of Arizona providers and facilities within the state of Arizona must submit all claims to:

BlueCross BlueShield of Arizona
P.O. Box 2924
Phoenix, AZ 85062-2924

Notification of Benefit Determination of Post-Service Claims

The *Plan* will *notify* you or your *authorized representative* of its *benefit determination* (whether adverse or not) no later the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. However, this period may be extended one (1) time by the *Plan* for up to the timeframe shown in the Timeframes for Claim and Appeal Processes subsection if the *Plan* both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original time period, of the circumstances requiring the extension and the date by which the *Plan* expects to render a decision.

The applicable time period for the *benefit determination* begins when your *claim* is filed in accordance with the reasonable procedures of the *Plan*, even if you haven't submitted all the information necessary to make a *benefit determination*. Refer to the Incomplete Claims subsection for information regarding incomplete *claims*.

Notification of Adverse Benefit Determination of Post-Service Claims

If a *post-service claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Plan Administrator* or its designee shall provide written or electronic *notification* of the *adverse benefit determination*. This *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based

4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination,* either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request
6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request
7. a description of the *Plan's* review or *appeal* procedures, including applicable time limits, and a statement of your right to bring suit under ERISA §502(a) with respect to any *claim* denied after an *appeal*
8. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

How to File an Appeal of Post-Service Claims

You may *appeal* any *adverse benefit determination* to the *Plan Administrator*. The *Plan Administrator* is the sole *fiduciary* of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes subsection in which a *claimant* may file a written request for an *appeal* of the decision on. However, for *concurrent care claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Plan Administrator* or its designee will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* or its designee written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *Plan Administrator* or its designee will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

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

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *Plan Administrator* issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of Appeals of Denied Post-Service Claims

You or your *authorized representative* must file an *appeal* of an *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection.

Requests for *appeal* which do not comply with the above requirement will not be considered.

All requests for a review of a denied *post-service claim* must be in writing and should include a copy of the *adverse benefit determination* and any other pertinent information that you wish the *Third Party Administrator* to review in conjunction with your *appeal*. Send all information to:

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707

Time Period for Deciding Appeals of Post-Service Claims

Appeals of *post-service claims* will be decided by the *Plan Administrator* or its designee within a reasonable period of time, but no later than thirty (30) days after the *Plan Administrator* or its designee receives the *appeal*. The *Plan Administrator's* decision will be provided to you in writing.

Notification of Appeal Denials of Post-Service Claims

If your *appeal* is denied, in whole or in part, the *Plan Administrator* or its designee will provide written *notification* of the *adverse benefit determination* on *appeal*. The *notice* will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One (1) way to find out what may be available is to contact your local U. S. Department of Labor Office.
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational,* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request
7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary
8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures

9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures, and a statement of your right to bring suit under ERISA §502(a)
10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

K. Second-Level Appeal Process of Post-Service Claims

The *Plan Administrator* or its designee manages the second-level *appeal* process for *post-service claim decisions*.

The *Plan Administrator* or its designee will be identified in the *notification* of denial of your first-level *appeal* and will not be the individual who made the original decision regarding the denial of your first-level *appeal* or a subordinate of such individual.

If your *appeal* of a *post-service claim* is denied, you or your *authorized representative* may request further review by the *Plan Administrator*. This request for a second-level *appeal* must be made in writing within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. For *claims*, this second-level review is mandatory; i.e., you are required to undertake this second-level *appeal* before you may pursue civil action under Section 502(a) of ERISA.

The *Plan Administrator* or its designee will promptly conduct a full and fair review of your *appeal*, independently from the individual(s) who considered your first-level *appeal* or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information, as described in more detail under the subsection entitled Post-Service Claims above.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was consulted neither in connection with the *adverse benefit determination* nor the initial *appeal* denial and who is not a subordinate of any such individuals.

Second-level *appeals* of *post-service claims* will be decided by the *Plan Administrator* or its designee within a reasonable period of time, but no later than the deadline shown in the Timeframes for Claim and Appeal Processes subsection. The *Plan Administrator's* decision will be provided to you in writing, and if the decision is a second denial, the *notification* will include all of the information described in the provision entitled Notification of Appeal Denials of Post-Service Claims above.

L. External Review Rights

If your final *appeal* for a *claim* is denied, you will be *notified* in writing that your *claim* is eligible for an *external review*, and you will be informed of the time frames and the steps necessary to request an *external review*. You must complete all levels of the internal *claims* and *appeals* procedures before you can request a voluntary *external review*.

If you decide to seek *external review*, an *independent review organization (IRO)* will be assigned your *claim*, and the *IRO* will work with a neutral, independent clinical reviewer with appropriate medical expertise. The *IRO* does not have to give deference to any earlier *claims* and *appeals* decisions, but it must observe the written terms of the plan document. In other words, the *IRO* is not bound by any previous decision made on your *claim*. The ultimate decision of the *IRO* will be binding on you, the *Third Party Administrator*, and the *Plan*.

M. External Review of Claims

The *external review* process is available only where the *final internal adverse benefit determination* is denied on the basis of any of the following:

1. a medical judgment (which includes but is not limited to: *Plan* requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of a covered benefit)
2. a determination that a treatment is *experimental* or *investigational*

3. a rescission of coverage

If your *appeal* is denied, you or your *authorized representative* may request further review by an *independent review organization (IRO)*. This request for *external review* must be made, in writing, within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. This *external review* is mandatory; i.e., you are required to undertake this *external review* before you may pursue civil action under Section 502(a) of ERISA.

The *Plan* will complete a preliminary review of the request within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection to determine whether:

1. the *claimant* is or was covered under the *Plan* at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the *Plan* at the time the health care item or service was provided
2. the *adverse benefit determination* or the *final internal adverse benefit determination* does not relate to the *claimant's* failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination)
3. the *claimant* has exhausted the *Plan's* internal *appeal* process
4. the *claimant* has provided all the information and forms required to process an *external review*

The *Plan* will notify the *claimant* of completion of its preliminary review within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection if either:

1. the request is complete but not eligible for *external review*, in which case the *notice* will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration [toll-free number 1-866-444-EBSA (3272)]
2. the request is not complete, in which case the *notice* will describe the information or materials needed to make the request complete, and allow the *claimant* to perfect the request for *external review* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection **NOTE:** If the *adverse benefit determination* or *final internal adverse benefit determination* relates to a *plan participant's* or beneficiary's failure to meet the requirements for eligibility under the terms of the *Plan*, it is not within the scope of the *external review* process, and no *external review* may be taken.

If the request is complete and eligible, the *Plan Administrator* will assign the request to an *IRO*. Once that assignment is made, the following procedure will apply:

1. The assigned *IRO* will utilize legal experts where appropriate to make coverage determinations under the *Plan*.
2. The assigned *IRO* will timely *notify* the *claimant* in writing of the request's eligibility and acceptance for *external review*. This *notice* will include a statement that the *claimant* may submit in writing to the assigned *IRO,* within ten (10) business days following the date of receipt of the *notice,* additional information that the *IRO* must consider when conducting the *external review*. The *IRO* is not required to, but may, accept and consider additional information submitted after ten (10) business days.
3. Within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection, the *Plan* must provide to the assigned *IRO* the documents and any information considered in making the *adverse benefit determination* or *final internal adverse benefit determination*. Failure by the *Plan* to timely provide the documents and information must not delay the conduct of the *external review*. If the *Plan* fails to timely provide the documents and information, the assigned *IRO* may terminate the *external review* and make a decision to the *adverse benefit determination* or *final internal adverse benefit determination*. The *IRO* must *notify* the *claimant* and the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection.
4. Upon receipt of any information submitted by the *claimant*, the assigned *IRO* must forward the information to the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. Upon receipt of any such information, the *Plan* may reconsider its *adverse benefit determination* or *final internal adverse benefit determination* that is the subject of the *external review*. Reconsideration by the *Plan* must not delay the *external review*. The *external review* may be terminated as a result of the reconsideration only if the *Plan* decides, upon completion of its reconsideration, to reverse its *adverse benefit determination* or *final internal adverse benefit determination* and provide coverage or payment. The *Plan* must provide written *notice* of its decision to the *claimant* and the assigned *IRO* within the timeframe shown in the Timeframes for Claim and

Appeal Processes subsection. The assigned *IRO* must terminate the *external review* upon receipt of the *notice* from the *Plan*.

5. The *IRO* will review all of the information and documents timely received. In reaching a decision, the assigned *IRO* will review the *claim* de novo and not be bound by any decisions or conclusions reached during the *Plan's* internal *claims* and *appeals* process. In addition to the documents and information provided, the assigned *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, will consider the following in reaching a decision:
    a. the *claimant's* medical records
    b. the attending health care professional's recommendation
    c. reports from appropriate health care professionals and other documents submitted by the *Plan*, *claimant*, or the *claimant's* treating provider
    d. the terms of the *claimant's Plan* to ensure that the *IRO's* decision is not contrary to the terms of the *Plan*, unless the terms are inconsistent with applicable law
    e. appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations
    f. any applicable clinical review criteria developed and used by the *Plan*, unless the criteria are inconsistent with the terms of the *Plan* or with applicable law
    g. the opinion of the *IRO's* clinical reviewer or reviewers after considering the information described in this *notice* to the extent the information or documents are available
6. The assigned *IRO* must provide written *notice* of the final *external review* decision within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection. The *IRO* must deliver the *notice* of *final external review decision* to the *claimant* and the *Plan*.
7. The assigned *IRO's* decision *notice* will contain:
    a. a general description of the reason for the request for *external review*, including information sufficient to identify the *claim* [including the date or dates of service, the health care provider, the *claim* amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial]
    b. the date the *IRO* received the assignment to conduct the *external review* and the date of the *IRO* decision
    c. the references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision
    d. a discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision
    e. a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health *Plan* or to the *claimant*
    f. a statement that judicial review may be available to the *claimant*
    g. current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman

If you remain dissatisfied with the outcome of the *external review*, you may pursue civil action under Section 502(a) of ERISA.

Generally, a *claimant* must exhaust the *Plan's claims* and *appeals* procedures in order to be eligible for the *external review* process. However, in some cases the *Plan* provides for an expedited *external review* if either:

1. The *claimant* receives an *adverse benefit determination* that involves a medical condition for which the time for completion of the *Plan's* internal *claims* and *appeals* procedures would seriously jeopardize the *claimant's* life, health, or ability to regain maximum function, and the *claimant* has filed a request for an expedited internal review.
2. The *claimant* receives a *final internal adverse benefit determination* that involves a medical condition where the time for completion of a standard *external review* process would seriously jeopardize the *claimant's* life or health or the *claimant's* ability to regain maximum function, or if the *final internal adverse benefit determination* concerns an admission, availability of care, continued stay, or health

care item or service for which the *claimant* received *emergency services*, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited *external review*, the *Plan* must determine and *notify* the *claimant* whether the request satisfies the requirements for expedited review, including the eligibility requirements for *external review* listed above. If the request qualifies for expedited review, it will be assigned to an *IRO*. The *IRO* must make its determination and provide a *notice* of the decision as expeditiously as the *claimant's* medical condition or circumstances require, but in no event more than seventy-two (72) hours after the *IRO* receives the request for an expedited *external review*. If the original *notice* of its decision is not in writing, the *IRO* must provide written confirmation of the decision to both the claimant and the Plan within the timeframe shown in the Timeframes for Claim and Appeal Processes subsection.

N. Appointment of Authorized Representative

A *plan participant* is permitted to appoint an *authorized representative* to act on his/her behalf with respect to a benefit *claim* or *appeal* of a denial. Neither a HIPAA authorization nor an *assignment of benefits* by a *plan participant* to a provider will constitute appointment of that provider as an *authorized representative*. To appoint such a representative, the *plan participant* must complete a form which can be obtained from the *Plan Administrator* or the *Third Party Administrator*. The form must clearly indicate on the form the nature and extent of the authorization. In connection with a *claim* involving urgent care, the *Plan* will permit a health care professional with knowledge of the *plan participant's* medical condition to act as the *plan participant's authorized representative*. In the event a *plan participant* designates an *authorized representative*, all future communications from the *Plan* will be with the representative, rather than the *plan participant*, unless the *plan participant* directs the *Plan Administrator*, in writing, to the contrary. If you wish to change/alter your authorized representative, or the time frame, you will need to submit these changes in writing.

O. Physical Examinations

The *Plan* reserves the right to have a *physician* of its own choosing examine any *plan participant* whose condition, *illness*, or *injury* is the basis of a *claim*. All such examinations shall be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan* may reasonably require during the pendency of a *claim*. The *plan participant* must comply with this requirement as a necessary condition to coverage.

P. Autopsy

The *Plan* reserves the right to have an autopsy performed upon any deceased *plan participant* whose condition, *illness*, or *injury* is the basis of a *claim*. This right may be exercised only where not prohibited by law.

Q. Payment of Benefits

All benefits under this *Plan* are payable, in U.S. dollars, to the *plan participant* whose *illness* or *injury*, or whose covered *dependent's illness* or *injury*, is the basis of a *claim*. In the event of the death or incapacity of a *plan participant,* and in the absence of written evidence to this *Plan* of the qualification of a guardian for his/her estate, this *Plan* may, in its sole discretion, make any and all such payments to the individual or *institution* which, in the opinion of this *Plan*, is or was providing the care and support of such *employee*.

R. Assignments

Benefits for medical expenses covered under this *Plan* may be assigned by a *plan participant* to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the *employee*, the *Plan* shall be deemed to have fulfilled its obligations with respect to such benefits. The *Plan* will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the *plan participant* and the assignee, has been received before the proof of loss is submitted.

No *plan participant* shall at any time, either during the time in which he or she is a *plan participant* in the *Plan*, or following his/her termination as a *plan participant*, in any manner, have any right to assign his/her right to sue to recover benefits under the *Plan*, to enforce rights due under the *Plan,* or to any other causes of action which he or she may have against the *Plan* or its fiduciaries.

A provider which accepts an *assignment of benefits*, in accordance with this *Plan* as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

S. Non-U.S. Providers

Medical expenses for care, supplies, or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (non-U.S. provider) are payable under the *Plan*, subject to all *Plan* exclusions, limitations, maximums, and other provisions, under the following conditions:

1. Benefits may not be assigned to a non-U.S. provider.
2. The *plan participant* is responsible for making all payments to non-U.S. providers and submitting receipts to the *Plan* for reimbursement.
3. Benefit payments will be determined by the *Plan* based upon the exchange rate in effect on the *incurred* date.
4. The non-U.S. provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements.
5. *Claims* for benefits must be submitted to the *Plan* in English.

T. Recovery of Payments

Occasionally, benefits are paid more than once; are paid based upon improper billing or a misstatement in a proof of loss or enrollment information; are not paid according to the *Plan's* terms, conditions, limitations, or exclusions; or should otherwise not have been paid by the *Plan*. As such this *Plan* may pay benefits that are later found to be greater than the *maximum allowable charge*. In this case, this *Plan* may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the *plan participant* or *dependent* on whose behalf such payment was made.

A *plan participant*, *dependent*, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the *Plan* or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the *Plan* within thirty (30) days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

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

Providers and any other person or entity accepting payment from the *Plan* or to whom a right to benefits has been assigned, in consideration of services rendered, payments, and/or rights, agrees to be bound by the terms of this *Plan* and agree to submit *claims* for reimbursement in strict accordance with their state's health care practice acts, ICD-10 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator* or insurer. Any payments made on *claims* for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the *Plan* must bring an action against a *plan participant*, provider, or other person or entity to enforce the provisions of this section, then that *plan participant*, provider, or other person or entity agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

Further, *plan participants* and/or their *dependents*, beneficiaries, estate, heirs, guardian, personal representative, or assigns (*plan participant*) shall assign or be deemed to have assigned to the *Plan* their right to recover said payments made by the *Plan*, from any other party and/or recovery for which the *plan*

participant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the *Plan* has not already been refunded.

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

1. in error
2. pursuant to a misstatement contained in a proof of loss or a fraudulent act
3. pursuant to a misstatement made to obtain coverage under this *Plan* within two (2) years after the date such coverage commences
4. with respect to an ineligible person
5. in anticipation of obtaining a recovery if a *plan participant* fails to comply with the *Plan's* **Reimbursement And Recovery Provisions**
6. pursuant to a *claim* for which benefits are recoverable under any policy or act of law providing for coverage for occupational *injury* or *disease* to the extent that such benefits are recovered

   This provision (6) shall not be deemed to require the *Plan* to pay benefits under this *Plan* in any such instance.

The *deduction* may be made against any *claim* for benefits under this *Plan* by a *plan participant* or by any of his/her covered *dependents* if such payment is made with respect to the *plan participant* or any person covered or asserting coverage as a *dependent* of the *plan participant*.

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

SECTION XI—COORDINATION OF BENEFITS

A. Coordination of the Benefit Plans

Coordination of benefits sets out rules for the order of payment of *covered charges* when two (2) or more plans, including *Medicare*, are paying. When a *plan participant* is covered by this *Plan* and another plan, or the *plan participant's* spouse is covered by this *Plan* and by another plan, or the couple's covered children are covered under two (2) or more plans, the plans will coordinate benefits when a *claim* is received.

Non-Duplication/Maintenance of Benefits

The plan that pays first according to the rules will pay as if there were no *other plan* involved. The secondary will pay up to its own plan formula minus whatever the primary plan paid.

Example: Assume all *deductibles* are met, billed services are considered *covered charges* under both plans, the primary plan pays 80% of the *allowable amount*, and the secondary plan pays 90% of the *allowable amount*. A *plan participant* incurs a *claim* with a *network* provider in which the *allowable amount* is $1,000.

Primary Plan	$800
Secondary Plan	$100
Patient Responsibility	$100
Total Amount Paid	$1,000

If the *plan participant* is *Medicare* primary, *claims* are coordinated with the *Plan* according to the *Medicare* allowed amounts. The coordination of these *claims* is standard coordination of benefits. The plan that pays first according to the rules will pay as if there were no *other plan* involved. The secondary and subsequent plans will pay the balance due up to 100% of the total *allowable charges*.

B. Excess Insurance

If at the time of *injury*, *illness*, *disease*, or disability there is available, or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlements), the benefits under this *Plan* shall apply only as an excess over such other sources of coverage.

The *Plan's* benefits will be excess to, whenever possible:

1. any primary payer besides the *Plan*
2. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured or underinsured motorist coverage
3. any policy of insurance from any insurance company or guarantor of a third party
4. workers' compensation or other liability insurance company

   This *Plan* does not provide benefits if the expenses are covered by workers' compensation or occupational disease law. If your *employer* contests the application of workers' compensation law for the *illness* or *injury* for which expenses are incurred, this *Plan* will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, you and/or your covered *dependent* must execute a subrogation and reimbursement agreement acceptable to the *Plan Administrator* or its designee.
5. any other source, including, but not limited to, crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payments

C. Allowable Charge

For a charge to be allowable it must be within the Plan's *maximum amount* and at least part of it must be covered under this *Plan*.

In the case of HMO (health maintenance organization) or other *network* only plans, this *Plan* will not consider any charges in excess of what an HMO or *network* provider has agreed to accept as payment in full. Also, when an HMO or *network* plan is primary and the *plan participant* does not use an HMO or *network* provider, this *Plan*

will not consider as an *allowable charge* any charge that would have been covered by the HMO or *network* plan had the *plan participant* used the services of an HMO or *network* provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the *allowable charge*.

D. General Limitations

When medical payments are available under any other insurance source, the *Plan* shall always be considered the secondary carrier.

E. Application to Benefit Determinations

The plan that pays first according to the rules in the subsection entitled Benefit Plan Payment Order will pay as if there were no *other plan* involved. The secondary and subsequent plans will pay up to its own plan formula minus whatever the primary plan paid. When there is a conflict in the rules, this *Plan* will never pay more than 50% of *allowable charges* when paying secondary. Benefits will be coordinated as referenced in the Claims Determination Period subsection.

When medical payments are available under automobile insurance, this *Plan* will pay excess benefits only, without reimbursement for automobile plan *deductibles*. This *Plan* will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the *other plan* will be ignored for the purposes of determining the benefits under this *Plan*. This is the case when either:

1. the *other plan* would, according to its rules, determine its benefits after the benefits of this *Plan* have been determined
2. the rules in the subsection entitled Benefit Plan Payment Order would require this *Plan* to determine its benefits before the *other plan*

F. Benefit Plan Payment Order

When two (2) or more plans provide benefits for the same *allowable charge*, benefit payment will adhere to these rules in the following order:

1. Plans that do not have a coordination provision, or one like this, will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits up to the *allowable charge*:
    a. The benefits of the plan which covers the person directly (that is, as an *employee*, member, or subscriber) are determined before those of the plan which covers the person as a *dependent*.
    b. An individual plan (that is, a non-group plan purchased by an individual), whether provided through a policy, subscriber contract, health care network plan, group practice or individual practice plan, or through the Health Insurance Marketplace, pays first and this *Plan* pays second.
    c. The benefits of a benefit plan which covers a person as an *employee* who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a *dependent* of an *employee* who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a *dependent* of a laid off or retired *employee*. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
    d. The benefits of a benefit plan which covers a person as an *employee* who is neither laid off nor retired or a *dependent* of an *employee* who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
    e. When a *child* is covered as a *dependent* and the parents are not separated or divorced, these rules will apply:

i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year.

ii. If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

f. When a *child's* parents are divorced or legally separated, these rules will apply:

i. This rule applies when the parent with custody of the *child* has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

ii. This rule applies when the parent with custody of the *child* has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the step-parent that covers the *child* as a *dependent* will be considered next. The benefit plan of the parent without custody will be considered last.

iii. This rule will be in place of items (i.) and (ii.) immediately above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the *child*. In this case, the benefit plan of that parent will be considered before other plans that cover the *child* as a *dependent*.

iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the *child*, the plans covering the *child* shall follow the order of benefit determination rules outlined above when a *child* is covered as a *dependent* and the parents are not separated or divorced.

v. For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

g. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the *Plan* will never pay more than 50% of *allowable charges* when paying secondary.

h. When a married *dependent* child is covered as a *dependent* on both a spouse's plan and a parent's plan, and the policies are both effective on the same day, the benefits of the policy holder whose birthday falls earlier in a year are determined before those of the policy holder whose birthday falls later in that year.

3. *Medicare* will pay primary, secondary, or last to the extent stated in federal law. Refer to the Medicare publication Your Guide to Who Pays First at **https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance/which-insurance-pays-first**. When *Medicare* would be the primary payer if the person had enrolled in *Medicare*, this *Plan* will base its payment upon benefits that would have been paid by *Medicare* under Parts A and B, regardless of whether or not the person was enrolled under any of these parts. The *Plan* reserves the right to coordinate benefits with respect to *Medicare* Part D. The *Plan Administrator* will make this determination based on the information available through Centers for Medicare & Medicaid Services (CMS). If CMS does not provide sufficient information to determine the amount *Medicare* would pay, the *Plan Administrator* will make reasonable assumptions based on published *Medicare* fee schedules.

4. If a *plan participant* is under a disability extension from a previous benefit plan, that benefit plan will pay first, and this *Plan* will pay second.

5. When an adult *dependent* is covered by his/her spouse's plan and is also covered by his/her parent's plan, the benefits of the benefit plan which has covered the patient for the longest time are determined before those of the *other plan*.

6. When an adult *dependent* is covered by multiple parents' plans, the benefits of the benefit plan of the parent whose birthday falls earlier in the year are determined before those of the benefit plan of the parent whose birthday falls later in that year. Should both/all parents have the same birthday, the benefits of the benefit plan which has covered the patient the longest shall be determined first.

G. Coordination with Government Programs

1. **Medicaid/IHS.** If a *plan participant* is covered by both this *Plan* and Medicaid or Indian Health Services (IHS), this *Plan* pays first and Medicaid or IHS pays second.
2. **Tricare.** If a covered *dependent* is covered by both this *Plan* and Tricare, the program that provides healthcare services to dependents of active armed services personnel, this *Plan* pays first and Tricare pays second. For an *employee* called to active duty for more than thirty (30) days, Tricare is primary and this *Plan* is secondary; otherwise, this *Plan* is primary and Tricare is secondary for the covered *employee*.
3. **Veterans Affairs or Military Medical Facility Services.** If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of a military service-related *illness* or *injury*, benefits are not covered by this *Plan*. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of any other condition that is not a military service-related *illness* or *injury*, benefits are covered by the *Plan* to the extent those services are medically necessary and the charges are within this *Plan's maximum allowable charge*.
4. **Other Coverage Provided by State or Federal Law.** If you are covered by both this *Plan* and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this *Plan* pays second.

H. Claims Determination Period

Benefits will be coordinated on a *calendar year* basis. This is called the claims determination period.

I. Right to Receive or Release Necessary Information

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

J. Facility of Payment

Whenever payments which should have been made under this *Plan* in accordance with this provision have been made under any *other plans*, the *Plan Administrator* may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this *Plan* and, to the extent of such payments, this *Plan* shall be fully discharged from liability. This *Plan* may repay *other plans* for benefits paid that the *Plan Administrator* determines it should have paid. That repayment will count as a valid payment under this *Plan*.

K. Right of Recovery

In accordance with the **Claims and Appeals** section, Recovery of Payments subsection, whenever payments have been made by this *Plan* with respect to *allowable charges* in a total amount, at any time, in excess of the *maximum amount* of payment necessary at that time to satisfy the intent of this article, the *Plan* shall have the right to recover such payments, to the extent of such excess, from any one (1) or more of the following as this *Plan* shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the *Plan* determines are responsible for payment of such *allowable charges*, and any future benefits payable to the *plan participant* or his/her *dependents*. Please see the Recovery of Payments subsection for more details.

L. Exception to Medicaid

In accordance with ERISA, the *Plan* shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the *Plan* or making a determination about the payments for benefits received by a *plan participant* under the *Plan*.

SECTION XII—MEDICARE

A. Application to Active Employees and Their Spouses

An *active employee* and his/her spouse (when eligible for *Medicare*) may, at the option of such *employee*, elect or reject coverage under this *Plan*. If such employee elects coverage under this *Plan*, the benefits of this *Plan* shall be determined before any benefits provided by *Medicare*. If coverage under this *Plan* is rejected by such *employee*, benefits listed herein will not be payable even as secondary coverage to *Medicare*.

B. Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by federal regulations, this *Plan* will pay before any *Medicare* benefits. There are some circumstances under which *Medicare* would be required to pay its benefits first. In these cases, benefits under this *Plan* would be calculated as the secondary payer (as described under the section entitled **Coordination of Benefits**). The *plan participant* will be assumed to have full *Medicare* coverage (that is, both Parts A & B) whether or not the *plan participant* has enrolled for the full coverage. If the provider accepts assignment with *Medicare*, *covered charges* will not exceed the *Medicare* approved expenses.

SECTION XIII—REIMBURSEMENT AND RECOVERY PROVISIONS

A. Payment Condition

The *Plan*, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an *injury*, *illness*, *disease,* or disability is caused in whole or in part by, or results from the acts or omissions of *plan participants*, and/or their *dependents*, beneficiaries, estate, heirs, guardian, personal representative, or assigns [collectively referred to hereinafter in this section as *plan participant(s)*] or a third party, where any party besides the *Plan* may be responsible for expenses arising from said incident, and/or other funds are available. This includes but is not limited to: *no-fault auto insurance* coverage, uninsured or underinsured motorist, medical payment provisions, third-party assets, third-party insurance, and/or grantor(s) of a third party (collectively referred to as coverage).

Plan participant(s), his/her attorney, and/or *legal guardian* of a minor or incapacitated individual agrees that acceptance of the *Plan's* conditional payment of medical benefits is constructive *notice* of these provisions in their entirety and agrees to maintain 100% of the *Plan's* conditional payment of benefits or the full extent of payment from any one (1) or combination of first and third-party sources in trust, without disruption except for reimbursement to the *Plan* or the *Plan's* assignee. By accepting benefits, the *plan participant(s)* agrees the *Plan* shall have an equitable lien on any funds received by the *plan participant(s)* and/or their attorney from any source, and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The *plan participant(s)* agrees to include the *Plan's* name as a co-payee on any and all settlement drafts. Further, by accepting benefits the *plan participant(s)* understands that any recovery obtained pursuant to this section is an asset of the *Plan* to the extent of the amount of benefits paid by the *Plan* and that the *plan participant* shall be a trustee over those *Plan* assets.

In the event a *plan participant(s)* settles, recovers, or is reimbursed by any coverage, the *plan participant(s)* agrees to reimburse the *Plan* for all benefits paid or that will be paid by the *Plan* on behalf of the *plan participant(s)*. When such a recovery does not include payment for future treatment, the *Plan's* right to reimbursement extends to all benefits paid, or that will be paid by the *Plan* on behalf of the *plan participant(s)* for charges *incurred* up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the *Plan.* If the *plan participant(s)* fails to reimburse the *Plan* out of any judgment or settlement received, the *plan participant(s)* will be responsible for any and all expenses (fees and costs) associated with the *Plan's* attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges *incurred* after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one (1) party responsible for charges paid by the *Plan*, or may be responsible for charges paid by the *Plan*, the *Plan* will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple *injured* parties of which the *plan participant(s)* is/are only one (1) or a few, that unallocated settlement fund is considered designated as an identifiable fund from which the *Plan* may seek reimbursement.

B. Subrogation

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

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

The *Plan* may, at its discretion, in its own name, or in the name of the *plan participant(s),* commence a proceeding or pursue a *claim* against any party or coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the *Plan*.

If the *plan participant(s)* fails to file a *claim* or pursue damages against:

1. any primary payer besides the *Plan*
2. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured or underinsured motorist coverage
3. any policy of insurance from any insurance company or guarantor of a third party
4. workers' compensation or other liability insurance company
5. any other source, including, but not limited to, crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payments

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

C. Right of Reimbursement

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

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

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

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

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

D. Participant is a Trustee Over Plan Assets

Any *plan participant* who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the *Plan* solely as it relates to possession of any funds which may be owed to the *Plan* as a result of any settlement, judgment or recovery through any other means arising from any *injury* or *accident*. By virtue of this status, the *plan participant* understands that he or she is required to:

1. notify the *Plan* or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds
2. instruct his or her attorney to ensure that the *Plan* and/or its authorized representative is included as a payee on all settlement drafts
3. in circumstances where the *plan participant* is not represented by an attorney, instruct the insurance company or any third party from whom the *plan participant* obtains a settlement, judgment or other

source of coverage to include the *Plan* or its authorized representative as a payee on the settlement draft

4. hold any and all funds so received in trust, on the *Plan's* behalf, and function as a trustee as it applies to those funds, until the *Plan's* rights described herein are honored and the *Plan* is reimbursed

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

No *plan participant*, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the *Plan's* interest on the *Plan's* behalf.

E. Release of Liability

The *Plan's* right to reimbursement extends to any incident related care that is received by the *plan participant(s)* prior to the liable party being released from liability. The *plan participant(s)*' obligation to reimburse the *Plan* is therefore tethered to the date upon which the claims were *incurred*, not the date upon which the payment is made by the *Plan*. In the case of a settlement, the *plan participant(s)* has an obligation to review the "lien" provided by the *Plan* for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the *Plan* of any incident related care *incurred* prior to the proposed date of settlement and/or release, which is not listed but has been or will be *incurred*, and for which the *Plan* will be asked to pay.

F. Excess Insurance

If at the time of *injury*, *illness*, *disease*, or disability there is available, or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlements), the benefits under this *Plan* shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the *Plan's* **Coordination of Benefits** section.

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

1. the responsible party, its insurer, or any other source on behalf of that party
2. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured or underinsured motorist coverage
3. any policy of insurance from any insurance company or guarantor of a third party
4. workers' compensation or other liability insurance company
5. any other source, including, but not limited to, crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payments

G. Separation of Funds

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

H. Wrongful Death

In the event that the *plan participant(s)* dies as a result of his/her *injuries* and a wrongful death or survivor claim is asserted against a third party or any coverage, the *Plan's* subrogation and reimbursement rights shall still apply, and the entity pursuing said *claim* shall honor and enforce these *Plan* rights and terms by which benefits are paid on behalf of the *plan participant(s)* and all others that benefit from such payment.

I. Obligations

It is the *plan participant's* obligation at all times, both prior to and after payment of medical benefits by the *Plan*:

1. to cooperate with the *Plan*, or any representatives of the *Plan*, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the *Plan's* rights
2. to provide the *Plan* with pertinent information regarding the *illness*, *disease*, disability, or *injury*, including accident reports, settlement information, and any other requested additional information
3. to take such action and execute such documents as the *Plan* may require to facilitate enforcement of its subrogation and reimbursement rights
4. to do nothing to prejudice the *Plan's* rights of subrogation and reimbursement
5. to promptly reimburse the *Plan* when a recovery through settlement, judgment, award, or other payment is received
6. to notify the *Plan* or its authorized representative of any settlement prior to finalization of the settlement
7. to *notify* the *Plan* or its *authorized representative* of any incident-related claims or care which may not be identified within the lien (but has been *incurred*) and/or reimbursement request submitted by or on behalf of the *Plan*
8. to not settle or release, without the prior consent of the *Plan*, any *claim* to the extent that the *plan participant* may have against any responsible party or coverage
9. to instruct his or her attorney to ensure that the *Plan* and/or its authorized representative is included as a payee on any settlement draft
10. in circumstances where the *plan participant* is not represented by an attorney, instruct the insurance company or any third party from whom the *plan participant* obtains a settlement to include the *Plan* or its authorized representative as a payee on the settlement draft
11. to make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the *Plan* and *plan participant* over settlement funds is resolved

If the *plan participant(s)* and/or his/her attorney fails to reimburse the *Plan* for all benefits paid or to be paid, incurred, or that will be *incurred* prior to the date of the release of liability from the relevant entity, as a result of said *injury* or condition, out of any proceeds, judgment, or settlement received, the *plan participant(s)* will be responsible for any and all expenses (whether fees or costs) associated with the *Plan's* attempt to recover such money from the *plan participant(s)*.

The *Plan's* rights to reimbursement and/or subrogation are in no way dependent upon the *plan participant's* cooperation or adherence to these terms.

J. Offset

Failure by the *plan participant(s)* and/or his/her attorney to comply with any of these requirements may, at the *Plan's* discretion, result in a forfeiture of payment by the *Plan* of medical benefits, and any funds or payments due under this *Plan* on behalf of the *plan participant(s)* may be withheld until the *plan participant(s)* satisfies his/her obligation. This provision applies even if the *plan participant(s)* has disbursed settlement funds.

K. Minor Status

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

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

L. Language Interpretation

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

SECTION XIV—CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain *employees* and their families covered under the HonorHealth Employee Health Plan (*Plan*) will be entitled to the opportunity to elect a temporary extension of health coverage (called COBRA continuation coverage) where coverage under the *Plan* would otherwise end. This notice is intended to inform *plan participants* and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

Complete instructions on COBRA, as well as election forms and other information, will be provided by the *Plan Administrator* or its designee to *plan participants* who become qualified beneficiaries under COBRA. Refer to the Quick Reference Chart for contact information for the *Plan Administrator* and COBRA Administrator.

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a thirty (30)-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

A. COBRA Continuation Coverage

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain *plan participants* and their eligible family members (called qualified beneficiaries) at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the *Plan* (the qualifying event). The coverage must be identical to the *Plan* coverage that the qualified beneficiary had immediately before the qualifying event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated *active employees* who have not experienced a qualifying event (in other words, similarly situated non-COBRA beneficiaries).

COBRA continuation coverage does not run concurrent with the coverage under the terms of the *Plan*.

B. Qualified Beneficiary

In general, a qualified beneficiary can be:

1. Any individual who, on the day before a qualifying event, is covered under a *Plan* by virtue of being on that day either a covered *employee*, the spouse of a covered *employee*, or a *dependent* child of a covered *employee*. If, however, an individual who otherwise qualifies as a qualified beneficiary is denied or not offered coverage under the *Plan* under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the *Plan* coverage and will be considered a qualified beneficiary if that individual experiences a qualifying event.
2. Any child who is born to or placed for adoption with a covered *employee* during a period of COBRA continuation coverage, and any individual who is covered by the *Plan* as an *alternate recipient* under a *Qualified Medical Child Support Order*. If, however, an individual who otherwise qualifies as a qualified beneficiary is denied or not offered coverage under the *Plan* under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the *Plan* coverage and will be considered a qualified beneficiary if that individual experiences a qualifying event.
3. A covered *employee* who retired on or before the date of substantial elimination of *Plan* coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the *employer*, as is the spouse, surviving spouse, or *dependent* child of such a covered *employee* if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse, or *dependent* child was a beneficiary under the *Plan*.

The term 'covered *employee*' includes any individual who is provided coverage under the *Plan* due to his/her performance of services for the *employer* sponsoring the *Plan*, self-employed individuals, independent contractor, or corporate director. However, this provision does not establish eligibility of these individuals. Eligibility for *Plan* coverage shall be determined in accordance with *Plan's* **Eligibility, Effective Date, and Termination Provisions** section.

An individual is not a qualified beneficiary if the individual's status as a covered *employee* is attributable to a period in which the individual was a nonresident alien who received from the individual's *employer* no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a spouse or *dependent* child of the individual will also not be considered a qualified beneficiary by virtue of the relationship to the individual.

A *domestic partner* and his or her children are not qualified beneficiaries and do not have an independent right to elect COBRA continuation coverage. However, if an *employee* who is a qualified beneficiary elects COBRA continuation coverage for himself or herself, he or she may also elect to continue coverage for his or her *domestic partner* if they are covered under the *Plan* on the day before the qualifying event.

Each qualified beneficiary (including a child who is born to or placed for adoption with a covered *employee* during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

C. Qualifying Event

A qualifying event is any of the following if the *Plan* provided that the *plan participant* would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage:

1. the death of a covered *employee*
2. the termination (other than by reason of the *employee's* gross misconduct), or reduction of hours, of a covered *employee's* employment
3. the divorce or legal separation of a covered *employee* from the *employee's* spouse

   If the *employee* reduces or eliminates the *employee's* spouse's *Plan* coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.
4. a covered *employee's* enrollment in any part of the *Medicare* program
5. a *dependent* child's ceasing to satisfy the *Plan's* requirements for a *dependent* child (for example, attainment of the maximum age for dependency under the *Plan*)

If the qualifying event causes the covered *employee*, or the covered spouse or a *dependent* child of the covered *employee*, to cease to be covered under the *Plan* under the same terms and conditions as in effect immediately before the qualifying event [or in the case of the bankruptcy of the *employer*, any substantial elimination of coverage under the *Plan* occurring within twelve (12) months before or after the date the bankruptcy proceeding commences], the persons losing such coverage become qualified beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered *employee*, the spouse, or a *dependent* child of the covered *employee*, for coverage under the *Plan* that results from the occurrence of one (1) of the events listed above is a loss of coverage.

The taking of leave under the *Family and Medical Leave Act of 1993 (FMLA)* does not constitute a qualifying event. A qualifying event will occur, however, if an *employee* does not return to employment at the end of the *FMLA leave* and all other COBRA continuation coverage conditions are present. If a qualifying event occurs, it occurs on the last day of *FMLA leave,* and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the *Plan* provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered *employee* and family members will be entitled to COBRA continuation coverage even if they failed to pay the *employee* portion of premiums for coverage under the *Plan* during the *FMLA leave*.

D. Notice of Unavailability of Continuation Coverage

The *Plan* may sometimes deny a request for COBRA coverage, including an extension of coverage, when the *Plan Administrator* determines the *plan participant* is not entitled to receive it.

When a *Plan Administrator* makes the decision to deny a request for COBRA coverage from a *plan participant*, the *Plan* must give the *plan participant* a notice of unavailability of COBRA coverage. The notice must be provided within fourteen (14) days after the request is received relating to a qualifying event, second qualifying event, or determination of disability by the Social Security Administration, and the notice must explain the reason for denying the request.

E. Factors to Consider in Electing COBRA Continuation Coverage

When considering options for health coverage, qualified beneficiaries should consider:

1. **Premiums.** This *Plan* can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the marketplace, may be less expensive. Qualified beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within thirty (30) days after *Plan* coverage ends due to one of the qualifying events listed above.
2. **Provider Networks.** If a qualified beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a *network* in considering options for health coverage.
3. **Drug Formularies.** For qualified beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.
4. **Severance Payments.** If COBRA rights arise because the *employee* has lost his or her job and there is a severance package available from the *employer*, the former *employer* may have offered to pay some or all of the *employee's* COBRA payments for a period of time. This can affect the timing of coverage available in the marketplace. In this scenario, the employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.
5. **Service Areas.** If benefits under the *Plan* are limited to specific service or coverage areas, benefits may not be available to a qualified beneficiary who moves out of the area.
6. **Other Cost-Sharing.** In addition to premiums or contributions for health coverage, the *Plan* requires *participants* to pay *co-payments*, *deductibles*, *co-insurance*, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher *deductible* and higher *co-payments*.

Other Coverage Options

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for qualified beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a special enrollment period. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

F. Procedure for Obtaining COBRA Continuation Coverage

The *Plan* has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

G. The Election Period

The election period is the time period within which the qualified beneficiary must elect COBRA continuation coverage under the *Plan*. The election period must begin no later than the date the qualified beneficiary would lose coverage on account of the qualifying event and ends sixty (60) days after the later of the date the qualified beneficiary would lose coverage on account of the qualifying event or the date notice is provided to the qualified beneficiary of his/her right to elect COBRA continuation coverage. If coverage is not elected within the sixty (60) day period, all rights to elect COBRA continuation coverage are forfeited.

H. Responsibility for Informing the Plan Administrator of the Occurrence of a Qualifying Event

The *Plan* will offer COBRA continuation coverage to qualified beneficiaries only after the *Plan Administrator* or its designee has been timely notified that a *qualifying event* has occurred. The *employer* (if the *employer* is

not the *Plan Administrator*) will notify the *Plan Administrator* of the *qualifying event* within thirty (30) days following the date coverage ends when the *qualifying event* is any of the following:

1. the end of employment or reduction of hours of employment
2. death of the *employee*
3. commencement of a proceeding in bankruptcy with respect to the *employer*
4. enrollment of the *employee* in any part of *Medicare*

IMPORTANT:

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within sixty (60) days after the qualifying event occurs, using the procedures specified below. If these procedures are not followed, or if the notice is not provided in writing to the Plan Administrator or its designee during the sixty (60) day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

Notice Procedures

Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax, or hand-deliver your notice to the person, department, or firm listed below, at the following address:

AmeriBen
P.O. Box 7186
Boise, ID 83707
Fax: 1-208-424-0595

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state all of the following:

1. the name of the plan or plans under which you lost or are losing coverage
2. the name and address of the *employee* covered under the *Plan*
3. the name(s) and address(es) of the qualified beneficiary(ies)
4. the qualifying event and the date it happened

If the qualifying event is a **divorce or legal separation**, your notice must include a **copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the *Plan Administrator* or its designee receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered *employees* may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that *Plan* coverage would otherwise have been lost. If you or your spouse or *dependent* children do not elect continuation coverage within the sixty (60) day election period described above, the right to elect continuation coverage will be lost.

I. Waiver Before the End of the Election Period

If, during the election period, a qualified beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the *Plan Administrator* or its designee, as applicable.

J. If a Qualified Beneficiary Has Other Group Health Plan Coverage or Medicare

Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to *Medicare* benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to *Medicare* or becomes covered under other group health plan coverage.

K. When a Qualified Beneficiary's COBRA Continuation Coverage Can be Terminated

During the election period, a qualified beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a qualified beneficiary must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates:

1. the last day of the applicable maximum coverage period
2. the first day for which *timely payment* is not made to the *Plan* with respect to the qualified beneficiary
3. the date upon which the *employer* ceases to provide any group health plan (including a successor plan) to any *employee*
4. the date, after the date of the election, that the qualified beneficiary first becomes covered under any *other plan*
5. the date, after the date of the election that the qualified beneficiary first enrolls in the *Medicare* program (either Part A or Part B, whichever occurs earlier)
6. in the case of a qualified beneficiary entitled to a disability extension, the later of:
    a. twenty-nine (29) months after the date of the qualifying event
    b. the first day of the month that is more than thirty (30) days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled qualified beneficiary whose disability resulted in the qualified beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier
    c. the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension

The *Plan* can terminate for cause the coverage of a qualified beneficiary on the same basis that the *Plan* terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent *claim*.

In the case of an individual who is not a qualified beneficiary and who is receiving coverage under the *Plan* solely because of the individual's relationship to a qualified beneficiary, if the *Plan's* obligation to make COBRA continuation coverage available to the qualified beneficiary ceases, the *Plan* is not obligated to make coverage available to the individual who is not a qualified beneficiary.

When the *Plan* terminates COBRA coverage early for any of the reasons listed above, the *Plan Administrator* must give the qualified beneficiary a notice of early termination. The notice must be given as soon as practicable after the decision is made, and it must describe all of the following:

1. the date of termination of COBRA coverage
2. the reason for termination
3. any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage, such as a right to convert to an individual policy

L. Maximum Coverage Periods for COBRA Continuation Coverage

The maximum coverage periods are based on the type of the qualifying event and the status of the qualified beneficiary, as shown below.

1. In the case of a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends either:
    a. eighteen (18) months after the qualifying event if there is not a disability extension

   b. twenty-nine (29) months after the qualifying event if there is a disability extension

2. In the case of a covered *employee's* enrollment in the *Medicare* program before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period for qualified beneficiaries other than the covered *employee* ends on the later of:

   a. thirty-six (36) months after the date the covered *employee* becomes enrolled in the *Medicare* program

   b. eighteen (18) months [or twenty-nine (29) months, if there is a disability extension] after the date of the covered *employee's* termination of employment or reduction of hours of employment

3. In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered *employee* during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the qualifying event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

4. In the case of any other qualifying event than that described above, the maximum coverage period ends thirty-six (36) months after the qualifying event.

M. Circumstances in Which the Maximum Coverage Period Can Be Expanded

If a qualifying event that gives rise to an eighteen (18) month or twenty-nine (29) month maximum coverage period is followed, within that eighteen (18) or twenty-nine (29) month period, by a second qualifying event that gives rise to a thirty-six (36) months maximum coverage period, the original period is expanded to thirty-six (36) months, but only for individuals who are qualified beneficiaries at the time of and with respect to both qualifying events. In no circumstance can the COBRA maximum coverage period be expanded to more than thirty-six (36) months after the date of the first qualifying event. The *Plan Administrator* must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to the *Plan Sponsor* in accordance with the procedures above.

N. How a Qualified Beneficiary Becomes Entitled to a Disability Extension

A disability extension will be granted if an individual (whether or not the covered *employee*) who is a qualified beneficiary in connection with the *qualifying event* that is a termination or reduction of hours of a covered *employee's* employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first sixty (60) days of COBRA continuation coverage. To qualify for the disability extension, the qualified beneficiary must also provide the *Plan Administrator* with notice of the disability determination on a date that is both within sixty (60) days after the date of the determination and before the end of the original eighteen (18) month maximum coverage. Said notice shall be provided to the *Plan Administrator*, in writing, and should be sent to the *Plan Sponsor* in accordance with the procedures above.

O. Payment for COBRA Continuation Coverage

For any period of COBRA continuation coverage under the *Plan*, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled qualified beneficiary due to a disability extension. The *Plan* will terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which *timely payment* is not made.

The *Plan* must allow payment for COBRA continuation coverage to be made in monthly installments. The *Plan* is also permitted to allow for payment at other intervals.

P. Timely Payment for COBRA Continuation Coverage

Timely payment means a payment made no later than thirty (30) days after the first day of the coverage period. Payment that is made to the *Plan* by a later date is also considered *timely payment* if either under the terms of the *Plan*, covered *employees* or qualified beneficiaries are allowed until that later date to pay for their coverage for the period, or under the terms of an arrangement between the *employer* and the entity that

provides *Plan* benefits on the *employer's* behalf, the *employer* is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the *Plan* does not require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than forty-five (45) days after the date on which the election of COBRA continuation coverage is made for that qualified beneficiary. Payment is considered made on the date on which it is postmarked to the *Plan*.

If *timely payment* is made to the *Plan* in an amount that is not significantly less than the amount the *Plan* requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the *Plan's* requirement for the amount to be paid, unless the *Plan* notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A reasonable period of time is thirty (30) days after the notice is provided. A shortfall in a *timely payment* is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Q. Non-Sufficient Funds Payments (NSF)

Non-Sufficient Funds (NSF) payments are payments that are received timely but are later returned by the bank. The following conditions will apply to NSF payments:

1. If notification that a *timely payment* is being returned as a NSF payment **within** the grace period for the month the payment was for, a replacement payment can be submitted before the end of the grace period.
2. If notification that a *timely payment* is being returned due to a NSF payment **after** the grace period has expired and a subsequent payment was not received timely, COBRA continuation coverage will be retro terminated.
3. If notification that a *timely payment* is being returned as a NSF payment **after** the grace period has expired and a subsequent payment was postmarked beyond the grace period for the month the NSF payment was for, the subsequent payment will be refunded and coverage will be retro terminated.

R. Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage

If a qualified beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the *Plan* will, during the one hundred eighty (180) day period that ends on that expiration date, provide the qualified beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the *Plan*.

S. If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the *Plan Sponsor*. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at **www.dol.gov/ebsa**.

T. Keep Your Plan Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the *Plan Administrator* informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the *Plan Administrator*.

U. If You Wish to Appeal

In general, COBRA-related *claims* are not governed by ERISA and the related federal regulations. In an effort to provide all qualified beneficiaries with a fair and thorough review process for COBRA related *claims*, all determinations regarding COBRA eligibility and coverage will be made in accordance with the **Continuation**

Coverage Rights Under COBRA section of this governing plan document. Accordingly, if a qualified beneficiary wishes to *appeal* a COBRA eligibility or coverage determination made by the *Plan*, such *claims* must be submitted consistent with the *appeals* procedure set forth in the **Claims and Appeals** section of this document. The *Plan* will respond to all complete *appeals* in accordance with the *appeals* procedure set forth in the **Claims and Appeals** section of this document. The Plan offers one (1) level of appeal. A qualified beneficiary who files an *appeal* with the *Plan* must exhaust the administrative remedies afforded by the *Plan* prior to pursuing civil action in federal court under COBRA.

SECTION XV—FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the *Plan* is funded as follows:

A. For Employee and Dependent Coverage

Funding is derived from the funds of the *employer* and contributions made by the covered *employees*.

The level of any *employee* contributions will be set by the *Plan Administrator*. These *employee* contributions will be used in funding the cost of the *Plan* as soon as practicable after they have been received from the *employee* or withheld from the *employee's* pay through payroll deduction.

Benefits are paid directly from the *Plan* through the *Third Party Administrator*.

Payment for Coverage

The specific amount you must pay for coverage is announced each *plan year*. You pay your contributions for medical coverage on a **before-tax** basis. This means that your payments for these coverages come from your pay before federal, and in most cases, state taxes are withheld. That way, you should pay less in taxes.

The amount and frequency of that contribution is determined by HonorHealth (within permissible government guidelines) and announced on an annual basis.

NOTE: If you elect coverage for a domestic partner and that domestic partner is not your tax-qualified *dependent*, the contributions you make toward the cost of this domestic partner coverage must be deducted on an after-tax basis, in accordance with IRS regulations. The amount your *employer* pays toward the cost of your domestic partner coverage must be imputed as income and therefore is taxable to you, the *employee*. If you have questions about the tax implications of covering a domestic partner, contact your financial or tax advisor. **HonorHealth does not provide tax advice, and nothing in this paragraph should be construed as providing tax advice.**

B. Plan is not an Employment Contract

The *Plan* is not to be construed as a contract for or of employment.

C. Clerical Error

Any clerical error by the *Plan Administrator* or an agent of the *Plan Administrator* in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a *Plan* reimbursement amount, the *Plan* retains a contractual right to the overpayment. The person or *institution* receiving the overpayment will be required to return the incorrect amount of money. In the case of a *plan participant*, the amount of overpayment may be deducted from future benefits payable.

SECTION XVI—CERTAIN PLAN PARTICIPANTS' RIGHTS UNDER ERISA

Plan participants in this *Plan* are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all *plan participants* shall be entitled to:

1. examine, without charge, at the *Plan Administrator's* office, all plan documents and copies of all documents governing the *Plan*, including a copy of the latest annual report (form 5500 series) filed by the *Plan* with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration
2. obtain copies of all plan documents and other *Plan* information upon written request to the *Plan Administrator*

   The *Plan Administrator* may make a reasonable charge for the copies.
3. continue health care coverage for a *plan participant*, spouse, or other *dependents* if there is a loss of coverage under the *Plan* as a result of a qualifying event

   Employees or *dependents* may have to pay for such coverage.
4. review this summary plan description and the documents governing the *Plan* or the rules governing COBRA continuation coverage rights

A. Enforce Your Rights

If a *plan participant's claim* for a benefit is denied or ignored, in whole or in part, the *plan participant* has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to *appeal* any denial, all within certain time schedules.

Under ERISA, there are steps a *plan participant* can take to enforce the above rights. For instance, if a *plan participant* requests a copy of plan documents or the latest annual report from the *Plan* and does not receive them within thirty (30) days, he or she may file suit in a federal court. In such a case, the court may require the *Plan Administrator* to provide the materials and to pay the *plan participant* up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the *Plan Administrator*. If the *plan participant* has a *claim* for benefits which is denied or ignored, in whole or in part, the *plan participant* may file suit in state or federal court.

In addition, if a *plan participant* disagrees with the *Plan's* decision or lack thereof concerning the qualified status of a *medical child support order*, he or she may file suit in federal court.

B. Prudent Actions by Plan Fiduciaries

In addition to creating rights for *plan participants*, ERISA imposes obligations upon the individuals who are responsible for the operation of the *Plan*. The individuals who operate the *Plan*, called fiduciaries of the *Plan*, have a duty to do so prudently and in the interest of the *plan participants* and their beneficiaries. No one, including the *employer* or any other person, may fire a *plan participant* or otherwise discriminate against a *plan participant* in any way to prevent the *plan participant* from obtaining benefits under the *Plan* or from exercising his/her rights under ERISA.

If it should happen that the *Plan* fiduciaries misuse the *Plan's* money, or if a *plan participant* is discriminated against for asserting his/her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the *plan participant* is successful, the court may order the person sued to pay these costs and fees. If the *plan participant* loses, the court may order him/her to pay these costs and fees (for example, if it finds the *claim* or suit to be frivolous).

C. Assistance with Your Questions

If the *plan participant* has any questions about the *Plan*, he or she should contact the *Plan Administrator*. If the *plan participant* has any questions about this statement or his/her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, that *plan participant* should contact either the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at **www.dol.gov/ebsa**. Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.

This *Plan* will be construed, administered, and enforced according to the laws of the State of Arizona, to the extent not superseded by the Internal Revenue Code of 1986, ERISA, or any other federal law.

SECTION XVII—FEDERAL NOTICES

A. Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

An *employee* or *dependent* who is eligible, but not enrolled in this *Plan*, may enroll if:

1. The *employee* or *dependent* is covered under a Medicaid plan under Title XIX of the Social Security Act or a state children's health insurance program (CHIP) under Title XXI of such Act, and coverage of the *employee* or *dependent* is terminated due to loss of eligibility for such coverage, and the *employee* or *dependent* requests enrollment in this *Plan* within sixty (60) days after such Medicaid or CHIP coverage is terminated.
2. The *employee* or *dependent* becomes eligible for assistance with payment of *employee* contributions to this *Plan* through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the *employee* or *dependent* requests enrollment in this *Plan* within sixty (60) days after the date the *employee* or *dependent* is determined to be eligible for such assistance.

If a *dependent* becomes eligible to enroll under this provision and the *employee* is not then enrolled, the *employee* must enroll in order for the *dependent* to enroll.

Coverage will become effective as of the date the request for enrollment is received by the *employer*.

B. Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA Title I applies to group health plans sponsored by local government *employers*. Title I generally prohibits discrimination in group premiums based on *genetic information* and the use of *genetic information* as a basis for determining eligibility or setting premiums, and places limitations on genetic testing and the collection of *genetic information* in group health plan coverage. Title I provides a clarification with respect to the treatment of *genetic information* under privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

C. Mental Health Parity and Addiction Equity Act of 2008

Regardless of any limitations on benefits for *mental disorders/substance use disorders* treatment otherwise specified in the *Plan*, any aggregate lifetime limit, annual limit, financial requirement, *non-network* exclusion, or treatment limitation on *mental disorders/substance use disorder* benefits imposed by the *Plan* shall comply with federal parity requirements, if applicable.

D. Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not do any of the following:

1. restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section
2. set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) or ninety-six (96) hours, as applicable, stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay
3. require that a *physician* or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) or ninety-six (96) hours, as applicable

However, the plan or issuer may pay for a shorter stay than forty-eight (48) hours following a vaginal delivery, or ninety-six (96) hours following a delivery by cesarean section if the attending provider (e.g., your *physician*, nurse midwife or physician assistant), discharges the mother or newborn after consultation with the mother.

E. Non-Discrimination Policy

This *Plan* will not discriminate against any *plan participant* based on race, color, religion, national origin, disability, gender, sexual orientation, or age. This *Plan* will not establish rules for eligibility based on health

status, medical condition, *claims* experience, receipt of health care, medical history, evidence of insurability, *genetic information*, or disability.

This *Plan* intends to be nondiscriminatory and to meet the requirements under applicable provisions of the Internal Revenue Code of 1986. If the *Plan Administrator* determines before or during any *plan year* that this *Plan* may fail to satisfy any non-discrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated individuals, the *Plan Administrator* shall take such action as the *Plan Administrator* deems appropriate, under rules uniformly applicable to similarly situated covered *employees*, to assure compliance with such requirements or limitation.

F. Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Employees going into or returning from military service may elect to continue *Plan* coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) under the following circumstances. These rights apply only to *employees* and their *dependents* covered under the *Plan* immediately before leaving for military service.

1. The maximum period of coverage of a person and the person's *dependents* under such an election shall be the lesser of:
    a. the twenty-four (24) month period beginning on the date on which the person's absence begins
    b. the day after the date on which the person was required to apply for or return to a position of employment and fails to do so
2. A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the *Plan*, except a person on active duty for thirty (30) days or less cannot be required to pay more than the *employee's* share, if any, for the coverage.
3. An exclusion or *waiting period* may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or *waiting period* may be imposed for coverage of any *illness* or *injury* determined by the Secretary of Veterans Affairs to have been *incurred* in, or aggravated during, the performance of *uniformed service*.

If the *employee* wishes to elect this coverage or obtain more detailed information, contact the *Plan Administrator*. The *employee* may also have continuation rights under USERRA. In general, the *employee* must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The *employee* may elect USERRA continuation coverage for the *employee* and their *dependents*. Only the *employee* has election rights. *Dependents* do not have any independent right to elect USERRA health plan continuation.

G. Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires that you be informed of your rights to *surgery* and prostheses following a covered *mastectomy*.

The *Plan* will pay charges *incurred* for a *plan participant* who is receiving benefits in connection with a *mastectomy* and then elects breast reconstruction in connection with the *mastectomy*. Coverage will include:

1. reconstruction of the breast on which the *mastectomy* has been performed
2. *surgery* and reconstruction of the other breast to produce a symmetrical appearance
3. prosthesis and treatment of physical complications of all stages of *mastectomy*, including lymphedemas

SECTION XVIII—COMPLIANCE WITH HIPAA PRIVACY STANDARDS

A. Compliance with HIPAA Privacy Standards

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996.

Certain members of the *employer's* workforce perform services in connection with administration of the *Plan*. In order to perform these services, it is necessary for these *employees* from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the *Privacy Standards*), these *employees* are permitted to have such access subject to the following:

1. **General.** The *Plan* shall not disclose Protected Health Information to any member of the *employer's* workforce unless each of the conditions set out in this **Compliance with HIPAA Privacy Standards** section is met. 'Protected Health Information' shall have the same definition as set out in the *Privacy Standards* but generally shall mean individually identifiable health information about the past, present, or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
2. **Permitted Uses and Disclosures.** Protected Health Information disclosed to business associates and members of the *employer's* workforce shall be used or disclosed by them only for purposes of *Plan* administrative functions. The *Plan's* administrative functions shall include all *Plan* payment and health care operations. The terms 'payment' and 'health care operations' shall have the same definitions as set out in the *Privacy Standards*, but the term 'payment' generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill *Plan* responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. 'Health care operations' generally shall mean activities on behalf of the *Plan* that are related to quality assessment; evaluation, training, or accreditation of health care providers; underwriting, premium rating, and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management, and general administrative activities. *Genetic information* will not be used or disclosed for underwriting purposes.
3. **Authorized Employees.** The *Plan* shall disclose Protected Health Information only to members of the *employer's* workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the *Plan*. For purposes of this **Compliance with HIPAA Privacy Standards** section, members of the *employer's* workforce shall refer to all *employees* and other persons under the control of the *employer*.
    a. **Updates Required.** The *employer* shall amend the *Plan* promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
    b. **Use and Disclosure Restricted.** An authorized member of the *employer's* workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his/her duties with respect to the *Plan*.
    c. **Resolution of Issues of Noncompliance.** In the event that any member of the *employer's* workforce uses or discloses Protected Health Information other than as permitted by the *Privacy Standards*, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
        i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and whether the Protected Health Information was compromised
        ii. applying appropriate sanctions against the person(s) causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment
        iii. mitigating any harm caused by the breach, to the extent practicable
        iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages
        v. providing notification in accordance with HIPAA requirements

4. **Certification of Employer.** The *employer* must provide certification to the *Plan* that it agrees to all of the following:
    a. not use or further disclose the Protected Health Information other than as permitted or required by the plan documents or as required by law
    b. ensure that any agent or subcontractor to whom it provides Protected Health Information received from the *Plan* agrees to the same restrictions and conditions that apply to the *employer* with respect to such information
    c. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or *employee* benefit plan of the *employer*
    d. report to the *Plan* any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law
    e. make available Protected Health Information to individual *Plan* members in accordance with Section 164.524 of the *Privacy Standards*
    f. make available Protected Health Information for amendment by individual *Plan* members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the *Privacy Standards*
    g. make available the Protected Health Information required to provide any accounting of disclosures to individual *Plan* members in accordance with Section 164.528 of the *Privacy Standards*
    h. make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the *Plan* available to the Department of Health and Human Services for purposes of determining compliance by the *Plan* with the *Privacy Standards*
    i. if feasible, return or destroy all Protected Health Information received from the *Plan* that the *employer* still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible
    j. ensure the adequate separation between the *Plan* and member of the *employer's* workforce, as required by Section 164.504(f)(2)(iii) of the *Privacy Standards*
5. The following members of HonorHealth's workforce are designated as authorized to receive Protected Health Information from HonorHealth Employee Health Plan (*Plan*) in order to perform their duties with respect to the *Plan*:
    a. Senior Benefits Representative
    b. Benefits Representatives
    c. Benefits Compliance Analyst
    d. AVP-Comp/Benefits/HRIS
    e. Director of Health and Welfare Programs
    f. Paralegal Supervisor
    g. Chief Academic Officer
    h. Chief HR Officer
    i. Staff Accountant
    j. AVP-Controller
    k. Director of Accounting
    l. Senior Accountant
    m. Disability Manager

B. Compliance with HIPAA Electronic Security Standards

Under the *Security Standards* for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the *Security Standards*), the *employer* agrees to the following:

1. The *employer* agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the *employer* creates, maintains, or transmits on behalf of the *Plan*. Electronic Protected Health Information shall have the same definition as set out in the *Security Standards*, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
2. The *employer* shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
3. The *employer* shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in **Compliance With HIPAA Privacy Standards**, provisions Authorized Employees and Certification of Employers described above.

SECTION XIX—DEFINED TERMS

The following terms have special meanings and will be italicized when used in this *Plan*. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise.

Accident

A sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Accidental Injury (Accidental Injuries)

An objectively demonstrable impairment of bodily function caused by trauma from a sudden, unforeseen outside force or object, occurring at an identifiable time and place, and without the *plan participant's* foresight or expectation.

Active Employment

Performance by the *employee* of all the regular duties of his/her occupation at an established business location of the participating *employer*, or at another location to which he or she may be required to travel to perform the duties of his/her employment. An *employee* shall be deemed actively at work if the *employee* is absent from work due to a health factor. In no event will an *employee* be considered actively at work if he/she has effectively terminated employment.

Adoptive Cell Therapy

A type of immunotherapy in which T cells (a type of immune cell) are given to a patient to help the body fight diseases, such as cancer. In cancer therapy, T cells are usually taken from the patient's own blood or tumor tissue, grown in large numbers in the laboratory, and then given back to the patient to help the immune system fight the cancer. Sometimes, the T cells are changed in the laboratory to make them better able to target the patient's cancer cells and kill them. Types of adoptive cell therapy include, but not limited to, chimeric antigen receptor T-cell (CAR T-cell) therapy and tumor-infiltrating lymphocyte (TIL) therapy. Also called adoptive cell transfer, *cellular immunotherapy*, and T-cell transfer therapy.

Adverse Benefit Determination

Any of the following: a denial, reduction, rescission, or termination of a *claim* for benefits, or a failure to provide or make payment for such a *claim* (in whole or in part) including determinations of a *claimant's* eligibility, the application of any review under the Health Care Management Program, and determinations that an item or service is *experimental/investigational* or not *medically necessary* or appropriate.

Allowable Charges

The *maximum amount/maximum allowable charge* for any *medically necessary*, eligible item of expense, at least a portion of which is covered under a plan. When some *other plan* pays first in accordance with the Application to Benefit Determinations subsection in the **Coordination of Benefits** section herein, this *Plan's* allowable charges shall in no event exceed the *other plan's* allowable charges. When some *other plan* provides benefits in the form of services rather than cash payments, the *reasonable* cash value of each service rendered, in the amount that would be payable in accordance with the terms of the *Plan*, shall be deemed to be the benefit. Benefits payable under any *other plan* include the benefits that would have been payable had *claim* been duly made therefore.

Alternate Recipient

Any child of a *plan participant* who is recognized under a *medical child support order* as having a right to enrollment under this *Plan* as the *plan participant's* eligible *dependent*. For purposes of the benefits provided under this *Plan*, an alternate recipient shall be treated as an eligible *dependent*, but for purposes of the reporting and disclosure requirements under ERISA, an alternate recipient shall have the same status as a *plan participant*.

Ambulatory Surgical Center

A licensed facility that is used mainly for performing *outpatient surgery*, has a staff of *physicians*, has continuous *physician* and nursing care by registered nurses (R.N.s), and does not provide for overnight stays. An ambulatory surgical center that is part of a *hospital* will be considered an ambulatory surgical center for the purposes of this *Plan*.

Appeal

A review by the *Plan* of an *adverse benefit determination*, as required under the *Plan's* internal *claims* and appeals procedures.

Applied Behavioral Analysis (ABA) Therapy

Applied Behavioral Analysis (ABA) Therapy is an umbrella term describing principles and techniques used in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors. The goal of ABA Therapy is to teach new skills, promote generalization of these skills, and reduce challenging behaviors with systematic reinforcement. ABA Therapy is a combination of services for adaptive behavior treatment, which applies the principles of how people learn and motivations to change behavior. ABA Therapy is designed to address multiple areas of behavior and function such as to increase language and communication, enhance attention and focus, and help with social skills and memory. It generally includes psychosocial interventions, should address factors that may exacerbate behavioral challenges, and is most effective when initiated as soon as feasible after diagnosis is made.

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is described in **any** of the following subparagraphs:

1. The study or investigation is approved or funded by one or more of the following:
    a. The National Institutes of Health
    b. The Centers for Disease Control and Prevention
    c. The Agency for Health Care Research and Quality
    d. The Centers for Medicare and Medicaid Services
    e. a cooperative group or center of any of the entities described in sub-clauses a. through d. above, or the Department of Defense or the Department of Veterans Affairs
    f. a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    g. any of the following if the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines (1) to be comparable to the system of peer review studies and investigations used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by *qualified individuals* who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs
        ii. The Department of Defense
        iii. The Department of Energy
2. The study or investigation is conducted under an *investigational* new drug application reviewed by the Food and Drug Administration.
3. The study or investigation is a drug trial that is exempt from having such an *investigational* new drug application.

Assignment of Benefits

An arrangement by which a patient requests that their health benefit payments under this *Plan* be made directly to a designated medical provider or facility. By completing an assignment of benefits, the *plan participant* authorizes the *Plan Administrator* to forward payment for a covered procedure directly to the treating medical provider or facility. The *Plan Administrator* expects an assignment of benefits form to be completed, as between the *plan participant* and the provider.

Authorized Representative

An authorized representative is a person or organization a *plan participant* has designated to act on their behalf to submit or *appeal* a *claim*. By authorizing a person or organization to act on your behalf, you are giving them permission to see your protected health information (PHI) and act on all matters

related to your *claim* and/or *appeal*. If you choose to authorize a person to act on your behalf, all future communications shall be with the designee. However, where an *urgent care claim* is involved, a health care professional with knowledge of the medical condition will be permitted to act as a *claimant's* authorized representative without a prior written authorization.

Balance Bill/Surprise Bill

Balance bill refers to the difference between a *non-network provider's* total billed charges and the *allowable charges* off of which the *Plan* will base its reimbursement.

Non-network providers have no obligation to accept the *allowable charge* as payment in full. You are responsible to pay a *non-network provider's* billed charges, even though the *Plan's* reimbursement is based on the *allowable charge*. Any amounts paid for balance bills do not count toward the *deductible*, *co-insurance*, or *out-of-pocket limit*.

Refer to the **Consolidated Appropriations Act of 2021 Notice** section for additional provisions pertaining to *non-network* surprise billing *claims*.

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, depression, schizophrenia, and substance use and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by *behavioral health practitioners*. Certain behavioral health disorders, conditions, and diseases are specifically excluded from coverage as noted in the Medical Plan Exclusions subsection of this document. See also the definitions for *substance use disorders*.

Behavioral Health Practitioners

A psychiatrist, psychologist, or a mental health or *substance use disorders* 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; 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.

Behavioral Health Treatment

Behavioral health treatment includes all inpatient services, including room and board, given by a *behavioral health treatment facility* or area of a *hospital, including partial hospitalization,* that provides behavioral or mental health or *substance use disorders* 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* 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 which fully meets one (1) of the following 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* is covered by this *Plan* as a *hospital* and not a behavioral health treatment facility. A transitional facility, group home, halfway house, or temporary shelter is not a behavioral health treatment facility under this *Plan*.

Benefit Determination

The *Plan's* decision regarding the acceptance or denial of a *claim* for benefits under the *Plan*.

Birthing Center

Any freestanding health facility, place, professional office, or *institution* which is not a *hospital* or in a *hospital*, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located.

The birthing center must: provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a *physician* and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a *hospital* in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name

A trade name medication.

Calendar Year

January 1st through December 31st of the same year. All *deductibles* and benefit maximums accumulate during the calendar year.

Cellular Immunotherapy

A type of therapy that uses substances to stimulate or suppress the immune system to help the body fight cancer, infection, and other diseases. Some types of immunotherapy only target certain cells of the immune system. Others affect the immune system in a general way. Types of immunotherapy include cytokines, vaccines, bacillus Calmette-Guerin (BCG), and some monoclonal antibodies.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

The Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

Claim

Any request for a *Plan* benefit, made by a *claimant* or by a representative of a *claimant*, in accordance with a *Plan's* reasonable procedure for filing benefit claims.

Some requests made to the *Plan* are specifically not claims for benefits; for example:

1. an inquiry as to eligibility which does not request benefits
2. a request for prior approval where prior approval is not required by the *Plan*
3. casual inquiries about benefits such as verification of whether a service/item is a covered benefit or the estimated cost for a service

Claimant

Any *plan participant* or beneficiary making a *claim* for benefits. Claimants may file *claims* themselves or may act through an *authorized representative*. In this document, the words 'you' and 'your' are used interchangeably with 'claimant'.

Claims Administrator

See *Third Party Administrator*.

Co-Insurance

The portion of medical expenses (after the *deductible* has been satisfied) for which a *plan participant* is responsible.

Concurrent Care Claim

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

Co-Payment

A specific dollar amount a *plan participant* is required to pay and is typically payable to the health care provider at the time services or supplies are rendered.

Cost Sharing Amounts

The dollar amount a *plan participant* is responsible for paying when covered services are received from a provider. Cost sharing amounts include *co-insurance*, *co-payments*, *deductible amounts*, and *out-of-pocket limits*. Providers may bill you directly or request payment of *co-insurance* and/or *co-payments* at the time services are provided. Refer to the applicable Schedules of Benefits for the specific cost sharing amounts that apply to this *Plan*.

Courtesy Review

A pre-service review of requested services for benefits which are neither on the *pre-certification* list nor an exclusion of the *Plan*.

Covered Charges

The *maximum allowable charge* for a *medically necessary* service, treatment, or supply, meant to improve a condition or *plan participant's* health, which is eligible for coverage in this *Plan*. Covered charges will be determined based upon all other *Plan* provisions. When more than one (1) treatment option is available, and one (1) option is no more effective than another, the covered charge is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the applicable **Schedule of Benefits** section and as determined elsewhere in this document.

Custodial Care

Care (including *room and board* needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of custodial care are: help in walking and getting out of bed, assistance in bathing, dressing, feeding, or supervision over medication which could normally be self-administered.

Deductible

A specified portion of the *covered charges* that must be *incurred* by a *plan participant* before the *Plan* has any liability.

Dependent

For information regarding eligibility for dependents, refer to the section entitled **Eligibility, Effective Date, and Termination Provisions**.

Dentist

A person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Developmental Delay

A delay in the appearance of normal developmental milestones achieved during infancy and early child hood, caused by organic, psychological, or environmental factors. Conditions are marked by delayed development or functional limitations especially in learning, language, communication, cognition, behavior, socialization, or mobility.

Diagnostic Service

A test or procedure performed for specified symptoms to detect or to monitor a *disease* or condition. It must be ordered by a *physician* or other professional provider.

Disease

Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the *Plan* is furnished showing that the individual concerned is covered as an *employee* under any workers' compensation law, occupational disease law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one (1) not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the *Plan*, be regarded as a *sickness*, *illness*, or disease.

Diagnosis Related Grouping (DRG)

A method for reimbursing hospitals for inpatient services. A DRG amount can be higher or lower than the actual billed charge because it is based on an average for that grouping of diagnoses and procedures.

Durable Medical Equipment (DME)

Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an *illness* or *injury,* and is appropriate for use in the home.

Emergency

A situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An emergency includes poisoning, shock, and hemorrhage. Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the *Plan*, that an emergency did exist. The *Plan* may, at its own discretion, request satisfactory proof that an emergency or acute condition did exist.

Emergency Services

A medical screening examination [as required under Section 1867 of the Social Security Act (EMTALA)] within the capability of the *hospital* emergency department, including routine ancillary services, to evaluate a *medical emergency* and such further medical examination and treatment as are within the capabilities of the staff and facilities of the *hospital* and required under EMTALA to stabilize the patient.

Employee

A person who is active on the regular payroll of the *employer*, has begun to perform the duties of his/her job with the *employer*, and is regularly scheduled to work for the *employer* in an employee/employer relationship.

Employer

HonorHealth Hospitals

Enrollment Date

The first day of coverage, or if there is a *waiting period*, the first day of the *waiting period*.

Experimental/Investigational

Services, supplies, care, and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The *Plan Administrator* must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The *Plan Administrator* shall be guided by a reasonable interpretation of *Plan* provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the *claim* and the proposed treatment. The decision of the *Plan Administrator* will be final and binding on the *Plan*. The *Plan Administrator* will be guided by the following principles, any of which comprise a definition of experimental/investigational:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is furnished
2. if the drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval
3. if reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going Phase I or Phase II clinical trials, is the research, experimental study, or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis

4. if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis

   'Reliable evidence' shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility, or the protocol(s) of another facility studying substantially the same drug, service, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Benefits covered under the Clinical Trials provision are not considered experimental or investigational.

The *Plan Administrator* has the discretion to determine which drugs, services, supplies, care, and/or treatments are considered experimental, investigative, or unproven.

Explanation of Benefits (EOB)

A document sent to the *plan participant* by the *Third Party Administrator* after a *claim* for reimbursement has been processed. It includes the patient's name, claim number, type of service, provider, date of service, charges submitted for the services, amounts covered by this *Plan*, non-covered services, *cost sharing amounts,* and the amount of the charges that are the *plan participant's* responsibility. This form should be carefully reviewed and kept with other important records.

External Review

A review of an *adverse benefit determination*, including a *final internal adverse benefit determination,* under applicable state or federal external review procedures.

Family Unit

The covered *employee* and the family members who are covered as *dependents* under the *Plan*.

Fiduciary

A *fiduciary* exercises discretionary authority or control over management of the *Plan* or the disposition of its assets, renders investment advice to the *Plan*, or has discretionary authority or responsibility in the administration of the *Plan*.

Final Internal Adverse Benefit Determination

An *adverse benefit determination* that has been upheld by the *Plan* at completion of the *Plan's* internal *appeals* procedures; or an *adverse benefit determination* for which the internal *appeals* procedures have been exhausted under the deemed exhausted rule contained in the *appeals* regulations. For plans with two (2) levels of *appeals*, the second-level *appeal* results in a final internal adverse benefit determination that triggers the right to *external review*.

FMLA Leave

A *leave of absence* which the *employer* is required to extend to an *employee* under the provisions of the *FMLA*.

Formulary

A list of prescription medications compiled by the third party payer of safe and effective therapeutic drugs specifically covered by this *Plan*.

Gene Therapy

Human gene therapy seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use. It is a technique that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms:

1. replacing a disease-causing gene with a healthy copy of the gene
2. inactivating a disease-causing gene that is not functioning properly
3. introducing a new or modified gene into the body to help treat a disease

Generic Drug

A *prescription drug* which has the equivalency of the *brand name* drug with the same use and metabolic disintegration. This *Plan* will consider as a generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information

Information about the genetic tests of an individual or his/her family members and information about the manifestations of *disease* or disorder in family members of the individual. A genetic test means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, which detects genotypes, mutations, or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested *disease*, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

The *Plan* complies with Title I of the Genetic Information Nondiscrimination Act of 2008 (GINA) as it applies to group health plans.

Habilitative/Habilitation

Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with *developmental delays* that have never acquired normal functional abilities. Examples of habilitative services include physician-prescribed therapy for a child who is not walking or talking at the expected age.

Health Savings Account (HSA)

A tax-exempt or custodial account that you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you *incur*. You must be eligible to qualify for an HSA (refer to the **Schedule of Benefits** section of this document). Both *employer* and *employee* may contribute to an HSA in the same year. Annual contribution limits are subject to IRS guidelines. Participation in a qualified *high deductible health plan* is required for participation in an HSA program.

High Deductible Health Plan (HDHP)

A medical plan with lower premiums and a minimum *deductible* amount, set forth by federal law, which is higher than a traditional health plan *deductible*.

Home Health Care Agency

An organization that meets all of these tests: its main function is to provide *home health care services and supplies*; it is federally certified as a home health care agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan

Must meet these tests: it must be a formal written plan made by the patient's attending *physician* which is reviewed at least every thirty (30) days; it must state the diagnosis; it must certify that the home health care is in place of *hospital* confinement; and it must specify the type and extent of *home health care services and supplies* required for the treatment of the patient.

Home Health Care Services and Supplies

Include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a *home health care agency* (this does not include general housekeeping services); physical, occupational, and speech therapy; medical supplies; and laboratory services by or on behalf of the *hospital*.

Hospice Care Agency

An organization whose main function is to provide *hospice care services and supplies* and is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan

A plan of terminal patient care that is established and conducted by a *hospice care agency* and supervised by a *physician*.

Hospice Care Services and Supplies

Provided through a *hospice care agency* and under a *hospice care plan* and includes *inpatient* care in a *hospice unit* or other licensed facility, home health care, and family counseling during the bereavement period.

Hospice Unit

A facility or separate *hospital* unit that provides treatment under a *hospice care plan* and admits at least two (2) unrelated persons who are expected to die within six (6) months.

Hospital (Acute or Long-Term Acute Care Facility)

A provider licensed and operated as required by law, which provides all of the following and is fully accredited by The Joint Commission:

1. room, board, and nursing care
2. a staff with one (1) or more doctors on hand at all times
3. twenty-four (24) hour nursing service
4. all the facilities on site are needed to diagnose, care, and treat an *illness* or *injury*

The term hospital does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. custodial care
6. educational care
7. subacute care

Refer to the defined terms for *Residential Treatment Facility* and *Substance Use Disorders/Mental Health Treatment Center* for the specific requirements applicable to those facility types.

Illness

A bodily disorder, *disease*, physical illness, or *mental disorder*. Includes *pregnancy*, childbirth, miscarriage, or complications of *pregnancy*.

Incurred

An expense for a service or supply is incurred on the date the service or supply is furnished. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Review Organization (IRO)

An entity that performs independent *external reviews* of *adverse benefit determinations* and *final internal adverse benefit determinations*.

Infertility

Incapable of producing offspring.

Injury

An accidental bodily injury, which does not arise out of, which is not caused or contributed by, and which is not a consequence of, any employment or occupation for compensation or profit.

Inpatient

Treatment in an approved facility during the period when charges are made for *room and board*.

Institution

A facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a *hospital*, *ambulatory surgical center*, *psychiatric hospital*, community mental health center, *residential treatment facility,* psychiatric treatment facility, *substance use disorder treatment center*, alternative *birthing center*, home health care center, or any other such facility that the *Plan* approves.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a *hospital* solely for the care and treatment of patients who are critically *ill*. This also includes what is referred to as a coronary care unit or an acute care unit. It has facilities for special nursing care not available in regular rooms and wards of the *hospital*; special lifesaving equipment which is immediately available at all times; at least two (2) beds for the accommodation of the critically *ill*; and at least one (1) registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

In-Network

See *Network*.

Investigational

See *Experimental/Investigational*.

Late Enrollee

A *plan participant* who enrolls under the *Plan* other than during the first thirty-one (31) day period in which the individual is eligible to enroll under the *Plan* or during a special enrollment period.

Leave of Absence

A period of time during which the *employee* does not work, but which is of a stated duration, after which time the *employee* is expected to return to active work.

Legal Guardian

A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Life-Threatening Disease or Condition

Any *disease* or condition from which the likelihood of death is probable unless the course of the *disease* is interrupted.

Long Term Acute Care Hospitals

Facilities that specialize in the treatment of patients with serious medical conditions that require care on an ongoing basis but no longer require intensive care or extensive diagnostic procedures.

Long Term Care

Generally refers to non-medical care for patients who need assistance with basic daily activities such as dressing, bathing, and using the bathroom. Long-term care may be provided at home or in facilities that include nursing homes and assisted living.

Maintenance Care

Therapy or treatment intended primarily to maintain general physical conditions, including, but not limited to routine, long-term, or maintenance care which is provided after the resolution of an acute medical problem. This includes services performed solely to preserve the present level of function or prevent regression for an *illness*, *injury*, or condition that is resolved or stable.

Mastectomy

The surgical removal of all or part of a breast.

Maximum Amount or Maximum Allowable Charge

The benefit payable for a specific coverage item or benefit under the *Plan*. Maximum allowable charge(s) will be based on one (1) of the following options, depending on the circumstances of the *claim* and at the discretion of the *Plan Administrator*:

1. *network* allowed amount

2. *network non-participating provider* rate
3. 125% of the *Medicare* rate
4. the negotiated rate established in a contractual arrangement with a provider
5. the *usual and customary* and/or *reasonable* amount
6. the actual billed charges for the covered services

The maximum allowed amount for emergency care from a *non-network* provider will be determined using the median plan *network* contract rate paid to *network* providers for the geographic area where the service is provided.

The *Plan* has the discretionary authority to decide if a charge is *usual and customary* and/or *reasonable* for a *medically necessary* service. The maximum allowable charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Maximum Benefit

Any one (1) of the following, or any combination of the following:

1. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* during the entire time he or she is covered by this *Plan*
2. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* for a particular *covered charge*

   The *maximum amount* can be for either of the following:

   a. the entire time the *plan participant* is covered under this *Plan*
   b. a specified period of time, such as a *calendar year*
3. the maximum number as outlined in the *Plan* as a *covered charge*

   The maximum number relates to the number of:

   a. treatments during a specified period of time
   b. days of confinement
   c. visits by a *home health care agency*

Medical Care Facility

A *hospital*, a facility that treats one (1) or more specific ailments, or any type of *skilled nursing facility*.

Medical Child Support Order

Any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that mandates one (1) of the following:

1. provides for child support with respect to a *plan participant's* child or directs the *plan participant* to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law)
2. enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan

Medical Emergency

A medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child)
2. serious impairment to body functions
3. serious dysfunction of any body organ or part

A medical emergency includes such conditions as: heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, or other such acute medical conditions.

Emergency care does not typically include such conditions as sore throat, headache, non-specific stomach pains, medium-grade fever, ear infection, influenza, etc.

Medical Management Administrator

A team of medical care professionals selected to conduct *pre-certification* review, *emergency* admission review, continued stay review, discharge planning, patient consultation, and case management. For more information, see the **Health Care Management Program** section of this document.

Medical Non-Emergency Care

Care which can safely and adequately be provided other than in a *hospital*.

Medically Necessary/Medical Necessity

Care and treatment which is recommended or approved by a *physician* or *dentist*; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a *physician* recommends or approves certain care does not mean that it is medically necessary.

The *Plan Administrator* has the discretionary authority to decide whether care or treatment is medically necessary.

Medicare

The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder and Nervous Disorders/Substance Use Disorders

Any *disease* or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Mental Health or Substance Use Disorder Hold

An involuntary detainment, by an officer of the court, in an *in-patient facility*, of an individual who is either posing a danger to themselves or others, or determined to be gravely disabled due to a mental health condition. Typically lasting up to seventy-two (72) hours.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and *mental health* or *substance use disorders* benefits, such plan or coverage shall ensure all of the following:

1. The financial requirements applicable to such *mental health* or *substance use disorders* benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to *mental health* or *substance use disorders* benefits (if these benefits are covered by the group health *Plan* or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such *mental health* or *substance use disorders* benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to *mental health* or *substance use disorders* benefits (if these benefits are covered by the group health *Plan* or health insurance coverage offered in connection with such a plan).

Morbid Obesity

A diagnosed condition in which the body weight exceeds the medically recommended weight by either one hundred (100) pounds or is twice the medically recommended weight for a person of the same height, age, and mobility as the *plan participant*. Morbid obesity is a result of persistent and uncontrollable weight gain that constitutes a present or potential threat to life. The body mass index (BMI) is used to define obesity. For purposes of morbid obesity, a BMI value greater than or equal to forty (40) kg/m2 may be used to diagnose the condition.

Network

An arrangement under which services are provided to *plan participants* through a select group of providers.

No-Fault Auto Insurance

The basic reparations provision of a law providing for payments without determining fault in connection with automobile *accidents*.

Non-Network

Services rendered by a non-participating provider within the designated *network* area.

Notice/Notify/Notification

The delivery or furnishing of information to a *claimant* as required by federal law.

Office Visit

A direct personal contact between a *physician* or other healthcare practitioner and a patient in the healthcare 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 and with documentation that meets the requirement of such CPT coding. The following services are not considered to be an office visit under this *Plan*: visit to a healthcare practitioner's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection, or an eye exam.

Open Enrollment Period

The annual period during which you and your *dependents* are eligible to enroll for coverage or change benefit plan options.

Other Plan

Shall include but is not limited to:

1. any primary payer besides the *Plan*
2. any other group health plan
3. any other coverage or policy covering the *plan participant*
4. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured, or underinsured motorist coverage
5. any policy of insurance from any insurance company or guarantor of a responsible party
6. any policy of insurance from any insurance company or guarantor of a third party
7. workers' compensation or other liability insurance company
8. any other source, including, but not limited to, crime victim restitution funds, any medical, disability, school insurance coverage, or other benefit payments

Out-of-Network

See *Non-Network*.

Out-of-Pocket Limit

A *Plan's* limit on the amount a *plan participant* must pay out of their own pocket for medical expenses *incurred* during a *calendar year*. Out-of-pocket limits accumulate on an individual, family, or combined basis. After a *plan participant* reaches the out-of-pocket limit, the *Plan* pays benefits at a higher rate.

Outpatient

Treatment including services, supplies, and medicines provided and used at a *hospital* under the direction of a *physician* to a person not admitted as a registered bed patient; or services rendered in a *physician's* office, laboratory, or x-ray facility, an *ambulatory surgical center*, or the patient's home.

Patient Protection and Affordable Care Act of 2010 (PPACA)

The Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Jointly, these laws are referred to as PPACA.

Pharmacy

A licensed establishment where covered *prescription drugs* are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician

A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Acupuncturist, Audiologist, Behavioral Health Practitioner, Board Certified Behavior Analyst (BCBA), Breastfeeding/Lactation Educator, Certified Nurse Anesthetist, Certified Registered Nurse Anesthetist (CRNA), Certified Surgical Technician, Chiropractor, Dentist, Genetic Counselor, Licensed Counselor, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Narapath, (D.M.), Naturopath, Nurse, Nurse Practitioner, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physician Assistant, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Registered Behavior Technician (RBT), Registered Nurse First Assistant, Respiratory Therapist, Speech Language Pathologist, Surgical Assistant Professional, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his/her license.

Plan

HonorHealth Employee Health Plan, which is a benefits plan for certain *employees* of HonorHealth and is described in this document. HonorHealth Employee Health Plan is a distinct entity, separate from the legal entity that is your *employer*.

Plan Administrator

HonorHealth, which is the named *fiduciary* of the *Plan*, and exercises all discretionary authority and control over the administration of the *Plan* and the management and disposition of *Plan* assets.

Plan Participant/Participant

Any *employee* or *dependent* who is covered under this *Plan*.

Plan Sponsor

HonorHealth

Plan Year

The twelve (12) month period beginning on the effective date of the *Plan*.

Post-Service Claim

Any *claim* for a benefit under the *Plan* related to care or treatment that the *plan participant* or beneficiary has already received.

Pre-Admission Tests/Testing

Those *diagnostic services* done prior to scheduled *surgery*, provided that all of the following conditions are met:

1. The tests are approved by both the *hospital* and the *physician*.
2. The tests are performed on an *outpatient* basis prior to *hospital* admission.
3. The tests are performed at the *hospital* into which confinement is scheduled, or at a qualified facility designated by the *physician* who will perform the *surgery*.

Pre-Certification/Pre-Certified

An evaluation conducted by a utilization review team through the Health Care Management Program to determine the *medical necessity* and *reasonableness* of a *plan participant's* course of treatment.

Pregnancy

Childbirth and conditions associated with pregnancy, including complications.

Prescription Drug

Any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed *physician*. Such drug must be *medically necessary* in the treatment of an *illness* or *injury*.

Pre-Service Claim

Any *claim* that requires *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan* (e.g. a request for *pre-certification* under the Health Care Management Program).

Preventive Care

Certain preventive services mandated under the *Patient Protection and Affordable Care Act of 2010 (PPACA)* which are available without cost sharing when received from a *network* provider. To comply with *PPACA*, and in accordance with the recommendations and guidelines, the *Plan* will provide *network* coverage for:

1. evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations
2. recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention
3. comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA)
4. comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA)

Copies of the recommendations and guidelines may be found here: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/**. For more information, you may contact the *Plan Administrator/employer*.

Primary Care Physician (PCP)

Family practitioners, general practitioners, internists, and pediatricians.

Charges from nurse practitioners (N. P.) and physician's assistants (P.A.) will be considered at the level of the provider they bill under.

Prior Plan

The coverage provided on a group or group-type basis by the group insurance policy, benefit plan, or service plan that was terminated on the day before the effective date of the *Plan* and replaced by the *Plan*.

Prior to Effective Date or After Termination Date

Dates occurring before a *plan participant* gains eligibility from the *Plan*, or dates occurring after a *plan participant* loses eligibility from the *Plan*, as well as charges *incurred* prior to the effective date of coverage under the *Plan* or after coverage is terminated, unless extension of benefits applies.

Privacy Standards

The standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

Psychiatric Hospital

An *institution* constituted, licensed, and operated as set forth in the laws that apply to *hospitals*, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally *ill* persons either by, or under the supervision of, a *physician*.

2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided.
3. It is licensed as a psychiatric hospital.
4. It requires that every patient be under the care of a *physician*.
5. It provides twenty-four (24) hour per day nursing service.

The term psychiatric hospital does not include an *institution*, or that part of an *institution*, used mainly for nursing care, rest care, convalescent care, care of the aged, *custodial care*, or educational care.

Qualified Individual

An individual who is a covered participant or beneficiary in this *Plan* and who meets the following conditions:

1. the individual is eligible to participate in an *approved clinical trial* according to the trial protocol with respect to the treatment of cancer or other life-threatening *disease* or condition; and
2. either:
    a. The referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.
    b. The *participant* or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.

Qualified Medical Child Support Order (QMCSO)

A *medical child support order* that creates or recognizes the existence of an *alternate recipient's* right to, or assigns to an *alternate recipient* the right to, receive benefits for which a *plan participant* or eligible *dependent* is entitled under this *Plan*.

An order is not a QMCSO if it requires the *Plan* to provide any type or form of benefit or any option that the *Plan* does not otherwise provide, or if it requires an employee who is not covered by the *Plan* to provide coverage for a *dependent child*, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to healthcare coverage for any *dependent child* of the *employee*, the *Plan Administrator* or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the *employee*, the other parent, the child, and any other party acting on behalf of the child. The *Plan Administrator* or its designee will notify the parents and each child if an order is determined to be a QMCSO, and if the *employee* is covered by the *Plan*, and advise them of the procedures to be followed to provide coverage of the *dependent child(ren)*.

Reasonable

In the *Plan Administrator's* discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of *illness* or *injury* not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the *Plan Administrator*, taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or supply; industry standards, and practices as they relate to similar scenarios; and the cause of *injury* or *illness* necessitating the services and/or charges.

This determination will consider, but will not be limited to, the findings and assessments of the following entities:

1. The National Medical Associations, societies, and organizations
2. The Food and Drug Administration

To be reasonable, services and/or fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care, and/or treatment that results from

errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The *Plan Administrator* retains discretionary authority to determine whether services and/or fees are reasonable based upon information presented to the *Plan Administrator*. A finding of provider negligence and/or malpractice is not required for services and/or fees to be considered not reasonable.

Charges and/or services are not considered to be reasonable, and as such are not eligible for payment (exceed the *maximum allowable charge*), when they result from provider error(s) and/or facility-acquired conditions deemed reasonably preventable through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The *Plan* reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the *Plan* and to identify charges and/or services that are not reasonable, and therefore not eligible for payment by the *Plan*.

Rehabilitation Hospital

An *institution* which mainly provides therapeutic and restorative services to *ill* or *injured* people. It is recognized as such if it meets the following criteria:

1. It carries out its stated purpose under all relevant federal, state, and local laws.
2. It is accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities.
3. It is approved for its stated purpose by *Medicare*.

Residential Treatment Facility

A provider licensed and operated as required by law, which includes:

1. room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with twenty-four (24) hour availability
2. a staff with one (1) or more doctors available at all times
3. residential treatment takes place in a structured facility-based setting
4. the resources and programming to adequately diagnose, care, and treat a psychiatric and/or *substance use disorders*
5. facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care
6. is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

The term residential treatment facility does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. custodial care
6. educational care

Room and Board

A *hospital's* charge for:

1. room and linen service
2. dietary service, including meals, special diets, and nourishment
3. general nursing service
4. other conditions of occupancy which are *medically necessary*

Security Standards

The final rule implementing HIPAA's security standards for the Protection of Electronic PHI, as amended.

Sickness

See *Disease*.

Skilled Nursing Facility

A facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an *inpatient* basis to persons recovering from an *injury* or *illness*. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a *physician*.
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, *custodial care*, or educational care.

This term also applies to charges *incurred* in a facility referring to itself as an extended acute rehabilitation facility, long-term acute care facility, or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care

Skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a *physician* to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Substance Use Disorder

The DSM-5 definition is applied as follows: *Substance use disorder* describes a problematic pattern of using alcohol or another substance (whether obtained legally or illegally) that results in impairment in daily life or noticeable distress. An individual must display two (2) of the following eleven (11) symptoms within twelve (12) months:

1. consuming more alcohol or other substance than originally planned
2. worrying about stopping or consistently failed efforts to control one's use
3. spending a large amount of time using drugs/alcohol, or doing whatever is needed to obtain them
4. use of the substance results in failure to fulfill major role obligations such as at home, work, or school
5. craving the substance (alcohol or drug)
6. continuing the use of a substance despite health problems caused or worsened by it

   This can be in the domain of mental health (psychological problems may include depressed mood, sleep disturbance, anxiety, or blackouts) or physical health.
7. continuing the use of a substance despite its having negative effects in relationships with others (for example, using even though it leads to fights or despite people's objecting to it)
8. repeated use of the substance in a dangerous situation (for example, when having to operate heavy machinery, when driving a car)
9. giving up or reducing activities in a person's life because of the drug/alcohol use
10. building up a tolerance to the alcohol or drug

Tolerance is defined by the DSM-5 as either needing to use noticeably larger amounts over time to get the desired effect or noticing less of an effect over time after repeated use of the same amount.

11. experiencing withdrawal symptoms after stopping use

    Withdrawal symptoms typically include, according to the DSM-5: anxiety, irritability, fatigue, nausea/vomiting, hand tremor, or seizure in the case of alcohol.

Substance Use Disorders/Mental Health Treatment Center

An *institution* which provides a program for the treatment of *substance use disorders* by means of a written treatment plan approved and monitored by a *physician*. This *institution* must be at least one (1) of the following:

1. affiliated with a *hospital* under a contractual agreement with an established system for patient referral
2. accredited as such a facility by the Joint Commission or CARF
3. licensed, certified, or approved as an alcohol or *substance use disorders* treatment program center, *psychiatric hospital*, or *facility* for *mental health* by a state agency having legal authority to do so
4. is a facility operating primarily for the treatment of *substance use disorders* and meets these tests:
    a. maintains permanent and full-time facilities for bed care and full-time confinement of at least twenty-four (24) hour-per-day nursing service by a registered nurse (R.N.)
    b. has a full-time psychiatrist or psychologist on the staff
    c. is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of *substance use disorders*

Surgery/Surgical Procedure

Any of the following:

1. the incision, excision, debridement, or cauterization of any organ or part of the body and the suturing of a wound
2. the manipulative reduction of a fracture or dislocation or the manipulation of a joint, including application of cast or traction
3. the removal by endoscopic means of a stone or other foreign object from any part of the body, or the diagnostic examination by endoscopic means of any part of the body
4. the induction of artificial pneumothorax and the injection of sclerosing solutions
5. arthrodesis, paracentesis, arthrocentesis, and all injections into the joints or bursa
6. obstetrical delivery and dilatation and curettage
7. biopsy
8. surgical injection

Temporomandibular Joint (TMJ)

The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves, and other tissues related to the temporomandibular joint.

Third Party Administrator

AmeriBen has been hired as the Third Party Administrator by the *Plan Administrator* to perform *claims* processing and other specified administrative services in relation to the *Plan*. The Third Party Administrator is not an insurer of health benefits under this *Plan*, is not a *fiduciary* of the *Plan*, and does not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator*. The Third Party Administrator is not responsible for *Plan* financing and does not guarantee the availability of benefits under this *Plan*.

Timely Payment

As referenced in the section entitled **Continuation Coverage Rights Under COBRA**. Timely payment means a payment made no later than thirty (30) days after the first day of the coverage period.

Total Disability/Totally Disabled

In the case of a *dependent* child, the complete inability, as a result of *injury* or *illness,* to perform the normal activities of a person of like age and sex and in good health.

Uniformed Services

The Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; and any other category of persons designated by the President of the United States in time of war or emergency.

Urgent Care Facility

A free-standing facility, regardless of its name, at which a *physician* is in attendance at all times that the facility is open, that is engaged primarily in providing minor *emergency* and episodic medical care to a *plan participant*.

Urgent Care Claim

Any *pre-service claim* for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health, or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*. Whether a *claim* is an urgent care claim will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any *claim* that a *physician* with knowledge of the *claimant's* medical condition determines is an urgent care claim as described herein shall be treated as an urgent care claim under the *Plan*. Urgent care claims are a subset of *pre-service claims*.

Usual and Customary Charge

Covered charges which are identified by the *Plan Administrator*, taking into consideration the fees which the provider most frequently charges (or accepts) for the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same area by providers of similar training and experience for the service or supply, and the *Medicare* reimbursement rates. The term(s) 'same geographic locale' and/or 'area' shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons, or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be usual and customary, fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term 'usual' refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, *pharmacies*, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was *incurred*.

The term 'customary' refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one (1) individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age, and who has received such services or supplies within the same geographic locale.

The term 'usual and customary' does not necessarily mean the actual charge made (or accepted), nor the specific service or supply furnished to a *plan participant* by a provider of services or supplies, such as a *physician*, therapist, nurse, *hospital*, or pharmacist. The *Plan Administrator* will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service, or supply is customary.

Usual and customary charges may, at the *Plan Administrator's* discretion, alternatively be determined and established by the *Plan* using normative data such as, but not limited to, *Medicare* cost to charge ratios, average wholesale price (AWP) for prescriptions, and/or manufacturer's retail pricing (MRP) for supplies and devices.

Waiting Period

An interval of time during which the *employee* is in the continuous, *active employment* of his/her participating *employer*.

SECTION XX—PLAN ADOPTION

A. Severability

In the event that any provision of this document is held by a court of competent jurisdiction to be excessive in scope or otherwise invalid or unenforceable, such provision shall be adjusted rather than voided, if possible, so that it is enforceable to the maximum extent possible, and the validity and enforceability of the remaining provisions of this document will not in any way be affected or impaired thereby.

B. Adoption

HonorHealth hereby adopts the provisions of this HonorHealth Employee Health Plan, and its duly authorized officer has executed this plan document and summary plan description effective the first day of January 2022.

By: DocuSigned by: WAYNE FRANGESCH 6CFF65DA3C014E0...

Date: January 14, 2022 | 2:21 PM PST

Title: SVP-CHRO

If you have questions about your *Plan* benefits, please contact the *Third Party Administrator* at 1-602-231-8855.

P.O. Box 7186
Boise ID 83707