

The logo for HonorHealth, featuring the word "HONORHEALTH" in white, uppercase, sans-serif font. The text is set against a dark purple background that consists of two overlapping horizontal bars of different lengths, creating a stylized, modern look.

HONORHEALTH[®]

**HonorHealth
Employee Health Plan
Plan Document
and Summary Plan Description**

**Effective
January 1, 2024**

TABLE OF CONTENTS

SECTION I— INTRODUCTION	1
A. Quick Reference Information Chart	2
B. Plan is Not an Employment Contract	4
C. Plan Administrator	4
D. Duties of the Plan Administrator	4
E. Amending and Terminating the Plan	4
F. Plan Administrator Compensation	4
G. Fiduciary Duties	4
H. The Named Fiduciary	5
I. Type of Administration	5
J. Employer Information	5
K. Plan Name	5
L. Plan Number	5
M. Type of Plan	5
N. Plan Year	5
O. Plan Effective Date	5
P. Plan Sponsor	6
Q. Plan’s HIPAA Privacy Officer and HIPAA Security Officer	6
R. Third Party Administrator	6
S. Agent for Service of Legal Process	6
SECTION II— ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS	7
A. Eligibility	7
B. Enrollment	10
C. Timely Enrollment	10
D. Special Enrollment Rights	10
E. Special Enrollment Periods	11
F. Qualifying Events Chart	12
G. Termination of Coverage	13
H. Continuation During Periods of Employer-Certified Disability, Leave of Absence, or Layoff	14
I. Continuation During Family and Medical Leave	15
J. Rehiring a Terminated Employee	15
K. Open Enrollment	15
SECTION III— CONSOLIDATED APPROPRIATIONS ACT OF 2021 AND TRANSPARENCY IN COVERAGE REGULATIONS	16
A. Surprise Billing Claims	16
B. No Surprises Billing Act Requirements	16
C. How Cost-Shares Are Calculated	17
D. Appeals	17
E. Transparency Requirements	17
F. Continuity of Care	18
SECTION IV— MEDICAL NETWORK INFORMATION	19
A. Network and Non-Network Services	19
B. Choosing a Physician - Patient Protection Notice	19
C. Special Reimbursement Provisions	19
D. Network Information	21
SECTION V— SCHEDULE OF BENEFITS	22
A. Verification of Eligibility: 1-602-231-8855	22
B. Schedule of Benefits	22
C. Deductible Amount	25
D. Benefit Payment	25
E. Out-of-Pocket Limit	25
F. Diagnosis-Related Grouping (DRG)	25
G. Co-Insurance	25
H. Co-Payments	26
I. Balance Bill	26
J. Schedule of Medical Benefits - Coordinated Care Plan Option	27
K. Schedule of Behavioral Benefits - Coordinated Care Plan Option	37

L.	Schedule of Dialysis Benefits - Coordinated Care Plan Option	38
M.	Schedule of Prescription Drug Benefits - Coordinated Care Plan Option	39
N.	Schedule of Medical Benefits - Standard Plan Option	41
O.	Schedule of Behavioral Benefits - Standard Plan Option	51
P.	Schedule of Dialysis Benefits - Standard Plan Option	52
Q.	Schedule of Prescription Drug Benefits - Standard Plan Option	53
R.	High Deductible Health Plan (HDHP)	55
S.	Requirements for a Health Savings Account (HSA)	55
T.	Schedule of Medical Benefits - Health Savings Account Plan (HDHP) Option	56
U.	Schedule of Behavioral Benefits - Health Savings Account Plan (HDHP) Option	65
V.	Schedule of Dialysis Benefits - Health Savings Account (HDHP) Plan Option	66
W.	Schedule of Prescription Drug Benefits - Health Savings Account Plan (HDHP) Option	67
SECTION VI— MEDICAL BENEFITS		69
A.	Covered Medical Charges	69
B.	Medical Plan Exclusions	81
SECTION VII— OUTPATIENT DIALYSIS SERVICES		88
A.	Coordination with Medicare	88
SECTION VIII— HEALTH CARE MANAGEMENT PROGRAM		89
A.	Utilization Review	89
B.	Concurrent Review and Discharge Planning	91
C.	Case Management	91
D.	Courtesy Reviews	92
E.	Health Management Program	92
F.	Pregnancy Notification	93
SECTION IX— PRESCRIPTION DRUG BENEFITS		94
A.	About Your Prescription Benefits	94
B.	Out-of-Pocket Limit	94
C.	Co-Payments	94
D.	Co-Insurance	94
E.	Manufacturer Coupons	94
F.	Mail Order Drug Benefit Option	94
G.	OptumRx Walgreens90 Program	95
H.	Specialty Pharmacy Program	95
I.	Prior Authorization	95
J.	Step Therapy Program	95
K.	Medicare Part D Prescription Drug Plans for Medicare Eligible Participants	95
L.	Covered Prescription Drug Charges	95
M.	Limits to This Benefit	97
N.	Dispense As Written (DAW) Program	97
O.	Prescription Drug Plan Exclusions	97
SECTION X— CLAIMS AND APPEALS		99
A.	Timeframes for Claim and Appeal Processes	100
B.	Appropriate Claim Administrator	100
C.	Types of Claims Managed by the Medical Management Administrator	101
D.	Urgent Care Claims	101
E.	Concurrent Care Claims	104
F.	Other Pre-Service Claims	104
G.	Second Level Appeals Process for Urgent Care, Concurrent Care, and Other Pre-Service Claims	107
H.	External Review of Pre-Service Claims	108
I.	Incomplete Claims	108
J.	Post-Service Claims	108
K.	Second-Level Appeal Process of Post-Service Claims	112
L.	External Review Rights	112
M.	External Review of Claims	112
N.	Designation of Authorized Representative	115
O.	Physical Examinations	115
P.	Autopsy	115
Q.	Payment of Benefits	115
R.	Assignments	115

S.	Non-U.S. Providers	116
T.	Recovery of Payments	116
SECTION XI— COORDINATION OF BENEFITS		117
A.	Coordination of the Benefit Plans	117
B.	Excess Insurance	117
C.	Allowable Charge	117
D.	General Limitations	118
E.	Application to Benefit Determinations	118
F.	Benefit Plan Payment Order	118
G.	Coordination with Government Programs	120
H.	Claims Determination Period	120
I.	Right to Receive or Release Necessary Information	120
J.	Facility of Payment	120
K.	Right of Recovery	120
L.	Exception to Medicaid	120
SECTION XII— MEDICARE		121
A.	Application to Active Employees and Their Spouses	121
B.	Applicable to All Other Participants Eligible for Medicare Benefits	121
SECTION XIII— REIMBURSEMENT AND RECOVERY PROVISIONS		122
A.	Participant is a Trustee Over Plan Assets	122
B.	Release of Liability	122
C.	Excess Insurance	122
D.	Separation of Funds	123
E.	Wrongful Death	123
F.	Obligations	123
G.	Offset	124
H.	Minor Status	124
I.	Language Interpretation	124
J.	Severability	124
SECTION XIV— CONTINUATION COVERAGE RIGHTS UNDER COBRA If You Wish to Appeal		125 125
SECTION XV— FUNDING THE PLAN AND PAYMENT OF BENEFITS		126
A.	For Employee and Dependent Coverage	126
B.	Plan is not an Employment Contract	126
C.	Clerical Error	126
SECTION XVI— CERTAIN PLAN PARTICIPANTS' RIGHTS UNDER ERISA		127
SECTION XVII— FEDERAL NOTICES		128
A.	Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)	128
B.	Genetic Information Nondiscrimination Act of 2008 (GINA)	128
C.	Mental Health Parity and Addiction Equity Act of 2008	128
D.	Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)	128
E.	Non-Discrimination Policy	128
F.	Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)	128
G.	Women's Health and Cancer Rights Act of 1998 (WHCRA)	128
SECTION XVIII— COMPLIANCE WITH HIPAA PRIVACY STANDARDS		129
SECTION XIX— DEFINED TERMS		130
SECTION XX— PLAN ADOPTION		151
A.	Severability	151
B.	Adoption	151

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. 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.

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 the *Patient Protection and Affordable Care Act (PPACA)*, also known as 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. If there is any conflict between this summary plan description and the *Plan’s* wrap document, the wrap document will control, unless otherwise specified.

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. Refer to the [Quick Reference Information Chart](#) for contact information.

If you do not understand English and have questions about a claim denial, contact the appropriate *Claims Administrator* (see the [Quick Reference Information 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): Dineke'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-602-231-8855

A. Quick Reference Information Chart

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 Information Chart:

QUICK REFERENCE INFORMATION			
Information Needed	Whom to Contact		
Plan Administrator	<p>HonorHealth Attn: Employee Benefits Department 8125 N. Hayden Road Scottsdale, AZ 85258</p> <p>For questions about your benefits, please contact: Benefits Educators Phone: 1-480-583-4588 or 1-877-768-7182 Fax: 1-480-882-5802 www.HonorHealthBenefits.com employee.benefits@honorhealth.com</p> <p>Health Plan Care Navigator Phone: 1-280-210-5255 hhepcarenavigator@icphealth.com</p>		
<p>Medical Claims Administrator/Third Party Administrator (Medical)</p> <ul style="list-style-type: none"> • Claim Forms (Medical) • Medical Claims and Post-Service Appeals • Eligibility for Coverage • Plan Benefit Information 	<p>AmeriBen P.O. Box 7186 Boise, ID 83707 1-602-231-8855 www.MyAmeriBen.com</p>		
Medical Management Administrator	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>ICP Health Phone: 1-800-250-6647 Fax: 1-833-665-1252 www.ICPPatient.com/PriorAuth</p> </td> <td style="width: 50%; vertical-align: top;"> <p>Behavioral Health Services: Magellan Health P.O. Box 1659 Maryland Heights, MO 63043 1-800-424-4138</p> </td> </tr> </table>	<p>ICP Health Phone: 1-800-250-6647 Fax: 1-833-665-1252 www.ICPPatient.com/PriorAuth</p>	<p>Behavioral Health Services: Magellan Health P.O. Box 1659 Maryland Heights, MO 63043 1-800-424-4138</p>
<p>ICP Health Phone: 1-800-250-6647 Fax: 1-833-665-1252 www.ICPPatient.com/PriorAuth</p>	<p>Behavioral Health Services: Magellan Health P.O. Box 1659 Maryland Heights, MO 63043 1-800-424-4138</p>		
<p>PPO Provider Network <i>Names of Physicians & Hospitals</i></p> <ul style="list-style-type: none"> • Network Provider Directory - see website 	<table style="width: 100%; border: none;"> <tr> <td style="width: 70%; vertical-align: top;"> <p>HonorHealth Employee Physician Network 1-480-696-4020 https://icphealth.com/physician-search/</p> </td> <td style="width: 30%; vertical-align: top;"> <p>BlueCross BlueShield of Arizona (BCBSAZ) 1-800-650-5656 General provider directory: www.azblue.com/chsnetwork Mayo provider directory: www.azblue.com/chsnetworkmayo</p> </td> </tr> </table>	<p>HonorHealth Employee Physician Network 1-480-696-4020 https://icphealth.com/physician-search/</p>	<p>BlueCross BlueShield of Arizona (BCBSAZ) 1-800-650-5656 General provider directory: www.azblue.com/chsnetwork Mayo provider directory: www.azblue.com/chsnetworkmayo</p>
<p>HonorHealth Employee Physician Network 1-480-696-4020 https://icphealth.com/physician-search/</p>	<p>BlueCross BlueShield of Arizona (BCBSAZ) 1-800-650-5656 General provider directory: www.azblue.com/chsnetwork Mayo provider directory: www.azblue.com/chsnetworkmayo</p>		
	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><u>HonorHealth Facilities:</u> <u>Call AmeriBen at 1-602-231-8855 for additional network facilities.</u></p> <p>Osborn Medical Center 7400 E. Osborn Road Scottsdale, AZ 85251 1-480-882-4000</p> <p>Shea Medical Center 9003 E. Shea Blvd. Scottsdale, AZ 85260 1-480-323-3000</p> <p>Thompson Peak Medical Center 7400 E. Thompson Peak Parkway Scottsdale, AZ 85255 1-480-324-7000</p> </td> <td style="width: 50%; vertical-align: top;"> <p>Scottsdale Medical Imaging Limited (SMIL) dba Southwest Diagnostic Imaging For locations visit www.eSMIL.com</p> <p>Deer Valley Medical Center 19829 N. 27th Ave. Phoenix, AZ 85027 1-623-879-6100</p> <p>John C. Lincoln Medical Center 250 E. Dunlap Ave. Phoenix, AZ 85020 1-602-870-6060</p> <p>Sonoran Crossing Medical Center 33400 N. 32nd Ave. Phoenix, AZ 85085 1-623-683-5000</p> <p>Union Hills Pain Partners LLC dba HonorHealth Pain Management Center</p> </td> </tr> </table>	<p><u>HonorHealth Facilities:</u> <u>Call AmeriBen at 1-602-231-8855 for additional network facilities.</u></p> <p>Osborn Medical Center 7400 E. Osborn Road Scottsdale, AZ 85251 1-480-882-4000</p> <p>Shea Medical Center 9003 E. Shea Blvd. Scottsdale, AZ 85260 1-480-323-3000</p> <p>Thompson Peak Medical Center 7400 E. Thompson Peak Parkway Scottsdale, AZ 85255 1-480-324-7000</p>	<p>Scottsdale Medical Imaging Limited (SMIL) dba Southwest Diagnostic Imaging For locations visit www.eSMIL.com</p> <p>Deer Valley Medical Center 19829 N. 27th Ave. Phoenix, AZ 85027 1-623-879-6100</p> <p>John C. Lincoln Medical Center 250 E. Dunlap Ave. Phoenix, AZ 85020 1-602-870-6060</p> <p>Sonoran Crossing Medical Center 33400 N. 32nd Ave. Phoenix, AZ 85085 1-623-683-5000</p> <p>Union Hills Pain Partners LLC dba HonorHealth Pain Management Center</p>
<p><u>HonorHealth Facilities:</u> <u>Call AmeriBen at 1-602-231-8855 for additional network facilities.</u></p> <p>Osborn Medical Center 7400 E. Osborn Road Scottsdale, AZ 85251 1-480-882-4000</p> <p>Shea Medical Center 9003 E. Shea Blvd. Scottsdale, AZ 85260 1-480-323-3000</p> <p>Thompson Peak Medical Center 7400 E. Thompson Peak Parkway Scottsdale, AZ 85255 1-480-324-7000</p>	<p>Scottsdale Medical Imaging Limited (SMIL) dba Southwest Diagnostic Imaging For locations visit www.eSMIL.com</p> <p>Deer Valley Medical Center 19829 N. 27th Ave. Phoenix, AZ 85027 1-623-879-6100</p> <p>John C. Lincoln Medical Center 250 E. Dunlap Ave. Phoenix, AZ 85020 1-602-870-6060</p> <p>Sonoran Crossing Medical Center 33400 N. 32nd Ave. Phoenix, AZ 85085 1-623-683-5000</p> <p>Union Hills Pain Partners LLC dba HonorHealth Pain Management Center</p>		

	<p>HonorHealth Cancer Care For locations visit https://www.honorhealth.com/find-a-location</p> <p>Greenbaum Surgical Specialty Hospital (Osborn Campus) 3535 N. Scottsdale Rd. Scottsdale, AZ 85251 1-480-882-4588</p> <p>Piper Surgery Center (Shea Campus) 9007 E. Shea Blvd., Scottsdale, AZ 85258 1-480-323-3950</p> <p>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</p> <p>North Valley Surgery Center 8901 E. Raintree Dr. Suite 100 Scottsdale, AZ 85260 1-480-767-2100 Fax: 1-480-767-2101</p>	<p>4727 E. Union Hills, Suite 300 Phoenix, AZ 85050 1-480-207-3737 Fax: 1-623-266-0053</p> <p>Global Rehab Hospital—Scottsdale, LLC dba HonorHealth Rehabilitation Hospital 8850 E. Pima Center Parkway Scottsdale, AZ 85258 1-480-800-3900</p> <p>Spine Group of Arizona 3621 N. Wells Fargo Ave. Scottsdale, AZ 85251 1-480-882-5566 http://www.spinegrouparizona.com</p> <p>OrthoArizona 8405 N Pima Center Pkwy, Suite 102 Scottsdale, AZ 85258 Phone: 1-480-454-4211 Fax: 1-480-454-4212</p>
<p>Behavioral Health Provider Network <i>Names of Physicians & Hospitals</i></p> <ul style="list-style-type: none"> Behavioral health Claims Administrator Network Provider Directory - see website 	<p>Magellan Health P.O. Box 1659 Maryland Heights, MO 63043 1-800-424-4138 www.MagellanAscend.com</p>	
<p>Pharmacy Benefits Manager</p> <ul style="list-style-type: none"> 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 	<p>Retail OptumRx P.O. Box 29044 Hot Springs, AR 71903 1-844-368-9854 www.optumrx.com</p>	<p>Mail Order OptumRx P.O. Box 2975 Mission, KS 66201 1-844-368-9854 www.optumrx.com</p> <p>Specialty Optum Specialty Pharmacy 1-855-427-4682 www.specialty.optumrx.com</p>
<p>FSA Vendor</p>	<p>WEX 4321 20th Ave. S. Fargo, ND 58103 1-866-451-3399 www.wexinc.com</p>	
<p>Employee Assistance Program (EAP)</p> <ul style="list-style-type: none"> EAP Counseling and Referral Services 	<p>ComPsych 1-866-676-3524 www.guidanceresources.com (ID: HonorHealth)</p>	
<p>COBRA Administrator</p> <ul style="list-style-type: none"> Continuation Coverage 	<p>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</p>	

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

Refer to the *Plan's* wrap document for a description of the *Plan Administrator's* duties.

E. Amending and Terminating the Plan

Refer to the *Plan's* wrap document for provisions pertaining to amendment and termination of the *Plan*.

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

Refer to the *Plan's* wrap document for information pertaining to the type of administration.

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, 2024

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

Refer to the *Plan's* wrap document for information pertaining to HIPAA Security Protections and Protected Health Information (PHI).

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. 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* as outlined in the [Quick Reference Information Chart](#).

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.

Refer to the *Plan's* wrap document for additional information regarding *QMCSO*.

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

Refer to the *Plan's* wrap document for additional information pertaining to ineligible employees.

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* as outlined in the Quick Reference Information Chart.

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.

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 <i>dependents</i>
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 <i>dependent</i> 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 <i>dependent</i> 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 <i>dependent</i> child	Date of event	thirty (30) days of spouse's or <i>dependent's</i> death	Coverage will terminate for the <i>dependent</i> from your health coverage
A <i>change in employment status</i> (including a change from one <i>employment</i> classification to another, you or your spouse taking a qualified unpaid <i>leave of absence</i> , a strike or lockout, or a change in worksite)	First of the month following the date of the event	thirty (30) days of <i>change in employment status</i> classification.	Enroll yourself, if your employment change results in you being eligible for a new set of benefits Enroll your spouse and other eligible <i>dependents</i> Drop health coverage Drop your spouse and other eligible <i>dependents</i> 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 <i>dependents</i>
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 <i>dependent</i> 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 <i>dependent</i> children
Spouse or covered <i>dependent</i> 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 <i>dependent</i> 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 <i>dependent</i> 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 <i>dependent</i> 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 <i>Medicare</i> (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 <i>Medicare</i> , 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
<i>Qualified Medical Support Order</i> affecting a <i>dependent</i> child's coverage	Date enrollment is received by the <i>Plan</i>	thirty (30) days of order	Enroll yourself, if applicable Enroll the eligible child named on <i>QMCSO</i>

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*, 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, refer to the *Plan's* wrap document.

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 which 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, refer to the *Plan's* wrap document.

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 AND TRANSPARENCY IN COVERAGE REGULATIONS

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Billing Act. In addition, the Transparency in Coverage (TIC) regulations contain transparency requirements. Portions of the CAA and TIC are described briefly below. Enforcement dates, standards for implementation, coordination with other entities, legal developments, and updates offered by federal and/or state entities directly impact actions and availability of the items described. In addition, some plan types are not subject to the CAA and/or TIC, or certain provisions of either.

A. Surprise Billing Claims

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

1. *emergency services* in an emergency department of a hospital or independent freestanding emergency department provided by *non-network* providers or facility
2. services provided by a *non-network* provider at a *network* facility
3. *non-network* air ambulance services

The section below contains further information about how these *claim* categories apply to your *Plan* and are dependent on covered benefits.

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 in an emergency department of a hospital or independent freestanding emergency department are provided by a *non-network* provider or facility, covered services will be processed at the *network* benefit level in accordance with the CAA.

Note that if you receive *emergency services* from a *non-network* provider or facility, your out-of-pocket costs will be limited to amounts that would apply if the covered services had been furnished by a *network* provider or facility. 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 or facility determines you are stable and the *non-network* provider satisfies all of the following requirements:

1. determines that you are able to travel to a *network* facility by non-emergency or non-medical transport to an available *network* provider or facility within a reasonable distance based on your condition
2. complies with the *notice* and consent requirement
3. determines that 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.

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 defined as:

1. items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a *physician* or non-physician practitioner
2. items and services provided by assistant surgeons, hospitalists, and intensivists
3. diagnostic services, including radiology and laboratory services
4. items and services provided by a *non-participating provider* if there is no *participating provider* who can furnish such item or service at such facility

This *notice* and consent exception also 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 providers satisfy the *notice* and consent requirement by one (1) of the following:

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

To help you determine whether a provider is *non-network*, 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-sharing amount* will be calculated based upon the *maximum allowed amount*. In addition to your *network* cost-share, 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 sharing amounts* for emergency services in an emergency department of a hospital or independent freestanding emergency department or for covered services received by a *non-network* provider at a *network* facility will be calculated as defined by the CAA, such as the lesser of billed charges or the median plan *network* contract rate (called the Qualifying Paying Amount or QPA) that we pay *network* providers for the geographic area where the covered service is provided if other calculation criteria does not apply. Any out-of-pocket cost you pay to a *non-network* provider for either these *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*. Cost-sharing for air ambulance services is based on the lesser of billed charges or the QPA.

D. Appeals

If you receive *emergency services* in an emergency department of a hospital or independent freestanding emergency department from a *non-network* provider, covered services from a *non-network* provider at a *network* facility, or *non-network* air ambulance services, and believe those services are covered by your *Plan's* benefits and 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* provisions of the *Plan*. A provider can dispute the payment they received from the *Plan* by utilizing a process set up by the CAA, or if applicable, state law. The CAA process includes Open Negotiation, and if unresolved, Independent Dispute Resolution. Importantly, this process does not include the *plan participant*, and you are not required to participate. To learn more about the CAA, you can visit <https://www.cms.gov/nosurprises>.

E. Transparency Requirements

Under your *Plan*, the following are provided as required by the CAA and/or TIC. Depending on how the *Plan* interacts with other entities, these may be provided from the *Third Party Administrator*, the *network*, Pharmacy Benefit Manager, and/or other stakeholders (ex. Customer Care or Member Services):

1. protections with respect to *surprise billing claims* by providers
2. estimates on what *non-network* providers may charge for a particular service
3. information on contacting state and federal agencies in case you believe a provider has violated the No Surprise Billing Act's requirements

When asked, a paper copy of the type of information you request from the above list can be provided.

Through the price comparison/shoppable services tool(s) associated with your *Plan* or through Member Services at the phone number on the back of your ID card, you can receive the following:

1. cost sharing information that you may be responsible for, for a service from a specific *network* provider
2. a list of all *network* providers
3. cost sharing information on *non-network* provider's services what you may pay *non-network* providers for the service

As applicable, under machine readable requirements from the TIC, the *network*, Pharmacy Benefit Manager, *Third Party Administrator*, and/or entities associated with your *Plan* will provide access through separate publicly accessible websites that contain the following information:

1. *network* negotiated rates
2. historical *non-network* allowed amounts
3. drug pricing information

F. Continuity of Care

If a *network* provider leaves the *network* for any reason other than termination for failure to meet applicable quality standards, fraud, or otherwise defined by the CAA, you may be able to continue seeing that provider for a limited period of time and still receive *network* benefits. The CAA permits you to request and decide to continue to have benefits provided under the same terms and conditions as you would have had under the plan document had the provider not moved to *non-network* status. If authorized, continuity of care ends ninety (90) days after you are notified by the *Plan* or its delegate of the right to request continuity of care or the date you are no longer under care of the provider, whichever of these is earlier.

Continuity of care under the CAA is permitted for a *plan participant* who, with respect to a provider, qualifies based on any of the following circumstances:

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility
2. is undergoing a course of institutional or inpatient care from the provider or facility
3. is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility

Under the CAA, the term 'serious and complex condition' means, with respect to a *participant*, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage, one (1) of the following:

1. in the case of an acute *illness*, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm
2. in the case of a chronic *illness* or condition, a condition that satisfies both of the following criteria:
 - a. is life-threatening, degenerative, potentially disabling, or congenital
 - b. requires specialized medical care over a prolonged period of time

If you wish to continue seeing the same provider/facility and you believe continuity of care under the CAA applies, you or your provider/facility should contact the entity responsible for Member Services on back of your card for how to apply for continuity of care.

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* as outlined in the [Quick Reference Information Chart](#).

Refer to the [Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations](#) section for additional provisions pertaining to *non-network* services and 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*, 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. For the Coordinated Care Plan Option and Health Savings Account (HDHP) Plan Option, pediatric specialists require approval by ICP Health if the *plan participant* is age eighteen (18) or older.
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
ICP considers the *network* service area to be within fifty (50) miles from home, including services rendered in Arizona. *Claims* that fall outside the *network* service area will apply a standard gap review.

For the Coordinated Care Plan Option and Health Savings Account Plan (HDHP) 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 pre-notification by ICP Health.

For the Standard Plan 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*.
6. **Transition of Care.** Effective January 1, 2024, specialist visits will only be covered on the Health Savings Account Plan (HDHP) option when you visit an ICP *network* provider. *Plan participants* who enrolled in the HDHP medical plan for the 2024 calendar year and need to continue care with a current provider not in the ICP *network* may be eligible for a transition of care/continuity of care or gap approval. *Transition of care* applications must be submitted to ICP by December 31, 2023.

Examples of acute medical conditions that may qualify:

- a. pregnancy through first postpartum visit
- b. cancer during chemotherapy, radiation, or reconstruction
- c. transplant
- d. recent major surgeries still in a follow-up period
- e. acute conditions in active treatment such as heart attacks, strokes, or unstable chronic conditions
- f. care under a previously approved gap
- g. outpatient intravenous therapy for a resolving condition
- h. terminal illness with an anticipated life expectancy of six (6) months or less
- i. staged surgeries, such as cleft palate repair

Examples of conditions that do not qualify:

- a. Routine exams, vaccinations, and health assessments
- b. Preference for a *non-network* specialist when the specialty is available in the *network*

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and 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 Information 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* provisions of the *Plan*.

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. If you have questions about specific supplies, treatments, or procedures, please contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

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. Refer to the Quick Reference Information Chart for contact information of the applicable *Medical Management Administrator*.

Services rendered in an emergency room or urgent care setting do not require *pre-certification*. Pre-certification is not required for routine outpatient services.

For specialty drugs obtained through the Pharmacy Benefits Manager, please refer to the Prescription Drug Benefits section for additional information and requirements for prior authorization.

Services that must be pre-certified by the Innovation Care Partners (ICP):

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. 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, sigmoidoscopies, and diagnostic scope procedures)

NOTE: Ophthalmology authorizations will be for surgical procedures only, not for place of service.

4. all potential cosmetic procedures
5. *durable medical equipment* purchases in excess of \$1,000
6. breast pumps in excess of \$1,000
7. corrective appliances (orthotics/prosthetics) purchases in excess of \$2,000
8. gene therapy and adoptive cell therapy
9. insulin pumps in excess of \$1,000 (purchase price or combined rental cost)
10. neuropsychological testing

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. psychological testing
15. surgical treatment of TMJ conditions
16. *home health care services and supplies*
17. home infusion therapy services
18. specialty infusion/injectable medications which are covered under the Medical Benefits and not obtained through the Prescription Drug Benefits:
 - a. **Anticonvulsant.** Vigabatrin (Sabil®)
 - b. **Botulinum toxin type A and B.** Botox®, Dysport®, Jeuveau®, Myobloc®, and Xeomin®
 - c. **Cystic Fibrosis Agent.** Elexacaftor/Tezacaftor/Ivacaftor (Trikafta®)
 - d. **C1 Inhibitors.** Cinryze®, Haegarda® and Berinert®
 - e. **Blood Cell Deficiency/Erythropoiesis Stimulating Agents (ESA).** Epoetin (Epogen®, Procrit®, Retacrit®), Darbepoetin (Aranesp®), Methoxy polyethylene glycol-epoetin beta (Mircera®), and Oprelvekin (Neumega®)
 - f. **Growth Hormones:**
 - i. Somatropin (Genotropin®, Humatrope®, Norditropin FlexPro®, Nutropin AQ NuSpin®, Omnitrope®, Saizen®, Saizenprep®, Serostim®, Zomacton®, and Zorbtive®)
 - ii. Tesamorelin (Egrifta SV®)
 - iii. Macimorelin (Macrilen®)
 - iv. Lonapegsomatropin (Skytrofa®)
 - v. Somapacitan (Sogroya®)
 - g. **Growth Hormone Blocker.** Mecasermin (Increlex®)
 - h. **HIV Agent.** Bictegravir/Emtricitabine/Tenofovir (Biktaury®)
 - i. **Immunologic Agents/Immune Modulators/Biologics/Monoclonal Antibody Agents.** Abatacept (Orencia®), Adalimumab (Humira®), Anakinra (Kineret®), Belimumab (Benlysta®), Certolizumab (Cimzia®), Etanercept (Enbrel®), Eculizumab (Soliris®), Fingolimod (Gilenya®), Glatiramer Acetate (Copaxone®, Glatopa®), Golimumab (Simponi®), Infliximab (Remicade®, Inflectra®), Isankizumab-rzaa (Skyrizi®), Lanadelumab-flyo (Takhzyro®), Ocrelizumab (Ocrevus®), Secukinumab (Cosentyx®), Tofacitinib (Actemra®), Rituximab (Rituxan®) (except for chemotherapy), Ustekinumab (Stelara®), and Vedolizumab (Entyvio®)
 - j. **Immunoglobulins:**
 - i. **Intravenous.** Asceniv, Bivigam, Flebogamma DIF, Gammaked, Gammaplex, Gamunex-C, Octagam, Panzyga, and Privigen
 - ii. **Subcutaneous.** Cutaquig, Cuvitru, Gammagard Liquid, Gammaked, Gamunex-C, Hizentra, Hyqvia, and Xembify
 - iii. **Intramuscular.** GamaSTAN
 - k. **Bone Condition Agents.** Denosumab (Prolia®, Xgeva®), and Zoledronic Acid (Reclast®)
 - l. **Respiratory Conditions.** Reslizumab (Cinqair®), Dupilumab (Dupixent®), Benralizumab (Fasenra®), Mepolizumab (Nucala®), Tezepelumab (Tezspire®), and Omalizumab (Xolair®)
 - m. **Eye Conditions.** Aflibercept (Eylea®) and Ranibizumab (Lucentis®), Teprotumumab (Tepezza®)
 - n. **Enzyme Deficiency.** Agalsidase Beta (Fabrazyme®), alglucosidase alfa (Lumizyme®), alpha-l proteinase inhibitor (Glassia®), imiglucerase (Cerezyme®) and Pegloticase

(Krystexxa®)

- o. **Endocrine Disorders.** Octreotide (Sandostatin®), Lanreotide (Somatuline Depot®), and Pasireotide (Signifor LAR®)
- p. **Gene Therapy.** idecabtagene vicleucel (Abecma®), lisocabtagene maraleucel (Breyanzi®), ciltacabtagene autoleucel (Carvykti®), tisagenlecleucel (Kymriah®), voretigene neparvovec-rzyl (Luxturna®), talimogene laherparepvec (Imlygic®), brexucabtagene autoleucel (Tecartus®), axicabtagene (Yescarta®), and onasemnogene abeparvovec (Zolgensma®), exagamglogene autotemcel (Casgevy®), lovotibeglogene autotemcel (Lyfgenia®)
- q. **Alzheimer's Disease.** Aducanumab-avwa (Aduhelm®)
- r. **Miscellaneous Specialty Medications.** Nusinersen (Spinraza®), Eteplirsen (Exondys 51®), edaravone (Radicava®) and Cerliponase alfa (Brineura®), enteral formula and parenteral nutrition

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

- 19. 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.

- 20. 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.

- 21. genetic testing and related lab fees (excludes genetic counseling, amniocentesis, and mandated BRCA services)
- 22. medical foods administered orally, other than PKU
- 23. 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
- 24. 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.
- 25. hyperbaric oxygen therapy
- 26. ventricular assistive devices (VAD), life vests, implantable cardiac defibrillators
- 27. proton beam therapy
- 28. speech therapy (other than speech evaluation and assessment)
- 29. adoptive cell therapy
- 30. testosterone hormone therapy (for males only)
- 31. *outpatient* dialysis

Services that must be pre-certified by Magellan Health:

- 1. *inpatient* mental health/*substance use disorder* hospitalization
- 2. *residential treatment facility* services
- 3. intensive *outpatient* therapy (IOP)
- 4. electroconvulsive therapy (ECT)
- 5. partial hospitalization (PHP)
- 6. psychological testing
- 7. neuropsychological testing
- 8. transcranial magnetic stimulation (TMS)

9. applied behavioral analysis (ABA) therapy

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

Services rendered may have professional, facility, and other components for which *physicians* and facilities may bill separately.

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:

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

Refer to the Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations section for additional provisions pertaining to *non-network* services and billing.

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 and Transparency in Coverage Regulations section for additional provisions pertaining to *non-network* services and 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 <i>network</i> and <i>non-network deductible</i> amounts do not accumulate towards each other.			
<i>Co-payments, prescription drugs, and co-insurance</i> do not apply to the <i>deductible</i> .			
<i>Per plan participant</i>	\$500		Not Applicable
<i>Per family unit</i>	\$1,000		Not Applicable
Family Unit - Embedded Deductible			
If you are enrolled in the family option, your plan contains two (2) components: an individual <i>deductible</i> and a <i>family unit deductible</i> . Having two (2) components to the <i>deductible</i> allows for each member of your <i>family unit</i> the opportunity to have your <i>Plan</i> cover medical expenses prior to the entire dollar amount of the <i>family unit deductible</i> being met. The individual <i>deductible</i> is embedded in the family <i>deductible</i> .			
For example , if you, your spouse, and child are on a family plan with a \$1,000 <i>family unit embedded deductible</i> , and the individual <i>deductible</i> is \$500, and your child <i>incurs</i> \$500 in medical bills, their <i>deductible</i> is met, and your <i>Plan</i> will help pay subsequent medical bills for that child during the remainder of the <i>calendar year</i> , even though the <i>family unit deductible</i> of \$1,000 has not been met yet.			
Maximum Out-of-Pocket Limit, per Calendar Year			
The <i>out-of-pocket limit</i> includes <i>co-payments, co-insurance, deductibles, and covered prescription drug charges</i> .			
The <i>network</i> and <i>non-network out-of-pocket limits</i> do not accumulate towards each other.			
<i>Per plan participant</i>	\$5,000		Unlimited
<i>Per family unit</i>	\$10,000		Unlimited
Family Unit - Embedded Out-of-Pocket Limit			
If you are enrolled in the <i>family unit</i> option, your <i>Plan</i> contains two (2) components: an individual <i>out-of-pocket limit</i> and a <i>family unit out-of-pocket limit</i> . Having two (2) components to the <i>out-of-pocket limit</i> allows for each member of your <i>family unit</i> the opportunity to have his/her <i>covered charges</i> be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the <i>family unit out-of-pocket limit</i> being met. The individual <i>out-of-pocket limit</i> is embedded in the <i>family unit out-of-pocket limit</i> .			
The <i>Plan</i> will pay the designated percentage of <i>covered charges</i> until <i>out-of-pocket limits</i> are reached, at which time the <i>Plan</i> will pay 100% of the remainder of <i>covered charges</i> for the rest of the <i>calendar year</i> 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:			
<ol style="list-style-type: none"> 1. premiums 2. cost containment penalties 3. charges in excess of the <i>Plan's</i> maximum benefits 4. amounts over <i>the maximum allowable charges</i> 5. charges not covered under the <i>Plan</i> 6. <i>balanced billed</i> charges 7. expenses for medical services or supplies obtained from <i>non-network</i> providers or facilities, except as noted in the plan document 			

Benefits 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%, <i>deductible</i> waived	Not Covered	Not Covered	Generally, most <i>covered charges</i> 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 <i>covered charges</i> , including the expenses that must be <i>pre-certified</i> and those expenses to which the <i>out-of-pocket limit</i> does not apply. <i>Deductible</i> applies for <i>inpatient</i> services and <i>outpatient surgeries</i> .
FACILITY SERVICES				
The benefits outlined in this section apply only to facility charges. Physician charges may be billed separately.				
Advanced Imaging (Outpatient Facility)	\$150 <i>co-payment</i> , <i>deductible</i> waived	Not Covered	Not Covered	Includes facility fees for 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 <i>co-payment</i> per day per provider for all advanced imaging combined. <i>Pre-certification is required for MRI/MRA and PET scans.</i>
Blood Transfusions (Outpatient)	80%, <i>deductible</i> waived	Not Covered	Not Covered	
Diagnostic Testing (Outpatient Facility)	\$20 <i>co-payment</i> , <i>deductible</i> waived	75%, <i>deductible</i> waived	Not Covered	Facility fees associated with <i>diagnostic testing</i> such as (but not limited to): • EKG/EEG • Stress Test • Peripheral Vascular Test
Emergency Room	\$250 <i>co-payment</i> , <i>deductible</i> waived			Emergency room professional fees (for <i>physicians</i> who specialize in emergency medicine) are included in the <i>co-payment</i> . <i>Co-payments</i> are applied per visit. <i>Non-network</i> emergency room care will apply toward the annual <i>out-of-pocket limit</i> . Emergency room <i>co-payment</i> will be waived if admitted for hospitalization or observation.
Injections and Infusion Therapy	80%, <i>deductible</i> waived	Not Covered	Not Covered	Benefits are available for injections and infusion therapies received in an office setting or other covered facility.

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 <i>plan participant</i> for <i>inpatient</i> rehabilitation services. Pre-certification is required.
Room and Board (Emergency Admission)	80% after deductible	80% after deductible	80% after deductible	For maternity stays: refer to the <u>Healthcare Management Program</u> section for criteria. Observation room stays: pre-certification is required after seventy-two (72) hours.
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 <i>outpatient</i> surgery at a hospital. Pre-certification is required for <i>outpatient</i> surgical procedures (excluding <i>outpatient</i> office surgical procedures and colonoscopies).
Outpatient Hospital	80% deductible waived	Not Covered	Not Covered	Includes facility fees for biopsies, catheterization lab procedures, chemotherapy, and radiation therapy. 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 <i>plan participant</i> . 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	
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 retail clinics.
X-Rays and Ultrasounds (Outpatient Facility)	\$20 co-payment, deductible waived	50%, deductible waived	Not Covered	

Coordinated Care Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES				
The benefits outlined in this section apply only to physician charges. Facility charges may be billed separately.				
Acupuncture	75% up to \$1,000, then Plan pays 10% All services combined Deductible waived			<i>Non-network coinsurance</i> applies to <i>in-network out-of-pocket</i> . \$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 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 <i>physician</i> .
Biofeedback	80%, deductible waived			
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.
Durable Medical Equipment (DME)	75%, deductible waived	75%, deductible waived	Not Covered	Pre-certification is required for DME in excess of \$1,000 purchase price.
Genetic/Genomic Testing and Counseling	75%, deductible waived	75%, deductible waived	Not Covered	Pre-certification is required for genetic testing.

Coordinated Care Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES <i>continued</i>				
Hearing Aids	75%, <i>deductible</i> waived			Benefit Maximum: Maximum is per ear every three (3) years for hearing aids, hearing aid repairs, hearing aid batteries, and related supplies.
Home Health Care	80%, <i>deductible</i> waived	75%, <i>deductible</i> waived	Not Covered	Therapy provided in the home will apply to the Rehabilitation <i>calendar year</i> maximum. Home hospice services are covered under the Hospice benefit. Pre-certification is required.
Home Infusion	80%, <i>deductible</i> waived	Not Covered	Not Covered	Pre-certification is required.
Home Visits Rendered by Dispatch Health	Not Applicable	\$60 <i>co-payment</i> , <i>deductible</i> waived	Not Applicable	
Hospice Care				
Hospice Care	75% after <i>deductible</i>	75% after <i>deductible</i>	Not Covered	
Bereavement Counseling	75% after <i>deductible</i>	75% after <i>deductible</i>	Not Covered	
Infertility				
Primary Care Provider (PCP)	\$25 <i>co-payment</i> , <i>deductible</i> waived	Not Covered	Not Covered	<i>Co-payment</i> applies to the office visit only. Other charges will be considered at the applicable benefit level.
Specialist	\$50 <i>co-payment</i> , <i>deductible</i> waived	Not Covered	Not Covered	
Treatment	80%, <i>deductible</i> waived	Lab Fees ordered by a BCBSAZ provider: 70%, <i>deductible</i> waived	Not Covered	Calendar Year Maximum: \$1,500 for infertility treatment per <i>plan participant</i> , then <i>Plan</i> pays 10%. <i>Calendar year</i> maximum does not apply to office visits. <i>Outpatient</i> prescription drugs for the treatment of infertility are limited to \$25,000 per <i>plan participant</i> per lifetime.
Injections and Infusion Therapy	80%, <i>deductible</i> waived	Not Covered in an office setting 70%, <i>deductible</i> waived in a non-office setting	Not Covered	Benefits are available for injections and infusion therapies received in an office setting or other covered facility.

Coordinated Care Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES <i>continued</i>				
Maternity				
Pre-Natal and Post-Natal Care	100%, <i>deductible</i> waived	Not Covered	Not Covered	<i>Dependent child pregnancy</i> is covered. First ultrasound is covered at 100% under the Maternity benefit. Subsequent ultrasounds will be payable at the applicable medical benefit if <i>medically necessary</i> .
Other Covered Physician and Healthcare Practitioner Services in an Office Setting	80%, <i>deductible</i> waived	Not Covered	Not Covered	<i>Co-insurance, deductibles, and co-payments</i> are waived for well newborns that are discharged with the mother.
Labor and Delivery	80% after <i>deductible</i>	Not Covered	Not Covered	Includes coverage for home births.
Medical Foods	80%, <i>deductible</i> waived	70%, <i>deductible</i> waived	Not Covered	
Medical Supplies	75%, <i>deductible</i> waived	75%, <i>deductible</i> waived	Not Covered	Refer to Medical Benefits section, Medical Supplies provision for more information.
Office Visit				
Primary Care Physician (PCP)	\$25 <i>co-payment, deductible</i> waived	Pediatrician: \$25 <i>co-payment, deductible</i> waived Other PCP: Not Covered	Not Covered	The <i>co-payment</i> applies to the office visit and office consultations only, including when a <i>physician's</i> office is located within a <i>hospital</i> . If specialty is not included within HonorHealth/Innovation Care Partners, services rendered through BCBSAZ will pay at the HonorHealth benefit level.
Specialist	\$50 <i>co-payment, deductible</i> waived	Rheumatologists, Perinatologists, and Pediatric Specialists \$50 <i>co-payment, deductible</i> waived Other Specialists: Not Covered Not Covered	Not Covered	Includes virtual visits. <i>Plan participant</i> 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 <i>continued</i>				
Other Covered Physician and Healthcare Practitioner Services	80%, <i>deductible</i> waived	Not Covered in an office setting 70%, <i>deductible</i> waived in a non-office setting	Not Covered	Includes all other covered services rendered by a <i>physician</i> 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 <i>deductible</i>	80% after <i>deductible</i>	Not Covered	
Professional Fees related to Outpatient Surgery	80% after <i>deductible</i>	70% after <i>deductible</i>	Not Covered	
Pain Management	80%, <i>deductible</i> waived	Not Covered	Not Covered	Pre-certification is required.
Pre-Admission Testing	100% after <i>deductible</i>	Not Covered	Not Covered	Includes laboratory tests and x-rays.
Services Not Available at an HonorHealth and BCBSAZ Provider				
Surgical and Inpatient Services	Not Available	Not Available	Applicable <i>deductible</i> and HH/ICP <i>co-payment</i> , then <i>Plan</i> pays 70%	This provision is also known as a gap benefit. <i>Covered charges</i> not available at an HonorHealth and/or BCBSAZ provider will apply to the <i>out-of-pocket limit</i> . Services rendered by Medtronic/MiniMed when received from an HonorHealth facility will be considered under this benefit.
Other Outpatient Services	Not Available	Not Available	Applicable HH/ICP <i>co-payment</i> , then <i>Plan</i> pays 70%, <i>deductible</i> waived	PHCS <i>network of physicians and hospitals</i> is available when providers are outside of Arizona.

Coordinated Care Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES <i>continued</i>				
Therapy Services (Outpatient)				
Physical Therapy Occupational Therapy Speech Therapy	\$20 <i>co-payment, deductible waived</i>	\$20 <i>co-payment, deductible waived</i>	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 <i>co-payments</i> 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%, <i>deductible waived</i>	50%, <i>deductible waived</i>	Not Covered	Calendar Year Maximum: Twelve (12) weeks per therapy type per <i>plan participant</i> .
Wigs	80% up to \$1,000, then <i>Plan pays 10%, deductible waived</i>	70% up to \$1,000, then <i>Plan pays 10%, deductible waived</i>	Not Covered	Limited to the initial purchase of hair loss replacement toward a wig, toupee, or hairpiece if required as a result of an <i>illness</i> such as alopecia or cancer therapy. Benefit Maximum: Limited to one (1) wig per <i>plan participant</i> every three (3) years.

Coordinated Care Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
<p>PREVENTIVE CARE</p> <p>If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, Health Resources and Services Administration (HRSA), the IRS Safe Harbor preventive services list, or <i>preventive care</i> for children under Bright Future guidelines, then the service is covered at 100% when performed by a <i>network</i> provider at a Routine Wellness Care visit. For more information about preventive services please refer to the following websites:</p> <p style="text-align: center;">https://www.healthcare.gov/coverage/preventive-care-benefits/ http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/www.hrsa.gov</p> <p style="text-align: center;">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</p>				
Routine Wellness Care	100%, <i>deductible</i> waived	Lab fees ordered by a BCBSAZ provider: 100%, <i>deductible</i> 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 <i>plan participant</i> . 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%, <i>deductible</i> waived	Pediatricians and Pediatric Specialists only: 100%, <i>deductible</i> 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%, <i>deductible</i> waived	Lab fees ordered by a <i>network</i> provider: 100%, <i>deductible</i> 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%, <i>deductible</i> waived	100%, <i>deductible</i> 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	<p>Benefit Maximum: One (1) per pregnancy.</p> <p>Pre-certification is required for breast pumps in excess of \$1,000. Includes hospital-grade breast pumps when ordered by a <i>physician</i>.</p>
Cologuard	100%, deductible waived			
Contraceptive Services	100%, deductible waived	100%, deductible waived	Not Covered	<p>Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion.</p> <p>When preventive and diagnostic services occur during the same visit, the diagnostic benefit cost will apply.</p> <p>Benefit Limitations: Sterilization services are available to male and female <i>plan participants</i>; other contraceptive services are available to all female <i>plan participants</i>.</p>

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 <i>deductible</i>	Not Covered	<i>Pre-certification</i> is required.
Intensive Outpatient	\$20 <i>co-payment</i> , <i>deductible</i> waived	Not Covered	Includes Transcranial Magnetic Stimulation (TMS). <i>Pre-certification</i> is required.
Outpatient Therapy with PsyD, PhD, MD, Social Worker, or Mental Health/Substance Use Disorders Counselor	\$20 <i>co-payment</i> , <i>deductible</i> waived	Not Covered	Includes group, individual, family, and medication evaluation counseling.
Residential Treatment	80% after <i>deductible</i>	Not Covered	<i>Pre-certification</i> is required.
Applied Behavioral Analysis (ABA) Therapy	\$20 <i>co-payment</i> , <i>deductible</i> waived	Not Covered	<i>Pre-certification</i> is required.
Biofeedback	80%, <i>deductible</i> waived		

L. Schedule of Dialysis Benefits - Coordinated Care Plan Option

COVERED SERVICES	ALL PROVIDERS	SPECIAL COMMENTS
DIALYSIS, OUTPATIENT		
Dialysis, Outpatient	75%, deductible waived	<p>The following <i>outpatient dialysis</i> services will be considered at 125% of the <i>Medicare</i> rate, and then <i>Plan</i> benefits will apply:</p> <ul style="list-style-type: none"> • facility and professional charges from <i>outpatient hospitals</i> and dialysis facilities • home dialysis charges <p>Refer to the Dialysis Services section for a further description and limitations of this benefit.</p> <p>Pre-certification is required.</p>

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 <i>co-payment, deductible</i> <i>waived</i> Formulary Brand and Single Source Generic Drugs Tier 2 30% <i>co-insurance, deductible</i> <i>waived</i> \$30 minimum \$80 maximum Non-Formulary Brand Tier 3 60% <i>co-insurance, deductible</i> <i>waived</i> \$100 minimum No maximum	Generic Drugs Tier 1 \$25 <i>co-payment, deductible</i> <i>waived</i> Formulary Brand and Single Source Generic Drugs Tier 2 30% <i>co-insurance, deductible</i> <i>waived</i> \$75 minimum \$200 maximum Non-Formulary Brand Tier 3 100% <i>co-insurance,</i> <i>deductible waived</i>	Generic Drugs Tier 1 \$25 <i>co-payment, deductible</i> <i>waived</i> Formulary Brand and Single Source Generic Drugs Tier 2 30% <i>co-insurance, deductible</i> <i>waived</i> \$75 minimum \$200 maximum Non-Formulary Brand Tier 3 100% <i>co-insurance,</i> <i>deductible waived</i>	Generic Drugs Tier 1 \$25 <i>co-payment, deductible</i> <i>waived</i> Formulary Brand and Single Source Generic Drugs Tier 2 30% <i>co-insurance, deductible</i> <i>waived</i> \$75 minimum \$200 maximum Non-Formulary Brand Tier 3 100% <i>co-insurance,</i> <i>deductible waived</i>
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% <i>co-insurance, deductible waived</i> \$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/uspstf/recommendation-topics/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 the Pharmacy Benefits Manager at the address listed in the **Quick Reference Information Chart**.

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 the Pharmacy Benefits Manager at the address listed in the [Quick Reference Information Chart](#).

N. Schedule of Medical Benefits - Standard Plan Option

	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS
Deductible, per Calendar Year			
The <i>network</i> and <i>non-network deductible</i> amounts do not accumulate towards each other. <i>Co-payments, prescription drugs, and co-insurance</i> do not apply to the <i>deductible</i> .			
<i>Per plan participant</i>	\$500		Not Applicable
<i>Per family unit</i>	\$1,000		Not Applicable
Family Unit - Embedded Deductible			
If you are enrolled in the family option, your plan contains two (2) components: an individual <i>deductible</i> and a <i>family unit deductible</i> . Having two (2) components to the <i>deductible</i> allows for each member of your <i>family unit</i> the opportunity to have your <i>Plan</i> cover medical expenses prior to the entire dollar amount of the <i>family unit deductible</i> being met. The individual <i>deductible</i> is embedded in the family <i>deductible</i> .			
For example , if you, your spouse, and child are on a family plan with a \$1,000 <i>family unit embedded deductible</i> , and the individual <i>deductible</i> is \$500, and your child <i>incurs</i> \$500 in medical bills, their <i>deductible</i> is met, and your <i>Plan</i> will help pay subsequent medical bills for that child during the remainder of the <i>calendar year</i> , even though the <i>family unit deductible</i> of \$1,000 has not been met yet.			
Maximum Out-of-Pocket Limit, per Calendar Year			
The <i>out-of-pocket limit</i> includes <i>co-payments, co-insurance, deductibles, and covered prescription drug charges</i> . The <i>network</i> and <i>non-network out-of-pocket limits</i> do not accumulate towards each other.			
<i>Per plan participant</i>	\$6,450		Unlimited
<i>Per family unit</i>	\$12,900		Unlimited
Family Unit - Embedded Out-of-Pocket Limit			
If you are enrolled in the <i>family unit</i> option, your <i>Plan</i> contains two (2) components: an individual <i>out-of-pocket limit</i> and a <i>family unit out-of-pocket limit</i> . Having two (2) components to the <i>out-of-pocket limit</i> allows for each member of your <i>family unit</i> the opportunity to have his/her <i>covered charges</i> be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the <i>family unit out-of-pocket limit</i> being met. The individual <i>out-of-pocket limit</i> is embedded in the <i>family unit out-of-pocket limit</i> .			
The <i>Plan</i> will pay the designated percentage of <i>covered charges</i> until <i>out-of-pocket limits</i> are reached, at which time the <i>Plan</i> will pay 100% of the remainder of <i>covered charges</i> for the rest of the <i>calendar year</i> 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:			
<ol style="list-style-type: none"> 1. premiums 2. cost containment penalties 3. charges in excess of the <i>Plan's</i> maximum benefits 4. amounts over <i>the maximum allowable charges</i> 5. charges not covered under the <i>Plan</i> 6. <i>balanced billed</i> charges 7. expenses for medical services or supplies obtained from <i>non-network</i> providers or facilities, except as noted in the plan document 			

Benefits 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%, <i>deductible</i> waived	70%, <i>deductible</i> waived	Not Covered	Generally, most <i>covered charges</i> 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 <i>covered charges</i> , including the expenses that must be <i>pre-certified</i> and those expenses to which the <i>out-of-pocket limit</i> does not apply. <i>Deductible</i> applies for <i>inpatient</i> services and <i>outpatient surgeries</i> .
FACILITY SERVICES				
The benefits outlined in this section apply only to facility charges. Physician charges may be billed separately.				
Advanced Imaging (Outpatient Facility)	\$200 <i>co-payment</i> , <i>deductible</i> waived	\$200 <i>co-payment</i> , then <i>Plan</i> pays 50%, <i>deductible</i> waived	Not Covered	Includes facility fees for 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) <i>co-payment</i> per day per provider. <i>Pre-certification</i> is required for MRI/MRA and PET scans.
Blood Transfusions (Outpatient)	85%, <i>deductible</i> waived	70%, <i>deductible</i> waived	Not Covered	
Diagnostic Testing (Outpatient Facility)	\$15 <i>co-payment</i> , <i>deductible</i> waived	75%, <i>deductible</i> waived	Not Covered	Facility fees associated with <i>diagnostic testing</i> such as (but not limited to): • EKG/EEG • Stress Test • Peripheral Vascular Test
Emergency Room	\$300 <i>co-payment</i> , <i>deductible</i> waived			Emergency room professional fees (for <i>physicians</i> who specialize in emergency medicine) are included in the <i>co-payment</i> . <i>Co-payments</i> are applied per visit. <i>Non-network</i> emergency room care will apply toward the annual <i>out-of-pocket limit</i> . Emergency room <i>co-payment</i> will be waived if admitted for hospitalization or observation.
Injections and Infusion Therapy	85%, <i>deductible</i> waived	50%, <i>deductible</i> waived	Not Covered	Benefits are available for injections and infusion therapies received in an office setting or other covered facility.

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).
Room and Board (Emergency Admission)	85% after deductible	85% after deductible	85% after deductible	<p>Calendar Year Maximum: One hundred twenty (120) days per <i>plan participant</i> for <i>inpatient</i> rehabilitation services.</p> <p>Pre-certification is required.</p> <p>For maternity stays: refer to the <u>Healthcare Management Program</u> section for criteria.</p> <p>Observation room stays: pre-certification is required after seventy-two (72) hours.</p>
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 <i>outpatient</i> surgery at a hospital. Pre-certification is required for <i>outpatient</i> surgical procedures (excluding <i>outpatient</i> office surgical procedures, colonoscopies, and sigmoidoscopies).
Outpatient Hospital	85%, deductible waived	50%, deductible waived	Not Covered	Includes facility fees for biopsies, catheterization lab procedures, chemotherapy, and radiation therapy. 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	<p>Calendar Year Maximum: One hundred twenty (120) days per <i>plan participant</i>. Long-term acute care and rehabilitation hospital services apply toward this maximum.</p> <p>Pre-certification is required.</p>
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 <i>co-payment, deductible waived</i>	\$60 <i>co-payment, deductible waived</i>	Not Covered	<i>Co-payments</i> are applied per visit. Coverage provided for hospital-based facilities, freestanding facilities, and retail clinics.
X-Rays and Ultrasounds (Outpatient Facility)	\$20 <i>co-payment, deductible waived</i>	75%, <i>deductible waived</i>	Not Covered	
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES				
The benefits outlined in this section apply only to physician charges. Facility charges may be billed separately.				
Acupuncture	75% up to \$1,000, then <i>Plan</i> pays 10% All services combined <i>Deductible waived</i>			<i>Non-network coinsurance</i> applies to <i>in-network out-of-pocket</i> . \$1,000 limit is combined for acupuncture and alternative care.
Allergy Services	85%, <i>deductible waived</i>	70%, <i>deductible waived</i>	Not Covered	
Alternative Care	75% up to \$1,000, then <i>Plan</i> pays 10% All services combined <i>Deductible waived</i>			Alternative care includes chiropractic 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%, <i>deductible waived</i>			
Inter-Facility Transport	100%, <i>deductible waived</i>			<i>Pre-certification is required.</i>
Asthma Education Services	\$20 <i>co-payment, deductible waived</i>	Not Covered	Not Covered	Education services for individuals and parents of children diagnosed with asthma, only when ordered by a <i>physician</i> .
Biofeedback	85%, <i>deductible waived</i>			
Corrective Appliances (Orthotics/Prosthetics)	85%, <i>deductible waived</i>	70%, <i>deductible waived</i>	Not Covered	Only mastectomy items (i.e. breast prosthetics and bras) purchased at Tina's Treasures are available under the HonorHealth coverage level. <i>Pre-certification is required for orthotics/prosthetics in excess of \$2,000 purchase price per device.</i>
Diabetic Education	\$20 <i>co-payment, deductible waived</i>	Not Covered	Not Covered	
Diabetic Equipment	90%, <i>deductible waived</i>	90%, <i>deductible waived</i>	Not Covered	Includes continuous blood glucose monitor, insulin pump, and related supplies. Other coverage for diabetic equipment is provided by the Prescription Drug Benefits . <i>Pre-certification is required for insulin pumps in excess of \$1,000.</i>

Standard 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 (DME)	75%, deductible waived	75%, deductible waived	Not Covered	<i>Pre-certification</i> is required for DME in excess of \$1,000 purchase price.
Genetic/Genomic Testing and Counseling	75%, deductible waived	75%, deductible waived	Not Covered	<i>Pre-certification</i> is required for genetic testing.
Hearing Aids	75%, deductible waived			Benefit Maximum: Maximum is per ear every three (3) years for hearing aids, hearing aid repairs, hearing aid batteries, and related supplies.
Home Health Care	85%, deductible waived	70%, deductible waived	Not Covered	Therapy provided in the home will apply to the Rehabilitation <i>calendar year</i> maximum. Home hospice services are covered under the Hospice benefit. <i>Pre-certification</i> is required.
Home Infusion	85%, deductible waived	70%, deductible waived	Not Covered	<i>Pre-certification</i> 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	
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	<i>Co-payment</i> applies to the office visit only. Other charges will be considered at the applicable benefit level.

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 <i>plan participant</i> , then <i>Plan</i> pays 10%. <i>Calendar year</i> maximum does not apply to office visits. <i>Outpatient</i> prescription drugs for the treatment of infertility are limited to \$25,000 per <i>plan participant</i> per lifetime.
Injections and Infusion Therapy	85%, deductible waived	70%, deductible waived	Not Covered	Benefits are available for injections and infusion therapies received in an office setting or other covered facility.
Maternity				
Pre-Natal and Post-Natal Care	100%, deductible waived	100%, deductible waived	Not Covered	<i>Dependent child pregnancy</i> is covered. First ultrasound is covered at 100% under the Maternity benefit. Subsequent ultrasounds will be payable at the applicable medical benefit if <i>medically necessary</i> .
Other Covered Physician and Healthcare Practitioner Services in an Office Setting	85%, deductible waived	70%, deductible waived	Not Covered	<i>Co-insurance, deductibles, and co-payments</i> are waived for well newborns that are discharged with the mother.
Labor and Delivery	85% after deductible	70% after deductible	Not Covered	Includes coverage for home births.
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 <i>co-payment</i> applies to the office visit and office consultations only, including when a <i>physician's</i> office is located within a <i>hospital</i> .
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	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.

Standard Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES <i>continued</i>				
Other Covered Physician and Healthcare Practitioner Services	85%, <i>deductible</i> waived	70%, <i>deductible</i> waived	Not Covered	Includes all other covered services rendered by a <i>physician</i> 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 <i>deductible</i>	70% after <i>deductible</i>	Not Covered	
Professional Fees related to Outpatient Surgery	85% after <i>deductible</i>	70% after <i>deductible</i>	Not Covered	
Pain Management	85%, <i>deductible</i> waived	70%, <i>deductible</i> waived	Not Covered	Pre-certification is required.
Pre-Admission Testing	100%, <i>deductible</i> waived	50%, after <i>deductible</i>	Not Covered	Includes laboratory tests and x-rays.
Services Not Available at an HonorHealth and/or BCBSAZ Provider				
Surgical and Inpatient Services	Not Available	Not Available	Applicable <i>deductible</i> and HH/ICP <i>co-payment</i> , then <i>Plan</i> pays 70%	This provision is also known as a gap benefit. <i>Covered charges</i> not available at an HonorHealth and/or BCBSAZ provider will apply to the <i>out-of-pocket limit</i> . Services rendered by Medtronic/MiniMed when received from an HonorHealth facility will be considered under this benefit.
Other Outpatient Services	Not Available	Not Available	Applicable HH/ICP <i>co-payment</i> , then <i>Plan</i> pays 70%, <i>deductible</i> waived	PHCS <i>network</i> of <i>physicians</i> and <i>hospitals</i> is available when providers are outside of Arizona.

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN AND OTHER HEALTHCARE PRACTITIONER SERVICES continued				
Therapy Services				
Physical Therapy Occupational Therapy Speech Therapy	\$20 <i>co-payment</i> , <i>deductible</i> waived	\$20 <i>co-payment</i> , <i>deductible</i> 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 <i>co-payments</i> 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%, <i>deductible</i> waived	50%, <i>deductible</i> waived	Not Covered	Calendar Year Maximum: Twelve (12) weeks per therapy type per <i>plan participant</i> .
Wigs	85% up to \$1,000, then <i>Plan</i> pays 10%, <i>deductible</i> waived	70% up to \$1,000, then <i>Plan</i> pays 10%, <i>deductible</i> 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 <i>illness</i> such as alopecia cancer therapy. Benefit Maximum: Limited to one (1) wig per <i>plan participant</i> every three (3) years.

Standard Plan Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
<p>PREVENTIVE CARE</p> <p>If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, Health Resources and Services Administration (HRSA), or <i>preventive care</i> for children under Bright Future guidelines, then the service is covered at 100% when performed by a <i>network</i> provider at a Routine Wellness Care visit. For more information about preventive services please refer to the following websites:</p> <p style="text-align: center;">https://www.healthcare.gov/coverage/preventive-care-benefits/ http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/www.hrsa.gov</p> <p style="text-align: center;">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</p>				
Routine Wellness Care	100%, <i>deductible</i> waived	100%, <i>deductible</i> waived	Not Covered	<p>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.</p> <p>Calendar Year Maximum: One (1) routine exam per adult <i>plan participant</i>. This maximum does not include the well woman visit or colon cancer screening.</p> <p>Safe Harbor services and non-mandated diagnostic screenings performed at a wellness visit will be covered at the preventive level.</p> <p>Administrative, school, and sports physicals are also included in the preventive benefit.</p> <p>Please refer to the Medical Benefits section, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.</p>
Well-Child Care	100%, <i>deductible</i> waived	Pediatricians and Pediatric Specialists only: 100%, <i>deductible</i> 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%, <i>deductible</i> waived	100%, <i>deductible</i> 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%, <i>deductible</i> waived	100%, <i>deductible</i> waived	Not Covered	Lactation support, counseling, and education.
Breastfeeding Pump and Supplies	100%, <i>deductible</i> waived	100%, <i>deductible</i> waived	Not Covered	<p>Benefit Maximum: One (1) per pregnancy.</p> <p>Pre-certification is required for breast pumps in excess of \$1,000. Includes hospital-grade breast pumps when ordered by a <i>physician</i>.</p>

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

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 <i>deductible</i>	Not Covered	<i>Pre-certification</i> is required.
Intensive Outpatient	\$20 <i>co-payment</i> , <i>deductible</i> waived	Not Covered	Includes Transcranial Magnetic Stimulation (TMS). <i>Pre-certification</i> is required.
Outpatient Therapy with PsyD, PhD, MD, Social Worker, or Mental Health/Substance Use Disorders Counselor	\$20 <i>co-payment</i> , <i>deductible</i> waived	Not Covered	Includes group, individual, family, and medication evaluation counseling.
Residential Treatment	85% after <i>deductible</i>	Not Covered	<i>Pre-certification</i> is required.
Applied Behavioral Analysis (ABA) Therapy	\$20 <i>co-payment</i> , <i>deductible</i> waived	Not Covered	<i>Pre-certification</i> is required.
Biofeedback	85%, <i>deductible</i> waived		

P. Schedule of Dialysis Benefits - Standard Plan Option

COVERED SERVICES	ALL PROVIDERS	SPECIAL COMMENTS
DIALYSIS, OUTPATIENT		
Dialysis, Outpatient	75%, deductible waived	<p>The following <i>outpatient dialysis</i> services will be considered at 125% of the <i>Medicare</i> rate, and then <i>Plan</i> benefits will apply:</p> <ul style="list-style-type: none"> • facility and professional charges from <i>outpatient hospitals</i> and dialysis facilities • home dialysis charges <p>Refer to the Dialysis Services section for a further description and limitations of this benefit.</p> <p>Pre-certification is required.</p>

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, deductible waived Formulary Brand and Single Source Generic Drugs Tier 2 35% co-insurance, deductible waived \$40 minimum \$100 maximum Non-Formulary Brand Tier 3 60% co-insurance, deductible waived \$125 minimum No maximum	Generic Drugs Tier 1 \$37.50 co-payment, deductible waived Formulary Brand and Single Source Generic Drugs Tier 2 35% co-insurance, deductible waived \$100 minimum \$250 maximum Non-Formulary Brand Tier 3 100% co-insurance, deductible waived	Generic Drugs Tier 1 \$37.50 co-payment, deductible waived Formulary Brand and Single Source Generic Drugs Tier 2 35% co-insurance, deductible waived \$100 minimum \$250 maximum Non-Formulary Brand Tier 3 100% co-insurance, deductible waived	Generic Drugs Tier 1 \$37.50 co-payment, deductible waived Formulary Brand and Single Source Generic Drugs Tier 2 35% co-insurance, deductible waived \$100 minimum \$250 maximum Non-Formulary Brand Tier 3 100% co-insurance, deductible waived
Specialty Drugs Obtained Through OptumRx Specialty Pharmacy or HonorHealth Specialty Pharmacy (30-Day Supply) 30% co-insurance, deductible waived \$60 minimum \$150 maximum		Specialty Drugs NOT Obtained Through OptumRx Specialty Pharmacy or HonorHealth Specialty Pharmacy 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/uspstf/recommendation-topics/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 the Pharmacy Benefits Manager at the address listed in the Quick Reference Information Chart.

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 the Pharmacy Benefits Manager at the address listed in the Quick Reference Information Chart.

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 <i>network</i> and <i>non-network deductible</i> amounts do not accumulate towards each other.			
Behavioral services and <i>outpatient</i> prescription drug expenses apply to the <i>deductible</i> .			
Non-covered charges do not apply to the <i>deductible</i> .			
Per <i>plan participant</i>	\$3,200		\$3,600
Per <i>family unit</i>	\$6,400		\$7,200
<u>Family Unit - Embedded Deductible</u>			
If you are enrolled in the family option, your plan contains two (2) components: an individual <i>deductible</i> and a <i>family unit deductible</i> . Having two (2) components to the <i>deductible</i> allows for each member of your <i>family unit</i> the opportunity to have your <i>Plan</i> cover medical expenses prior to the entire dollar amount of the <i>family unit deductible</i> being met. The individual <i>deductible</i> is embedded in the family <i>deductible</i> .			
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 <i>plan participant</i> (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 <i>family unit embedded deductible</i> , and the individual <i>deductible</i> is \$2,800, and your child <i>incurs</i> \$2,800 in medical bills, his/her <i>deductible</i> is met, and your <i>Plan</i> will help pay subsequent medical bills for that child during the remainder of the <i>calendar year</i> , even though the <i>family unit deductible</i> of \$5,200 has not been met yet.			
Maximum Out-of-Pocket Limit, per Calendar Year			
The <i>out-of-pocket limit</i> includes <i>co-payments</i> , <i>co-insurance</i> , <i>deductibles</i> , and covered <i>prescription drug</i> charges.			
The <i>network</i> and <i>non-network out-of-pocket limits</i> do not accumulate towards each other.			
Per <i>plan participant</i>	\$6,450		Unlimited
Per <i>family unit</i>	\$12,900		Unlimited
<u>Family Unit - Embedded Out-of-Pocket Limit</u>			
If you are enrolled in the <i>family unit</i> option, your <i>Plan</i> contains two (2) components: an individual <i>out-of-pocket limit</i> and a <i>family unit out-of-pocket limit</i> . Having two (2) components to the <i>out-of-pocket limit</i> allows for each member of your <i>family unit</i> the opportunity to have his/her <i>covered charges</i> be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the <i>family unit out-of-pocket limit</i> being met. The individual <i>out-of-pocket limit</i> is embedded in the <i>family unit out-of-pocket limit</i> .			
The <i>Plan</i> will pay the designated percentage of <i>covered charges</i> until <i>out-of-pocket limits</i> are reached, at which time the <i>Plan</i> will pay 100% of the remainder of <i>covered charges</i> for the rest of the <i>calendar year</i> 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:			
<ol style="list-style-type: none"> 1. premiums 2. cost containment penalties 3. charges in excess of the <i>Plan's</i> maximum benefits 4. amounts over <i>the maximum allowable charges</i> 5. charges not covered under the <i>Plan</i> 6. <i>balanced billed</i> charges 7. expenses for medical services or supplies obtained from <i>non-network</i> providers or facilities, except as noted in the plan document 			

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	Not Covered	Not Covered	Generally, most <i>covered charges</i> 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 <i>covered charges</i> , including the expenses that must be <i>pre-certified</i> and those expenses to which the <i>out-of-pocket limit</i> does not apply.
FACILITY SERVICES				
The benefits outlined in this section apply only to facility charges. Physician charges may be billed separately.				
Advanced Imaging (Outpatient Facility)	80% after deductible	Not Covered	Not Covered	Includes facility fees for 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	Not Covered	Not Covered	
Diagnostic Testing (Outpatient Facility)	80% after deductible	80% after deductible	Not Covered	Facility fees associated with <i>diagnostic testing</i> such as (but not limited to): • EKG/EEG • Stress Test • Peripheral Vascular Test
Emergency Room	80% after deductible			<i>Non-network</i> emergency room care will apply toward the annual <i>out-of-pocket limit</i> .
Injections and Infusion Therapy	80% after deductible	Not Covered	Not Covered	Benefits are available for injections and infusion therapies received in an office setting or other covered facility.
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 <i>plan participant</i> for <i>inpatient</i> rehabilitation services.
Room and Board (Emergency Admission)	80% after deductible	80% after deductible	80% after deductible	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.

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	
Outpatient Ambulatory Facility	80% after deductible	Not Covered	Not Covered	Includes facility fees for <i>outpatient</i> surgery at a hospital. Pre-certification is required for <i>outpatient</i> surgical procedures (excluding <i>outpatient</i> office surgical procedures, colonoscopies, and sigmoidoscopies).
Outpatient Hospital	80% after deductible	Not Covered	Not Covered	Includes facility fees for biopsies, catheterization lab procedures, chemotherapy, and radiation therapy. 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	70% after deductible	Not Covered	Calendar Year Maximum: One hundred twenty (120) days per <i>plan participant</i> . Long-term acute care and rehabilitation hospital services apply toward this maximum. Pre-certification is required.
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 retail 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				
The benefits outlined in this section apply only to physician charges. Facility charges may be billed separately.				
Acupuncture	75% after <i>deductible</i> up to \$1,000, then <i>Plan</i> pays 10% All services combined			<i>Non-network deductible</i> and <i>coinsurance</i> applies to <i>in-network deductible</i> and <i>out-of-pocket</i> . \$1,000 limit is combined for acupuncture and alternative care.
Allergy Services	80% after <i>deductible</i>	70% after <i>deductible</i>	Not Covered	
Alternative Care	75% after <i>deductible</i> up to \$1,000, then <i>Plan</i> pays 10% All services combined			Alternative care includes chiropractic 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 <i>deductible</i>			
Inter-Facility Transport	100% after <i>deductible</i>			Pre-certification is required.
Asthma Education Services	80% after <i>deductible</i>	Not Covered	Not Covered	Education services for individuals and parents of children diagnosed with asthma, only when ordered by a <i>physician</i> .
Biofeedback	80% after <i>deductible</i>			
Corrective Appliances (Orthotics/Prosthetics)	80% after <i>deductible</i>	70% after <i>deductible</i>	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 <i>deductible</i>	Not Covered	Not Covered	
Diabetic Equipment	80% after <i>deductible</i>	80% after <i>deductible</i>	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 (DME)	75% after <i>deductible</i>	75% after <i>deductible</i>	Not Covered	Pre-certification is required for DME in excess of \$1,000 purchase price.
Genetic/Genomic Testing and Counseling	75% after <i>deductible</i>	75% after <i>deductible</i>	Not Covered	Pre-certification is required for genetic testing.

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 <i>continued</i>				
Hearing Aids	75% after <i>deductible</i>			Benefit Maximum: Maximum is per ear every three (3) years for hearing aids, hearing aid repairs, hearing aid batteries, and related supplies.
Home Health Care	80% after <i>deductible</i>	70% after <i>deductible</i>	Not Covered	Therapy provided in the home will apply to the Rehabilitation <i>calendar year</i> maximum. Home hospice services are covered under the Hospice benefit. Pre-certification is required.
Home Infusion	80% after <i>deductible</i>	Not Covered	Not Covered	Pre-certification is required.
Home Visits Rendered by Dispatch Health	Not Applicable	80% after <i>deductible</i>	Not Applicable	
Hospice Care				
Hospice Care	80% after <i>deductible</i>	80% after <i>deductible</i>	Not Covered	
Bereavement Counseling	80% after <i>deductible</i>	80% after <i>deductible</i>	Not Covered	
Infertility				
Primary Care Provider (PCP)	80% after <i>deductible</i>	Not Covered	Not Covered	
Specialist	80% after <i>deductible</i>	Not Covered	Not Covered	
Treatment	80% after <i>deductible</i>	70% after <i>deductible</i>	Not Covered	Calendar Year Maximum: \$1,500 for infertility treatment per <i>plan participant</i> , then <i>Plan</i> pays 10%. <i>Calendar year</i> maximum does not apply to office visits. <i>Outpatient</i> prescription drugs for the treatment of infertility are limited to \$25,000 per <i>plan participant</i> per lifetime.
Injections and Infusion Therapy	80% after <i>deductible</i>	Not Covered in an office setting 70% after <i>deductible</i> in a non-office setting	Not Covered	Benefits are available for injections and infusion therapies received in an office setting or other covered facility.
Male Sterilization	100% after <i>deductible</i>	100% after <i>deductible</i>	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 <i>continued</i>				
Maternity				
Pre-Natal and Post-Natal Care	100% after deductible	Not Covered	Not Covered	<i>Dependent child pregnancy</i> is covered. First ultrasound is covered at 100% under the Maternity benefit. Subsequent ultrasounds will be payable at the applicable medical benefit if <i>medically necessary</i> .
Other Covered Physician and Healthcare Practitioner Services in an Office Setting	80%, after deductible	Not Covered	Not Covered	
Labor and Delivery	80% after deductible	Not Covered	Not Covered	Includes coverage for home births.
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	Pediatrician: 80% after deductible Other PCP: Not Covered	Not Covered	Includes virtual visits. <i>Plan participant</i> 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.
Specialist	80% after deductible	Rheumatologists, Perinatologists, and Pediatric Specialists: 80% after deductible Other Specialists: Not Covered	Not Covered	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.
Other Covered Physician and Healthcare Practitioner Services	80% after deductible	Not Covered in an office setting 70% after deductible	Not Covered	Includes all other covered services rendered by a <i>physician</i> 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	Not Covered	Not Covered	Pre-certification is required.
Pre-Admission Testing	80% after deductible	Not Covered	Not Covered	Includes laboratory tests and x-rays.

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 <i>continued</i>				
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. <i>Covered charges</i> not available at an HonorHealth and/or BCBSAZ provider will apply to the <i>out-of-pocket limit</i> . Services rendered by Medtronic/MiniMed when received from an HonorHealth facility will be considered under this benefit. PHCS <i>network of physicians and hospitals</i> is available when providers are outside of Arizona.
Therapy Services (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 <i>plan participant</i> .
Wigs	80% after deductible up to \$1,000, then <i>Plan</i> pays 10%	70% after deductible up to \$1,000, then <i>Plan</i> 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 <i>illness</i> such as alopecia or cancer therapy. Benefit Maximum: Limited to one (1) wig per <i>plan participant</i> every three (3) years.

Health Savings Account Plan (HDHP) Option

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
<p>PREVENTIVE CARE</p> <p>If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, Health Resources and Services Administration (HRSA), or <i>preventive care</i> for children under Bright Future guidelines, then the service is covered at 100% when performed by a <i>network</i> provider at a Routine Wellness Care visit. For more information about preventive services please refer to the following websites:</p> <p style="text-align: center;"> https://www.healthcare.gov/coverage/preventive-care-benefits/ http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/www.hrsa.gov </p> <p style="text-align: center;"> 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 </p>				
<p>Routine Wellness Care</p>	<p>100%, <i>deductible</i> waived</p>	<p>Lab fees ordered by a BCBSAZ provider: 100%, <i>deductible</i> waived</p> <p>Other preventive services: Not Covered</p>	<p>Not Covered</p>	<p>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.</p> <p>Calendar Year Maximum: One (1) routine exam per adult <i>plan participant</i>. This maximum does not include the well woman visit or colon cancer screening.</p> <p>Safe Harbor services performed at a wellness visit will be covered at the preventive level.</p> <p>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.</p> <p>Please refer to the Medical Benefits section, <u>Covered Medical Charges</u>, Preventive Care, for a further description and limitations of this benefit.</p>
<p>Well-Child Care</p>	<p>100%, <i>deductible</i> waived</p>	<p>Pediatricians and Pediatric Specialists only: 100%, <i>deductible</i> waived</p>	<p>Not Covered</p>	<p>Coverage is provided for newborn and well-child visits for health exams and related testing. Includes immunizations per CDC recommendations.</p>

COVERED SERVICES	HONORHEALTH PROVIDERS & INNOVATION CARE PARTNERS	BCBSAZ PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE continued				
BRCA Genetic Counseling and Testing	100%, <i>deductible</i> waived	Lab fees ordered by a <i>network</i> provider: 100%, <i>deductible</i> 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%, <i>deductible</i> waived	100%, <i>deductible</i> waived	Not Covered	Lactation support, counseling, and education.
Breastfeeding Pump and Supplies	100%, <i>deductible</i> waived	100%, <i>deductible</i> 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 <i>physician</i> .
Cologuard	100%, <i>deductible</i> waived			
Contraceptive Services	100%, <i>deductible</i> waived	100%, <i>deductible</i> 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 <i>plan participants</i> .

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 <i>deductible</i>	Not Covered	<i>Pre-certification is required.</i>
Intensive Outpatient	80% after <i>deductible</i>	Not Covered	Includes Transcranial Magnetic Stimulation (TMS). <i>Pre-certification is required.</i>
Outpatient Therapy with PsyD, Social Worker, or Mental Health/Substance Use Disorders Counselor	80% after <i>deductible</i>	Not Covered	Includes group, individual, family, and medication evaluation counseling.
Outpatient Therapy with PhD or MD	80% after <i>deductible</i>	Not Covered	Includes group, individual, family, and medication evaluation counseling.
Residential Treatment	80% after <i>deductible</i>	Not Covered	<i>Pre-certification is required.</i>
Applied Behavioral Analysis (ABA) Therapy	80% after <i>deductible</i>	Not Covered	<i>Pre-certification is required.</i>
Biofeedback	80% after <i>deductible</i>		

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

COVERED SERVICES	ALL PROVIDERS	SPECIAL COMMENTS
DIALYSIS, OUTPATIENT		
Dialysis, Outpatient	75% after deductible	<p>The following <i>outpatient dialysis</i> services will be considered at 125% of the <i>Medicare</i> rate, and then <i>Plan</i> benefits will apply:</p> <ul style="list-style-type: none"> • facility and professional charges from <i>outpatient hospitals</i> and dialysis facilities • home dialysis charges <p>Refer to the Dialysis Services section for a further description and limitations of this benefit.</p> <p>Pre-certification is required.</p>

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 <i>co-payment</i> after <i>deductible</i> Formulary Brand and Single Source Generic Drugs Tier 2 35% <i>co-insurance</i> after <i>deductible</i> \$40 minimum \$100 maximum Non-Formulary Brand Tier 3 60% <i>co-insurance</i> after <i>deductible</i> \$125 minimum No maximum	Generic Drugs Tier 1 \$37.50 <i>co-payment</i> after <i>deductible</i> Formulary Brand and Single Source Generic Drugs Tier 2 35% <i>co-insurance</i> after <i>deductible</i> \$100 minimum \$250 maximum Non-Formulary Brand Tier 3 100% <i>co-insurance</i> after <i>deductible</i>	Generic Drugs Tier 1 \$37.50 <i>co-payment</i> after <i>deductible</i> Formulary Brand and Single Source Generic Drugs Tier 2 35% <i>co-insurance</i> after <i>deductible</i> \$100 minimum \$250 maximum Non-Formulary Brand Tier 3 100% <i>co-insurance</i> after <i>deductible</i>	Generic Drugs Tier 1 \$37.50 <i>co-payment</i> after <i>deductible</i> Formulary Brand and Single Source Generic Drugs Tier 2 35% <i>co-insurance</i> after <i>deductible</i> \$100 minimum \$250 maximum Non-Formulary Brand Tier 3 100% <i>co-insurance</i> after <i>deductible</i>
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% <i>co-insurance</i> after <i>deductible</i> \$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/uspstf/recommendation-topics/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 the Pharmacy Benefits Manager at the address listed in the Quick Reference Information Chart.

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 the Pharmacy Benefits Manager at the address listed in the [Quick Reference Information Chart](#).

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.** Facility charges for advanced imaging including: Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans. *Physician* charges for advanced imaging services may be billed separately, including the readings of these medical tests/scans. **Pre-certification is required for MRI/MRA and PET scans.**
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' (ABA) 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*:
- emergency* repair or replacement due to *injury* to teeth or jaw
 - restoration of the jaw if damaged by an external object
 - 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:
- continuous blood glucose monitor
 - 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 (DME).** 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 is covered if either:

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

- Oxygen.** Oxygen and its administration, including oxygen concentrators. Oxygen concentrators are not subject to purchase price requirements.
 - 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 and/or 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 covered only in the following instances:
- a. as mandated by *PPACA*
 - b. for mutations associated with multifactorial diseases
 - c. for fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis in covered pregnant women
 - d. 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. Over-the-counter hearing aids are covered with a prescription. 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.** Charges for routine and diagnostic 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* acting within the scope of their license and/or as defined under home health care services.
- 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*) only when the hospice patient is a *plan participant*.

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, counseling, maintenance, breast milk storage supplies, pump parts, and other supplies 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/uspstf/recommendation-topics/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 *Plan's* wrap document 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.** Enteral and parenteral 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.

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 certain mental health/substance abuse disorder services. Refer to Schedule of Benefits, Pre-Certification.

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 *Plan's* wrap document 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/Public Health Emergency.** In the event of a declared National Health Emergency (or Public Health Emergency), the *Plan* will offer coverage as mandated for the condition(s) as required by federal regulation. The *Plan* will also cover medications authorized for emergency use by the appropriate federal agencies in the event of a national and/or public health emergency. 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 national and/or 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*. ***Pre-certification is required.***
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 *maximum allowable charge*, 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*. You should make sure your *hospital* will accept the results of these tests.
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, every five (5) years for individuals age forty-five (45) and up. Stool-based tests (such as Cologuard) are covered at the mandated frequency. *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. Pre-test counseling only necessary if access for counseling by qualified counselor is not available within fifteen (15) days of request. 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*.
- l. **Tobacco Cessation.** Education, counseling, and behavioral intervention services provided by a *physician* for smoking/vaping cessation up to two (2) attempts per *calendar year*, consisting of four (4) visits lasting ten (10) minutes each.

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*, except as otherwise excluded herein.

Pre-certification is required.

Refer to the *Plan's* wrap document 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. Residential Treatment Facilities. *Pre-certification is required.*

55. 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.

56. School Setting. Services performed in a school setting.

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, colonoscopies, and sigmoidoscopies).***

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. **Therapy 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* Therapy Services 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 Therapy Services benefit. Wound debridement services do not apply toward the Therapy Services 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.

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

65. **Virtual Visits.** Services rendered telephonically or electronically when performed for an otherwise covered service.
66. **Vision Refraction Exam.** Covered only in conjunction with a medical diagnosis.
67. **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
68. **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.***

69. **Wigs.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

70. **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, treatment, or drugs 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*.
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, 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 due to a criminal offense. This exclusion does not apply to *mental health* or *substance use disorder* holds, as they are not court-ordered treatments.

15. **COVID-19 Home Tests.** At-home/over-the-counter COVID-19 tests.
16. **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.
17. **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.
18. **Developmental Delay.** Testing, office visits, habilitation therapy, and consultations for developmental delay, unless specifically covered herein.
19. **Dialysis, Outpatient .** Refer to the **Outpatient Dialysis Services** section for coverage.
20. **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.
21. **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.
22. **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
23. **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.
24. **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.
25. **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.

26. **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*.
27. **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.
28. **Foot Care.** Services for routine, palliative, or cosmetic foot care. Examples include 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 *medically necessary*.
29. **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*.
30. **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*.
31. **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*.
32. **Habilitation Services.** Habilitation services are excluded except for in conjunction with *ABA therapy*.
33. **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**. This exclusion does not apply to hair loss services attributed to a covered medical condition.
34. **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.
35. **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.
36. **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.
37. **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.
38. **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 (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. This exclusion does not apply to simple traffic violations such as speeding.
39. **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.
40. **Immunizations.** Immunizations and vaccinations for the purpose of travel outside of the United States.

41. **Infertility.** Expenses associated with a surrogate, donor egg/semen, cryostorage of egg or sperm, ovarian transplant, infertility donor expenses, and reversal of sterilization procedures.
42. **Long Term Care.**
43. **Maintenance Therapy.**
44. **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.
45. **Maternity.** Expenses for childbirth education and Lamaze classes. Charges for services related to surrogate *pregnancy* if the surrogate is not a *plan participant*.
46. **Medical Students and Interns.** Expenses for the services of a medical student or intern.
47. **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**.
48. **Milieu Therapy.** A treatment program based on manipulation of the *plan participant's* environment for their benefit.
49. **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.
50. **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.
51. **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
52. **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.
53. **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*.
54. **Non-Compliance.** Any additional *inpatient* charges in connection with treatments or medications which were directly caused by, and attributed to, the patient's non-compliance with or discharge from an *inpatient 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*. This exclusion does not apply to any subsequent emergency room visits or *outpatient* services.
55. **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.
56. **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.

57. **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; 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.
58. **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, *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.
59. **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.
60. **Not Medically Necessary.** Any charge for care, supplies, treatment, and/or services that are not *medically necessary*, unless specifically stated as covered herein.
61. **Nutritional Counseling/Nutritional Therapy.** Dietary counseling/instructions from any provider, except for dietary counseling services received through diabetes education benefits or as required by law.
62. **Obesity/Morbid Obesity.** Screening and counseling for obesity will be covered to the extent required under applicable federal law. 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.
63. **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.
64. **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.
65. **Outside Scope of License.** Expenses for healthcare practitioners providing services not within the scope of their license.
66. **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/items (except as specified herein), 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.
67. **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.

68. **Prescription Drugs.** Prescription drugs charges covered under the Prescription Drug Benefits, other than those covered in a *physician's* office or *inpatient* admission.
69. **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.
70. **Private-Duty Nursing.** Charges in connection with care, treatment, or services of a private-duty nurse, unless *medically necessary* as determined by the *Plan*.
71. **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.
72. **Prohibited by Law.** Any charge for care, supplies, treatment, and/or services to the extent that payment under this *Plan* is prohibited by law.
73. **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.
74. **Repair of Purchased Equipment.** Maintenance and repairs needed due to misuse or abuse are not covered.
75. **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*.
76. **Smoking Cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under applicable federal law. Tobacco cessation care and treatment, including hypnotherapy, is otherwise excluded under the Medical Benefits. Vaping is not considered under the smoking cessation benefit. Refer to the **Prescription Drug Benefits** section for details on coverage of certain tobacco cessation medications.
77. **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.
78. **Sterilization Reversal.** Care and treatment for reversal of surgical sterilization, including related follow-up care.
79. **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 *Plan's* wrap document.
80. **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.
81. **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
82. **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*.
83. **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), Automated Lamellar Keratoplasty (ALK), or Laser In-Situ Keratomileusis (LASIK)
 - b. diagnosis and treatment of refractive errors, including routine 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
84. **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 *Plan's* wrap document for information regarding filing *claims*.

SECTION VIII—HEALTH CARE MANAGEMENT PROGRAM

Health Care Management Program Phone Number

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

1. Utilization Review
2. Concurrent Review and Discharge Planning
3. Case Management
4. 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 and 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.

How to Request Pre-Certification

Refer to Schedule of Benefits, Pre-certification for a list of services which require *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 includes 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 ID 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 ID card at participating *pharmacies* provides you with the best economic benefit.

Claims for reimbursement of *prescription drugs* are to be submitted to the Pharmacy Benefits Manager at the address listed in the [Quick Reference Information Chart](#).

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 Information 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. **Abortion.** Drugs that induce abortion such as Mifepristone (RU-486).
2. **Compounded Prescription Drugs.** All compounded *prescription drugs* containing at least one (1) prescription ingredient in a therapeutic quantity.

3. **Diabetic.** Insulin and glucometers when prescribed by a *physician*. Includes continuous glucose monitor disposable sensor strips such as DexCom or similar device.

Visit <https://www.irs.gov/pub/irs-drop/n-19-45.pdf> for a current listing of diabetic supplies related *preventive care* benefits.

4. **Growth Hormones.** Charges for drugs to enhance physical growth.
5. **Impotence.** A charge for impotence medication. Quantity limitations may apply.
6. **Infertility Drugs.** *Outpatient prescription drugs* for the treatment of infertility are limited to \$25,000 per *plan participant* per lifetime.
7. **Injectable Drugs.** Injectable drugs or any prescription directing administration by injection. Prior authorization may be required.
8. **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*.

9. **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/uspstf/recommendation-topics/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. **COVID-19 Home Tests.** At-home/over-the-counter COVID-19 tests.
4. **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.
5. **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.
6. **Experimental/Investigational.** *Experimental/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."
7. **FDA.** Any drug not approved by the Food and Drug Administration.
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, <i>claimant</i> must submit <i>claim</i> for benefit determination within:	twelve (12) months	twenty-four (24) hours	N/A	N/A
After receipt of the <i>claim</i> , <i>Plan</i> must make initial <i>benefit determination</i> 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 <i>benefit determination</i> :	fifteen (15) days	No	No	Fifteen (15) days
After receiving notification of adverse benefit determination, first-level <i>appeal</i> review must be submitted to the <i>Plan</i> within:	one hundred eighty (180) days	one hundred eighty (180) days	one hundred eighty (180) days	one hundred eighty (180) days
After the <i>Plan Administrator</i> or its designee receives the <i>appeal</i> , <i>Plan</i> must make first <i>appeal benefit determination</i> as soon as possible but no later than:	thirty (30) days	thirty-six (36) hours	Before the benefit is reduced or treatment terminated	fifteen (15) days
Extension permitted during <i>appeal</i> 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 <i>Plan Administrator</i> or its designee receives the <i>appeal</i> , <i>Plan</i> must make second <i>appeal benefit determination</i> 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 <i>external review</i> request, <i>Plan</i> will complete preliminary review of <i>IRO</i> request within:	five (5) business days	five (5) business days	five (5) business days	five (5) business days
If request is ineligible for <i>external review</i> , <i>Plan</i> will notify <i>claimant</i> of preliminary review within:	one (1) business day	one (1) business day	one (1) business day	one (1) business day
<i>IRO</i> 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
<i>Claims Administrator</i>	Medical <i>post-service claims</i>
<i>Medical Management Administrator</i>	Medical urgent care, <i>concurrent care</i> , and other <i>pre-service claims</i>
Prescription Drug Benefits Administrator	<i>Outpatient prescription drug pre-service and post-service claims</i>
Behavioral Health Services Administrator	Urgent, <i>pre-service</i> , <i>concurrent</i> , and <i>post-service claims</i> related to <i>inpatient</i> 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 . 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 , 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 . 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 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 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 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 . 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.

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. 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 after the oral *notice* no later than the timeframe shown in the Timeframes for Claim and Appeal Processes. 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 *Health 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. 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 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. 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](#) 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 .

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 . 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 the timeframe shown in the Timeframes for Claim and Appeal Processes. 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. 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](#) 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](#) 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 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. 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.

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 . 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 . 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. 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 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 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

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, 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.
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. 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 *notice* of its decision to the *claimant* and the assigned *IRO* within the timeframe shown in the Timeframes for Claim and Appeal Processes. 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. 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 reasons 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.

N. Designation 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. 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.

Refer to the *Plan's* wrap document for information pertaining to non-alienation of benefits provisions under the *Plan*.

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

Refer to the *Plan's* wrap document for information pertaining to recovery of payment provisions.

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 *Plan's* wrap document 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

Refer to the *Plan's* wrap document for provisions pertaining to reimbursement, subrogation, and right to recovery.

A. 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.

B. Release of Liability

The *Plan's* right to reimbursement extends to any incident related care that is received by the *plan participant(s)* (*incurred*) 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* and reflecting *claims* paid 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.

C. Excess Insurance

If at the time of *injury*, *illness*, 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, including any similar coverage under a different name in a particular state

3. any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an *employer's* policy
4. workers' compensation or other liability insurance company
5. any other source of coverage, including, but not limited to, the following:
 - a. crime victim restitution funds
 - b. civil restitution funds
 - c. no-fault restitution funds such as vaccine *injury* compensation funds
 - d. any medical, applicable disability or other benefit payments
 - e. school insurance coverage

D. 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.

E. 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.

F. 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*, 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, 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.

G. Offset

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

H. 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.

I. Language Interpretation

Refer to the *Plan's* wrap document for language interpretation information.

J. Severability

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

SECTION XIV—CONTINUATION COVERAGE RIGHTS UNDER COBRA

Refer to the *Plan's* wrap document for information pertaining to rights under the Consolidated Omnibus Budget Reconciliation Act.

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 COBRA provisions of the *Plan*. 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 *Plan's claims and appeals* procedures. The *Plan* will respond to all complete *appeals* in accordance with the *appeals* procedures set forth in the *claims and appeals* provisions of the *Plan's wrap 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

Refer to the *Plan's* wrap document for additional information pertaining to the *Plan's* funding provisions.

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

Refer to the *Plan’s* wrap document for a Statement of ERISA Rights.

SECTION XVII—FEDERAL NOTICES

A. Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Refer to the *Plan’s* wrap document for information pertaining to CHIPRA special enrollment rights.

B. Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA 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. GINA provides 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

Refer to the *Plan’s* wrap document for information pertaining to Mental Health Parity.

D. Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA)

Refer to the *Plan’s* wrap document for provisions pertaining to the Newborns’ and Mothers’ Health Protection Act.

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.

Refer to the *Plan’s* wrap document for additional information regarding the *Plan’s* non-discrimination rules.

F. Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Refer to the *Plan’s* wrap document for a summary of the *Plan’s* USERRA provisions.

G. Women’s Health and Cancer Rights Act of 1998 (WHCRA)

Refer to the *Plan’s* wrap document for information pertaining to Women’s Health and Cancer Rights.

SECTION XVIII—COMPLIANCE WITH HIPAA PRIVACY STANDARDS

Refer to the *Plan's* wrap document for information pertaining to HIPAA Security Protections and Protected Health Information (PHI).

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 (1) 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, 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 to be comparable to the system of peer review studies and investigations used by the National Institutes of Health, and 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 may request 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.

Refer to the *Plan's* wrap document for information pertaining to non-alienation of benefits provisions under the *Plan*.

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. When 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 and Transparency in Coverage Regulations](#) section for additional provisions pertaining to *non-network* services and billing.

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*.

Birth 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 the following:

1. facilities for obstetrical delivery and short-term recovery after delivery
2. care under the full-time supervision of a *physician* and either a registered nurse (R.N.) or a licensed nurse-midwife
3. 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.

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.

Cosmetic

Procedures are considered cosmetic when intended to change a physical appearance that would be considered within normal human anatomic variation. Cosmetic services are often described as those that are primarily intended to preserve or improve appearance.

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 include 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 childhood, 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.

Refer to the *Plan's* wrap document for a list of ineligible employees.

Employer

HonorHealth Hospitals

Enrollment Date

The first day of coverage, or if there is a *waiting period*, the first day of the *waiting period*.

Essential Health Benefits

Benefits set forth under the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, including the categories listed in the state of Utah benchmark plan.

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 protocols 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*.

Refer to the *Plan's* wrap document for further description of the *Plan's* FMLA provisions.

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

Includes 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, congenital defects, *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 *inpatient 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, Naturopath, (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/BrowseRec/Index/browse-recommendations>. For more information, you may contact the *Plan Administrator/employer* as outlined in the Quick Reference Information Chart.

Primary Care Physician (PCP)

Family practitioners, general practitioners, internists, and pediatricians.

Charges from nurse practitioners and physician's assistants 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)

Refer to the *Plan's* wrap document for information pertaining to QMCSO under the *Plan*.

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*.

Reconstructive

Procedures are considered reconstructive when intended to address a significant variation from normal related to accidental *injury*, *disease*, trauma, treatment of a *disease*, or a congenital defect.

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 *Plan's* wrap document. 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.

Transition of Care

Transition of care gives certain new *participants* the option to request extended coverage from their current *non-network* healthcare professional at *network* rates for a limited time. This extended coverage only applies for specific medical conditions until the safe transfer to a *network* health care professional can be arranged.

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 2024.

DocuSigned by:
By: WAUNE FRANGESCA
6CFF65DA3C014E0...

Date: March 14, 2024 | 7:24 AM PDT

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