Kairos Health Arizona, Inc.
Employee Welfare Benefits Health Pool

Plan Document and
Summary Plan Description

Amended and Restated effective July 1, 2020

Kairos Health Arizona, Inc. is a not-for-profit public entity pool established pursuant to Arizona Revised Statutes Section 11-952.01.

Original Effective Date: July 1, 2017

Kairos Health Arizona, Inc. Employee Welfare Benefits Health Pool Plan Document and Summary Plan Description

PREAMBLE AND EXECUTION

WHEREAS, the Plan Administrator desires to adopt and formally document the terms of the Kairos Health Arizona, Inc. Employee Welfare Benefits Health Pool Plan Document and Summary Plan Description (hereinafter referred to as the "Plan") in this document; and

WHEREAS, the Company desires to amend and restate the Plan;

NOW, THEREFORE by virtue and in exercise of the amending power reserved to the Company, the Kairos Health Arizona, Inc., Plan Document and Summary Plan Description ("the Plan") is hereby amended and restated as one Employee Benefit Plan Document and Summary Plan Description, which amendment and restatement shall be effective July 1, 2020.

IN WITNESS WHEREOF, the undersigned has caused the Plan to be executed by its duly authorized officer this 23 day of June, 2020.

BOARD OF DIRECTORS KAIROS HEALTH ARIZONA, INC.

By: Jesus R. Rodriguez

Its: President, Kairos Health AZ

Witness:_____

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ESTABLISHMENT OF PLAN; GENERAL PLAN INFORMATION

Effective Date

The Effective Date (as defined herein) of the Plan is July 1, 2017.

Amended and Restated July 1, 2020.

Purpose

The Plan Administrator maintains the Plan for the exclusive benefits of its eligible employees and their eligible dependents. The purpose of the Plan is to supplement the terms of the applicable benefit booklets, certificates of coverage, or other descriptions that describe the key provisions of the benefit programs listed in Appendix A to this Plan (individually a "Component Benefit Plan" and collectively the "Component Benefit Plans"). The terms of this Plan and the terms of the applicable Component Benefit Plan are intended to serve as the plan document for each medical plan, dental plan, or other benefit plan listed in Appendix A that is sponsored by the Plan Administrator.

The insurance contracts, summary plan descriptions, policies and procedures, and any other documents making up the Component Benefit Plans are hereby incorporated by reference into this document. Eligible employees may obtain an additional copy upon written request at no charge. These documents in the aggregate, to the extent applicable to a particular benefit program, serve as the written plan document and the summary plan description for each benefit plan listed on Appendix A.

Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however, the Plan Administrator, in its sole discretion and in accordance with the provisions herein may amend or terminate the Plan or any provision of the Plan including, but not limited to, the existence and duration of coverage for Employees and/or Dependents of Employees (these terms are defined below), eligibility and requirements for coverage, the availability, nature and extent of benefits, and the conditions for and method of payment of benefits.

General Information about the Plan

Name of Plan:
Kairos Health Arizona, Inc. Employee Welfare Benefits Health Pool Plan Document and Summary Plan Description

Plan Sponsor:
Board of Directors of Kairos Health Arizona, Inc.
333 E. Osborn Road, Ste. 300
Phoenix, AZ 85012
Phone: (888) 331-0222
Website: www.svc.kairoshealthaz.org

Plan Administrator:
(Named Fiduciary)
Board of Directors of Kairos Health Arizona, Inc.
333 E. Osborn Road, Ste. 300
Phoenix, AZ 85012
Phone: (888) 331-0222
Website: www.svc.kairoshealthaz.org

Plan Sponsor ID No. (EIN):
82-0612889

Plan Year:
July 1 through June 30

Effective Date:
July 1, 2020

Type of Plan:
Employee benefits plan providing group:
Medical/Prescription Drug/Employee Assistance Program (EAP)
Dental
Vision

Cafeteria Plan - Each participating Employer has its own separate cafeteria plan and each Employer may or may not also offer a Health Flexible Spending Arrangement and/or contribute to Health Savings Accounts of its Employees.

Non-English Language Notice:
This Plan Document contains a summary in English of a Covered Person's plan rights and benefits under the Plan. If a Covered Person has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.

Type of Plan Administration:
The Plan Administrator administers the Plan and the availability of group insurance and health plans to fund the benefits. The Plan Administrator shares some responsibility with the insurance companies and third party administrators for administering group insurance policies and health plans as described in the Administration Section. Premiums and contributions paid for by the Employer will normally be paid out of the Employer's general assets. Premiums and contributions paid by eligible participating employees are paid in part by pre-tax or post-tax payroll deductions. The Plan Administrator provides the employees a schedule of the applicable premiums and contributions during the initial and subsequent open enrollment periods and on written request for each Component Benefit Plan as applicable.

Insurance Companies and/or Administrators:
Please refer to Appendix A for a list of all carriers and/or administrators.

Participating Employer(s):
Please refer to Appendix C for a list of all participating Employers.

The Plan shall take effect for each participating Employer on the Effective Date, unless a different date is set forth opposite such participating Employer's name.

Important Disclaimer: All benefits under the Plan are provided through group insurance policies and/or self-insured benefit plans. If the terms of this document conflict with the terms of such insurance policies and/or self-insured benefit plans listed in Appendix A or otherwise, the terms of the group insurance policies and/or self-insured benefit plans will control, unless otherwise required by law.

Important Updates Regarding COVID-19 Relief – Tolling of Certain Plan Deadlines
In accordance with 85 FR 26351, "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak," notwithstanding any existing Plan language to the contrary, the Plan will disregard the period from March 1, 2020 until sixty (60) days after (1) the end of the public health emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 247d or (2) such other date announced by the Departments of Treasury and/or Labor, for purposes of determining the following periods and dates:

1) The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA section 701(f) and Internal Revenue Code section 9801(f);

2) The 60-day election period for COBRA continuation coverage under ERISA section 605 and Internal Revenue Code section 4980B(f)(5);
3) The date for making COBRA premium payments pursuant to ERISA section 602(2)(C) and (3) and Internal Revenue Code section 4980B(f)(2)(B)(iii) and (C);
4) The date for individuals to notify the Plan of a qualifying event or determination of disability under ERISA section 606(a)(3) and Internal Revenue Code section 4980B(f)(6)(C);
5) The date within which individuals may file a benefit claim under the Plan's claims procedure pursuant to 29 CFR 2560.503-1;
6) The date within which Claimants may file an appeal of an Adverse Benefit Determination under the Plan's claims procedure pursuant to 29 CFR 2560.503-1(h);
7) The date within which Claimants may file a request for an external review after receipt of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination pursuant to 29 CFR 2590.715-2719(d)(2)(i) and 26 CFR 54.9815-2719(d)(2)(i); and
8) The date within which a Claimant may file information to perfect a request for external review upon a finding that the request was not complete pursuant to 29 CFR 2590.715-2719(d)(2)(ii) and 26 CFR 54.9815-2719(d)(2)(ii).

This period may also be disregarded in determining the applicable date for the Plan’s duty to provide a COBRA election notice under ERISA section 606(c) and Internal Revenue Code section 4980B(f)(6)(D), however, note that the Plan intends to continue follow all established COBRA parameters.

DEFINITIONS

The following words and phrases, when capitalized, shall have the following meanings. Words and phrases not defined in this Section shall have the meaning set forth in an applicable Component Benefit Plan, and if not defined in an applicable Component Benefit Plan, then such words and phrases shall have the meaning customarily given them by the applicable insurance company, third party administrator, or other service provider, as the case may be.

Cafeteria Plan
A Cafeteria Plan is a type of tax-advantaged employee benefits program created under Code Section 125 that allows Employees to pay certain qualified expenses on a pre-tax basis.

Claimants
A Covered Person (or his or her duly authorized representative) may file a claim for benefits to which such Claimant believes he or she is entitled.

COBRA
COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X), as amended, and the regulations issued thereunder. COBRA applies only to the following benefits provided under this Plan:

Medical/Prescription Drug/Employee Assistance Program (EAP)
Dental
Vision
Health Care Flexible Spending Account in the Cafeteria Plan

Code
Code means the Internal Revenue Code of 1986, as amended, and its regulations.

Component Benefit Plan
Component Benefit Plan means an insurance policy, administrative services agreement, plan, trust, certificate of coverage, evidence of coverage, summary plan description or other document incorporated by reference in the General Plan Information Section, Governing Instrument Section, or in other sections of the Plan, together with any exhibits, supplements, addendums or amendments thereto. The Component Benefit Plans are listed in Appendix A.

Covered Person
Covered Person means, for purposes of a Component Benefit Plan, an individual who has properly enrolled in, and who participates in such Component Benefit Plan in accordance with the terms and conditions of such Component Benefit Plan, and who has not for any reason become ineligible to participate further in that benefit plan. Participation requirements (except for the Cafeteria Plan) are described in the “Eligibility, Participation, and Coverage” section herein. The participation requirements in this document will supersede in the event of a discrepancy between this document and the participation requirements in the Medical/Prescription Drug/EAP Plans and the Dental and Vision Plans. Participation requirements for the Cafeteria Plan are described in its Component Benefit Plan.

Dependent
Dependent means any of the following individuals: Dependent Child(ren) or Spouse or Domestic Partner.

Dependent Child(ren)
For purposes of this plan a dependent is any of the following a Dependent Child is any of the employee’s/retiree’s children listed below who are under the age of 26 (whether married or unmarried):

1. natural child, (proof of relationship and age may be required).

2. stepchild, (proof of relationship and age may be required).
3. legally adopted child, or child placed for adoption with the employee/retiree; (proof of adoption or placement for adoption may be requested) or
4. child for whom the employee/retiree has legal guardianship under a court order (proof of guardianship may be requested); or
5. foster child lawfully placed with the employee/retiree by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction (proof of relationship and age and foster child placement may be requested); or
6. a child named in a qualified medical child support order (QMCSO) is also an covered person under this Plan. See the Eligibility chapter for details on QMCSOs.

Disabled Adult Child: The child has reached his or her 26th birthday and the unmarried child is mentally or physically Disabled; and the child is incapable of self-sustaining employment as a result of that disability; and that disability existed before the attainment of this Plan's age limit, the dependent chiefly relies on you and/or your Spouse for support and maintenance and the child is claimed as a dependent on the employee's/retiree's tax return for each plan year for which coverage is provided. This Plan may require initial and periodic proof of disability. A Dependent Child who is not covered under the Plan but becomes disabled after reaching the Plan's Dependent age limit is not eligible to enroll as a Dependent under this Plan.

1. Children of Employees/Retirees may be covered under the Plan if they meet the definition of Dependent Child outlined in this section.
2. The following individuals are not eligible under this Plan: children of a Domestic Partner, a spouse of a Dependent Child (e.g. employee's/retiree's son-in-law or daughter-in-law) or a child of a Dependent Child (e.g. employee's/retiree's grandchild) unless the employee/retiree is the legal guardian of the child.
3. It is the employee's/retiree's obligation to inform the Plan promptly if any of the requirements set out in this definition of a Dependent child are NOT met with respect to any child for whom coverage is sought or is being provided.
4. With the exception of a Dependent Child who is permanently and totally disabled, coverage of a Dependent Child ends at the end of the month in which that child:
    a. reaches his or her 26th birthday; or
    b. ceases to be eligible as a Dependent child under this Plan.

Dependent Care Assistance Program

Dependent Care Assistance Program (the "DCAP") means a benefit that allows Employees to use pre-tax dollars to pay for the care of eligible Dependents while Employees are at work. The DCAP is part of the Cafeteria Plan.

Domestic Partner

Domestic Partner means a person of the same or opposite sex who has the same principal place of abode as the Employee and will continue to share the abode for the entire Plan Year and both the Employee and Domestic Partner meet all the following requirements:

1. Both are of legal age to marry in the State in which the Employee and Domestic Partner reside;
2. They are not related to each other by blood to the extent that it would prohibit them from legally marrying in the State in which they reside;
3. They have lived with each other and have been responsible for each other's welfare or share financial responsibilities as evidenced by jointly owned property, mortgage, lease or bank account for a consecutive period of at least 12 months prior to the date of initial or open enrollment;
4. Neither one is legally married to anyone else or in another domestic partnership;

5. The Domestic Partner is the Employee's dependent under IRC Section 152(d) (note that if the Domestic Partner is not the Employee's tax-qualified dependent, benefits for the Domestic Partner will become taxable to the employee); and
6. They complete and the Employee submits the Plan's required Statement of Domestic Partnership form affirming domestic partnership status along with any other required documentation.

A Domestic Partner is not considered to be a spouse under this Plan. Children of Domestic Partners are not covered under this Plan. Children of Employees may be covered under the Plan if they meet the definition of Dependent.

Effective Date
Effective Date means the date this amended and restated Plan becomes operative; the Effective Date is July 1, 2020. The effective date of each Component Benefit Plan is set forth in the applicable Component Benefit Plan.

Employee
For purposes of eligibility under the Plan only, Employee means a common law employee of an Employer, or an individual who is not a common law employee of an Employer but is actively serving as a school board member or city/town council member of a participating Employer of Kairos, and the school or city/town has agreed to allow the school board member or city/town council member to participate in the Plan. The term Employee does not mean any of the following persons:

1. A self-employed individual, as defined in Code Section 401(c)(1)(A),
2. A member of the board of directors or council of the Plan who is not otherwise an Employee,
3. A person the Plan Administrator determines is an Employer's independent contractor, or
4. A person the Plan Administrator determines an Employer engages as a consultant or advisor on a retainer or fee basis.

A person the Plan Administrator determines is not an "Employee" as defined above shall not be eligible to participate in the Plan regardless of whether such determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters.

Employer
Employer means the participating employer that an Employee works for, unless the context of the document language dictates otherwise.

Health Flexible Spending Arrangement
Health Flexible Spending Arrangement (the "Health FSA") means a benefit plan that allows Employees to use pre-tax dollars to pay for certain medical and dental expenses not reimbursed under other programs. The Health FSA is part of the Cafeteria Plan. *NOTE: This benefit is only available to Employees who work for a participating Employer that has adopted a Cafeteria Plan that provides for such a benefit.*

Health Savings Account (HSA)
Health Savings Account (HSA) means a health savings account within the meaning of Section 223 of the Code.

HIPAA
HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations issued pursuant thereto.

Plan
Plan means the Kairos Health Arizona, Inc. Employee Welfare Benefits Health Pool Plan Document and Summary Plan Description as herein set forth and as amended from time to time.

Plan Administrator
Plan Administrator means the Board of Directors of Kairos Health Arizona, Inc.

Plan Year
Plan Year means the 12-month period beginning July 1 through June 30.

Retiree
Retiree means a former active Employee of a participating Employer who is eligible to participate in the public sector retirement system within the state of Arizona and is less than age 65 and not entitled to Medicare and is not a Board/Council member.

ELIGIBILITY, PARTICIPATION, AND COVERAGE

Eligibility

For the Cafeteria Plans: Refer to the participating Employer's Cafeteria Plan Document for its eligibility provisions.

For the Medical/Prescription Drug/Employee Assistance Program, Dental and Vision Plans: Each Employer that participates in Kairos Health Arizona, Inc. (Kairos) is responsible to provide Kairos with accurate and timely information on employee eligibility.

Failure of the Employee or participating Employer to provide timely and accurate eligibility, changes and coverage termination information to Kairos' Plan Administrator can impact the Employee and/or Employer's liability for claims payment/repayment and impact eligibility for COBRA coverage.

Kairos' Plan Administrator does not determine eligibility for benefits. The Employee is eligible to participate in this Plan, if:

a. The Employee is classified as a full-time Employee averaging 30 hours of service or more per week. Eligibility continues beyond age 65 as long as the Employee remains employed by an Employer that participates in Kairos.

   Hour(s) of Service: means (1) each hour for which an Employee is paid, or entitled to payment, for the performance of duties for an Employer; and (2) each hour for which an Employee is paid, or entitled to payment, by an Employer on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. An hour of service does not include any hour of service performed as a bona fide volunteer, as part of a Federal Work-Study Program (or a substantially similar program of a State or political subdivision thereof) or (according to the final Shared Responsibility regulations) to the extent the compensation for services performed constitutes "income from sources without the United States"; or

b. The Employee is classified as a benefits eligible non-full-time Employee working at least 20 hours of service and less than 30 hours of service for an Employer that participates in Kairos. Eligibility continues beyond age 65 so long as the Employee remains employed by an Employer that participates in Kairos; or

c. The Employee is an eligible Retiree of a participating Employer of Kairos. The Employee may elect (within 60 days of his or her retirement) either Retiree coverage under this Plan at Retiree rates or COBRA at COBRA rates. If he or she elects Retiree coverage, he or she will not have the option to elect COBRA coverage once Retiree coverage ends. If he or she elects COBRA coverage he or she may not elect Retiree coverage after COBRA ends. If the Employee does not elect either Retiree coverage or COBRA coverage within 60 days of his or her retirement, his or her eligibility for coverage under this Plan ends and re-enrollment as a Retiree is not permitted; or

d. The Employee is actively serving as a school board member or city/town council member of a participating Employer of Kairos and the school or city/town has agreed to allow the Employee to participate in the Plan. Eligibility continues beyond age 65 so long as the Employee remains actively serving as a school board or city/town council member of a participating Employer of Kairos. Once the Employee is no longer serving as an active school board or city/town council member his or her coverage terminates and he or she will be given the option of electing COBRA.

The applicable large employers participating in Kairos reserve the right to use a Monthly Measurement Method and a Look Back Measurement Method to determine if an Employee reaches the level of a full-time Employee, in accordance with IRS regulations under the Affordable Care Act.

- The Monthly Measurement Method identifies full-time Employees based on the hours of service achieved for each calendar month.
- The Look-Back Measurement Method determines the status of a new Employee or an ongoing Employee as full-time or not for a future period (called a stability period) based on the average number of hours of service per week the Employee attained in a prior period (called a measurement period).
- Contact your Employer for more information about Employee eligibility rules.

Refer to the Initial Enrollment provisions for details on when coverage starts for new Covered Persons.

Dependents' Eligibility

If the Employee is enrolled in the Plan, the Employee is also eligible for medical coverage for his or her eligible Dependents on the later of the day he or she becomes eligible for his or her own medical coverage or the day he or she acquires an eligible Dependent, either by marriage, birth, adoption or placement for adoption, but only if he or she has requested enrollment by following the enrollment procedure outlined in this section.

- A Dependent may not be enrolled for coverage unless the Employee is enrolled for coverage.
- An Employee's eligible Dependents include his or her lawful spouse, his or her Dependent child(ren) up to age 26 or his or her Domestic Partner. Anyone who does not qualify as a Dependent child or spouse or Domestic Partner as those terms are defined by this Plan has no right to any coverage for plan benefits or services under this Plan.
- Eligible Dependents may be enrolled during initial enrollment, open enrollment or special enrollment.
- Once an Employee loses coverage, his or her Dependents also lose coverage. See the COBRA provisions in this document regarding how to temporarily continue benefits after coverage ends.

Domestic Partner Eligibility

- Individuals who qualify as a Domestic Partner may be eligible to enroll for coverage upon completion of a statement of Domestic Partnership and completion of the enrollment process. The coverage for the Domestic Partner will generally be the same as if covering a spouse. Contact your Employer for the Statement of Domestic Partnership form.
- The Domestic Partner will generally not be a tax-qualified dependent and as such, the Employee will be taxed on the value of the benefit provided to the Domestic Partner. This is called "imputed income" and the Employee will have to pay tax on this amount.
- A Domestic Partner may enroll during initial enrollment or during the open enrollment period and coverage of the Domestic Partner will become effective the first of the month after receipt and approval of the Statement of Domestic Partnership.
- Children of Domestic Partners are not eligible under this Plan. Only children who qualify as Dependent children of the Employee are eligible for coverage.

Surviving Lawful Spouse and Surviving Dependent(s) of Law Enforcement Officers

The surviving lawful spouse and surviving dependent child(ren) of a deceased law enforcement officer who was employed with a participating Employer of Kairos, are entitled to continue health coverage under the Plan after the death of the law enforcement officer (in compliance with Harrolle's law, as amended), unless they no longer are eligible (see the section on "When Coverage Ends" for termination provisions).

"Law enforcement officer" means (1) a peace officer who is certified by the Arizona peace officer standards and training board, (2) a firefighter, detention officer, corrections officer, probation officer or surveillance officer who is employed by the State of Arizona or a political subdivision of this State, or (3) a corrections officer or firefighter who works on behalf of State of Arizona or a political subdivision of this State through a contract with a private company.

- To be eligible for this extended benefit, the law enforcement officer must have been killed in the line of duty or died from injuries suffered in the line of duty while employed with a participating Employer of the Trust.
- Premiums for this extended coverage will continue to the surviving lawful spouse and dependents at the same rate that applies to active Employees (if single) or active Employees and their families (if had family coverage).
- Upon termination of extended coverage, the surviving lawful spouse and dependent(s) will have the opportunity to elect COBRA continuation of coverage.
- The participating Employer of Kairos is responsible to collect and submit the appropriate premium during the extended coverage period in a timely manner to Kairos.

Proof of Dependent Status

Specific documentation to substantiate Dependent status will be required by the Plan and may include a certified birth certificate, certified marriage certificate, proof of the Dependent's age, and the Dependent's social security number.

Failure to provide the required proof of Dependent status means that claims for potentially eligible individuals will not be considered a payable claim for the affected individuals. Also, if the adult child the Employee plans to add for coverage does not qualify as a tax dependent under IRC § 152 or where a state law definition of a dependent does not match with the federal law definition of a dependent, the Employee's Employer must include in the Employee's gross income the fair market value of the coverage provided to the adult child. This is known as "imputed income." This will likely increase both the Employee's taxable income and tax liability.

Important: Failure to provide timely proof of dependent status means that claims submitted to the Plan for the Dependents will not be able to be considered for payment until such proof is provided.

Below are other items the Plan may request to substantiate Dependent status:

- **Marriage:** copy of the certified marriage certificate.
- **Birth:** copy of the certified birth certificate.
- **Adoption or placement for adoption**: court order paper signed by the judge.
- **Stepchild**: Certified marriage certificate and certified birth certificate.
- **Foster Child:** Court order documents signed by a judge verifying legal custody of the foster child (e.g. placement papers from a qualified state placement agency), or proof of judgment, decree or court order from a court of competent jurisdiction.
- **Legal Guardianship:** a copy of the legal guardianship documents and a copy of the certified birth certificate.
- **Involuntary loss of Dependent coverage:** Certificate of coverage from previous Employer and marriage certificate (for spouse) or birth certificate (for child), if not already on file.
- **Disabled Dependent Child:** Current written statement from the unmarried child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically Disabled (as that term is defined in this document) and is incapable of self-sustaining employment as a result of that disability; and dependent chiefly relies on the Employee and/or his or her spouse for support and maintenance and there is evidence that the disability existed before the attainment of this Plan's age limit. The Plan may require that the Employee show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent child.
- **Qualified Medical Child Support Order (QMCSO):** Valid QMCSO document signed by a judge or a National Medical Support Notice.

- **Domestic Partner**: Signed statement by the Employee and Domestic Partner that they meet the requirements of this Plan's Domestic Partner eligibility using the Plan's "Statement of Domestic Partnership" form available from the Kairos Employer.

An Employee or Retiree must reimburse the Plan for any benefits that were paid for a Dependent at a time when that Dependent did not satisfy the definition of a Dependent or was not otherwise eligible for benefits under this Plan.

Declining (Waiving/Opting Out) of Coverage

Full-time, part-time Employees and school board members or city/town council members may decline medical expense coverage under this Plan. To decline coverage he or she must complete the portion of the enrollment form that indicates his or her desire to decline coverage through Kairos. Remember that a Dependent may not be enrolled for coverage unless the Employee is also enrolled.

Important: If an Employee chooses not to enroll in the Plan and at a later date wants the coverage, he or she may enroll only under the Special Enrollment provisions (when applicable) or the annual Open Enrollment provisions described later in this section.

However this Plan cannot offer any financial incentive for an Employee to opt out or decline coverage.

Enrollment Procedures

There are three opportunities to enroll for coverage under this Plan: Initial Enrollment, Special Enrollment and Open Enrollment. These opportunities are described further in this section.

Procedure to Request Enrollment:
Generally an individual must call, fax, complete enrollment electronically, or hand deliver to the Benefits Office/Department of their Employer and indicate their desire to enroll in the Plan. Note that the Open Enrollment procedure can differ from this process and if so, the procedure on how to enroll will be announced by the Plan at the beginning of the Open Enrollment period. Once enrollment is requested, the Employee will be provided with the steps to enroll that include all of the following:

a. Submit a completed enrollment (online enrollment and paper enrollment forms may be obtained from and submitted to the Employee's Employer or, for Retirees, the former Employer), and
b. Provide proof of Dependent status (as requested), and
c. Payment of any required contributions for coverage, and
d. Perform steps a through c above in a timely manner according to the timeframes noted under the Initial, Special, or Open enrollment provisions of this Plan.

Proper enrollment is required for coverage under this Plan. A person who has not properly enrolled by completing the above noted steps, in a timely manner, has no right to any coverage for Plan benefits or services under this Plan.

Dependent Social Security Numbers Needed:
To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, an Employee must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of his or her eligible Dependents for whom the Employee has elected, or are electing, Plan coverage, and information on whether he or she or any of such Dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when an Employee first enrolls for Plan coverage but may also be requested at a later date.

If a Dependent does not yet have a social security number, the Employee can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

Failure to provide the SSN or failure to complete the CMS model form (form is available from the third party administrator or participating Employer or http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedHICNSSNForm081809.pdf) means that claims for eligible individuals may not be considered a payable claim for the affected individuals.

Initial Enrollment

The Employee must request enrollment no later than 31 days after the date on which the Employee is eligible for coverage by following the enrollment procedure outlined below. If the Employee wants Dependent coverage, he or she must request enrollment for his or her eligible Dependents at the same time.

For new Retirees who will be choosing between COBRA and the Retiree plan coverage, a Retiree must request enrollment for himself or herself and any desired Dependents no later than 60 days after the date on which the Employee is eligible for Retiree coverage by following the enrollment procedure outlined below.

Start of Coverage Following Initial Enrollment:

- For benefits-eligible Employees, coverage will become effective in accordance with the Employer's rules for benefits eligibility. For new full-time Employees this is generally as of the first day of the month following an Employee's date of hire into a benefits eligible position or, for contracted Employees, the date of contract in a benefits-eligible position, but only if the individual has completed the enrollment procedures outlined in this section.

  Benefits eligible Employees may decline or opt-out of this Plan's medical coverage; however, there is no financial incentive for declining coverage.

- For school board members and city/town council members, coverage will become effective on the first day of the month following the date the individual starts serving as a benefits eligible board or council member.
- For Retirees, coverage will become effective at midnight on the day the benefits-eligible active Employee status ends, but only if the individual has completed the enrollment procedures outlined in this section.

Each Employer that participates in Kairos sets their own eligibility rules. Please refer to your Employer's eligibility policy for further details.

Failure to Enroll During Initial Enrollment:

There is no failure to enroll during initial enrollment provision under this Plan.

Important: If an Employee does not enroll his or her eligible Dependents during the Initial Enrollment period, unless the Employee and/or his or her eligible Dependent(s) qualify for the Special Enrollment described in the following section, the Employee will have to follow the Open Enrollment procedure.

Special Enrollment

See **Important Updates Regarding COVID-19 Relief – Tolling of Certain Plan Deadlines** in the section "Establishment of Plan; General Plan Information" for important updates regarding Special Enrollment

Special Enrollment for Newly Acquired Spouse or Domestic Partner and/or Dependent child(ren) (as those terms are defined in this Plan):

- If the Employee is enrolled for coverage and if he or she acquires a spouse by marriage, or if he or she acquires a Domestic Partner or any Dependent children by birth, adoption, placement for adoption or

marriage, he or she may request enrollment for his or her newly acquired spouse or Domestic Partner and/or any Dependent child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption. Note: A child is "Placed for Adoption" with the Employee on the date he or she first becomes legally obligated to provide full or partial support of the child whom he or she plans to adopt.

- If the Employee is not enrolled for coverage and if he or she acquires a spouse or Domestic Partner by marriage, or if he or she acquires any Dependent children by birth, adoption, placement for adoption or marriage, and if the Employee is benefits-eligible, he or she may request enrollment for himself or herself and/or his or her newly acquired spouse or Domestic Partner and/or any Dependent child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption. If the Employee is not already enrolled for coverage, he or she must enroll himself or herself in order to enroll a newly acquired Dependent.
- If the Employee did not enroll his or her spouse or Domestic Partner for coverage within 31 days of the date on which he or she became eligible for coverage, and if the Employee subsequently acquires a Dependent child by birth, adoption, placement for adoption or marriage, the Employee may (if the Employee is benefits-eligible) request enrollment for his or her spouse or Domestic Partner and/or his or her newly acquired Dependent child as well as any Dependent child(ren) no later than 31 days after the date of his or her newly acquired Dependent child's birth, or placement for adoption. If the Employee is not already enrolled for coverage, he or she must enroll himself or herself in order to enroll a newly acquired Dependent.

See the Enrollment Procedure section for details on how to enroll for coverage. To obtain more information about Special Enrollment, contact your Benefits Office/Department.

This Special Enrollment for birth, adoption and marriage also applies to a Retiree who is covered under this Plan. However, a Retiree who declines coverage at retirement and later acquires a new Dependent will not be entitled to special enrollment under this Plan and neither will the Retiree's Dependents.

Special Enrollment for Loss Of Other Coverage:

If an Employee did not request enrollment under this Plan for himself or herself, his or her spouse or Domestic Partner and/or any Dependent child(ren) within 31 days after the date on which coverage under the Plan was previously offered because the Employee or the Employee's Dependents had health care coverage under any other health insurance policy or program or Employer plan, including COBRA Continuation Coverage, individual health insurance, Medicare, or other public program; and the Employee, the Employee's spouse or Domestic Partner and/or any Dependent child(ren) cease to be covered by that other health insurance policy or plan; the Employee may (if the Employee is benefits-eligible) request enrollment for himself or herself and/or that spouse or Domestic Partner and/or any Dependent child(ren) within 31 days after the termination of their coverage under that other health insurance policy or plan if that other coverage terminated because:

- Of loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of Employee to pay premiums on a timely basis or termination of the other coverage for cause); or
- Of termination of Employer contributions toward that other coverage (an Employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
- If that other coverage was COBRA Continuation Coverage, the COBRA coverage was "exhausted" or
- Of moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
- Of the other plan ceases to offer coverage to a group of similarly situated individuals; or
- Of the loss of dependent status under the other plan's terms; or

- Of the termination of a benefit package option under the other plan, unless substitute coverage offered; or

COBRA Continuation Coverage is "Exhausted" if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- Due to the failure of the Employer or other responsible entity to remit premiums on a timely basis;
- When the Employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
- When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
- Because the 18-month, 29-month or 36-month period (as applicable) of COBRA Continuation Coverage has expired.

Medicaid or a State Children's Health Insurance Program (CHIP):

The Employee (if the Employee is benefits-eligible) and his or her Dependents may also enroll in this Plan if the Employee (or his or her eligible Dependents):

a. Have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and the Employee (or the Employee's Dependents) lose eligibility for that coverage. However, the Employee must request enrollment in this Plan within 60 days after the Medicaid or CHIP coverage ends; or

b. Become eligible for a premium assistance program through Medicaid or CHIP. However, the Employee must request enrollment in this Plan within 60 days after the Employee (or the Employee's Dependents) are determined to be eligible for such premium assistance.

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

Start of Coverage Following Special Enrollment:

- If the individual requests Special Enrollment within 31 days of the Special Enrollment due to marriage, birth, adoption, placement for adoption or loss of coverage opportunity, (except for newborn and newly adopted child or Medicaid or CHIP opportunity discussed below) generally coverage will become effective on the first day of the month following the date of the event that allowed the Special Enrollment opportunity.
- If the individual requests Special Enrollment within 60 days of the date of the Special Enrollment opportunity related to Medicaid or a State Children's Health Insurance Program (CHIP), generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity.
- Coverage of a newborn or newly adopted Dependent child who requests enrollment within 31 days after birth will become effective as of the date of the child's birth. Coverage of a newly adopted Dependent child who requests enrollment more than 31 days after birth, but within 31 days after the child is adopted or placed for adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.

Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options (when such options exist) at the same costs and the same enrollment requirements as are available to similarly-situated Employees at Initial Enrollment.

Failure to Enroll During Special Enrollment:

There is no failure to enroll during special enrollment provision under this Plan.

IMPORTANT: If an Employee fails to request enrollment for himself or herself and/or any of his or her eligible Dependents within 31 days (or as applicable 60 days) after the date on which the Employee and/or the Employee's Dependents first become eligible for Special Enrollment, the Employee will have to follow the Open Enrollment procedure described later in this section.

Open Enrollment

Open Enrollment Period:

Open Enrollment is the period of time held each year (to be designated by the Plan Administrator) during which eligible Employees, Retirees and Board and Council members may make the elections specified below. The steps to enroll will be announced by the Employee's Employer.

Elections Available During Open Enrollment:

During the Open Enrollment period, the Employee may elect, for himself or herself and for his or her eligible Dependents who are eligible for coverage, to **enroll** in one of the health plans offered by the Plan; or **add or drop** eligible Dependents to the health plan coverages; or **change** health plan options.

Restrictions on Elections During Open Enrollment:

No Dependent may be covered unless the Employee is covered. The Employee and all his or her covered eligible Dependents must be enrolled for the same health plan coverages. All relevant parts of the online enrollment application or enrollment form must be completed and submitted to the Employee's Employer before the end of the Open Enrollment period, along with proof of Dependent status (as appropriate).

Start of or Changes to Coverage Following Open Enrollment:

- If the Employee or his or her spouse or Domestic Partner or Dependent child(ren) are enrolled for the first time during an Open Enrollment period, that person's coverage will begin on the first day of the Plan Year following the Open Enrollment.
- If the Employee or his or her spouse or Domestic Partner or Dependent children are changing or discontinuing coverage during Open Enrollment, such changes will become effective on the first day of the Plan Year following Open Enrollment.

Failure to Make a New Election During Open Enrollment:

If the Employee has been enrolled for coverage and he or she fails to make a new election during the Open Enrollment period, he or she will be considered to have made an election to retain the same health plan coverage he or she had during the preceding Plan Year (if the process for open enrollment differs from this, the Employee will be notified).

Failure to Enroll During Open Enrollment:

There is no failure to enroll during open enrollment provision under this Plan.

IMPORTANT: If the Employee fails to enroll himself or herself and/or any of his or her eligible Dependents within 31 days after the date on which the Employee or his or her Dependents become eligible for Open Enrollment, unless the Employee's eligible Dependents qualify for the Special Enrollment described in the previous section, the Employee will not be able to enroll himself or herself and/or his or her Dependents until the next Open Enrollment period.

Failure to Provide Proof of Dependent Status:

If the Employee fails to provide proof of Dependent status within 31 days of the effective date of coverage, the Plan will “pend” the Dependent(s) proof of enrollment until such proof is provided although, the Plan will begin the required contribution for coverage. The Dependent's eligibility status will be considered to be "pending proof of Dependent status."

- Covered claims related to that Dependent cannot be considered as payable under the Plan until such proof of Dependent status is received by the Plan and determined by the Plan Administrator, or its designee, to meet the Plan's definition of Dependent child and/or spouse.
- No refund/reimbursement of premium contributions is made by this Plan if the Employee enrolls a Dependent for coverage and fails to provide proof of Dependent status or such proof does not satisfy the Plan's definition of Dependent child and/or spouse.
- Remember, Employees may drop Dependents from coverage only at Open Enrollment or if the Employee has a mid-year change of status that makes dropping a Dependent consistent with the change of status event.

Late Enrollment

There is no Late Enrollment provision under this Plan.

Newborn Dependent Children (Special Rule for Coverage)

An Employee’s newborn Dependent child(ren) will be covered from the date of birth, only if the Employee requests enrollment for that newborn Dependent child within 31 days after the child’s date of birth. To enroll, follow the Enrollment Procedures described in this section.

Remember that an Employee may not enroll a newborn Dependent child for coverage unless the Employee is also enrolled for coverage. See also the Special Enrollment provisions and the Enrollment Procedures in this section.

Submitting a claim to the Plan for maternity care/delivery or for care of a newborn child is not considered proper enrollment of that child for coverage under this Plan.

Adopted Dependent Children (Special Rule for Coverage)

An Employee’s adopted Dependent child will be covered from the date that child is adopted or “Placed for Adoption” with the Employee, whichever is earlier. A child is “Placed for Adoption” with the Employee on the date the Employee first becomes legally obligated to provide full or partial support of the child whom the Employee plans to adopt.

- A newborn child who is placed for adoption with the Employee within 31 days after the child was born will be covered from the date the child was placed for adoption if the Employee complies with the Plan’s requirements and timing for obtaining coverage for a newborn Dependent child, described above.
- A Dependent child adopted more than 31 days after the child’s date of birth will be covered from the date that child is adopted or “Placed for Adoption” with the Employee, whichever is earlier, if the Employee submits an online enrollment application or a completed written enrollment form to his or her Employer and provides proof of Dependent status and pays any required contribution for that Dependent child’s coverage, within 31 days of the child’s adoption or placement for adoption.
- If the adopted Dependent child is not properly enrolled in a timely manner, the Employee must wait until the next Open Enrollment period or Special Enrollment period, if applicable.

However, if a child is Placed for Adoption with the Employee, and if the adoption does not become final, coverage of that child will terminate as of the date the Employee no longer has a legal obligation to support that child. Remember that an Employee may not enroll an adopted child or a child Placed for Adoption for coverage unless the Employee is also benefits-eligible and enrolled for coverage. See also the Special Enrollment provisions in this section.

Transferring to Work for an Alternate Kairos Employer

If a benefits-eligible Employee was covered by the Kairos medical plan when that Employee was working for a participating Employer of Kairos and that Employee terminates and goes to work in a benefit-eligible position for another participating Employer of Kairos, the start date for benefits coverage for the transferring Employee under the new participating Employer of Kairos will be according to that new Employer's benefits start date guidelines (this is often the first day of the month following the date of hire).

- For example, in a scenario where Plan A and Plan B are both participating Employers of Kairos, Bob is benefits-eligible under Plan A and terminates work on June 4th. His coverage under Plan A continues until the end of the month (June 30th). Bob takes 2 weeks off between jobs and starts his new job in a benefits-eligible position at Plan B on June 28th. Coverage under Plan B will start on July 1. But if Bob takes three weeks of vacation before starting employment with that new Employer, Bob's coverage under the new Employer will not start until August 1 and Bob may need to elect COBRA coverage for one month in July if he needs health coverage during that month that he was on vacation.

When the Employee, the Employee's Dependents, or Domestic Partner Both Work for a Participating Employer of Kairos: (Special Rule For Enrollment)

1. No individual may be covered under this Plan as follows:
   a. Covered as an Employee or Retiree and also as a Dependent or Domestic Partner.
   b. Covered as the Dependent of more than one Employee or Retiree.
   c. Covered as both an Employee and a Retiree.
2. If both the Employee and his or her spouse or Domestic Partner are eligible Employees of a participating Employer of Kairos:
   a. The Employee and his or her spouse both will be considered as an Employee; however, an Employee's Dependents may only be enrolled under the Employee **or** the Employee's spouse, not both.
   b. The Employee and his or her Domestic Partner will each be considered as an Employee; however, Dependent children of the Employee may only be enrolled under the Employee.
   c. If the spouse or Domestic Partner who selected coverage as an Employee terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, the benefits-eligible Employee who was covered as spouse or Domestic Partner will immediately be deemed to have Employee coverage, and the Employee who had Employee coverage will immediately be deemed to be covered as a spouse or Domestic Partner, and all Dependent children will retain their coverage. Contributions for Dependent coverage will be collected according to the Employer's policies of the Employee-spouse/Domestic Partner who is now deemed to be the eligible Employee. As a result, neither Employee will sustain a loss of coverage because of termination of employment or reduction in hours.
   d. The Employee-spouse/Domestic Partner who is then deemed to be the eligible Employee will have the option to terminate the coverage of the spouse or Domestic Partner or any Dependent child or otherwise elect any alternative coverage available under the plan for the family members provided such election is consistent with the change in the family's circumstances as a result of the termination of employment or reduction in hours.
   e. If, during a Plan Year, a spouse or Domestic Partner who has been a Dependent of an Employee is hired into a benefits-eligible position with a participating Employer of Kairos, this new Employee may elect any plan option at their Initial Enrollment period. If the new Employee chooses to continue their enrollment in the same plan option that they were enrolled in when they were a Dependent spouse or Domestic Partner, their deductible and out-of-pocket limit (that had already been accumulated in the Plan Year) will be applied toward the deductible and out-of-pocket limit for the remainder of the Plan Year.

3. If, while an Employee's family coverage is in effect, any of the Employee's Dependent children becomes an Employee of a participating Employer of Kairos and becomes eligible for coverage as an Employee:

    a. If the Employee-child terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, and still qualifies as a Dependent child, the Employee-child would be able to continue eligibility under the Plan as a Dependent child of the Employee-parent only if a completed enrollment form is obtained and submitted to the Employee's Employer indicating a change of status. As a result, the Employee-child will not sustain a loss of coverage because of termination of employment or reduction in hours. Contributions for Dependent coverage will be collected according to the policies of the Employer of the Employee-parent, and will be adjusted as may be required when a Dependent child becomes an Employee and ceases to have coverage as a Dependent child, or when the Employee-child ceased to be an Employee and resumes coverage as a Dependent child.

Qualified Medical Child Support Orders (QMCSOs) (Special Rule for Enrollment)

1. This Plan will provide benefits in accordance with a National Medical Support Notice. In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the plan recognize the child as a dependent even though the child may not meet the plan's definition of dependent. A QMCSO usually results from a divorce or legal separation and typically:
    a. Designates one parent to pay for a child's health plan coverage;
    b. Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
    c. Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
    d. States the period for which the QMCSO applies; and
    e. Identifies each health care plan to which the QMCSO applies.
2. An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an Employee who is not covered by the Plan to provide coverage for a Dependent child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.
3. If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent child of the Employee, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the Employee, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO, and if the Employee is covered by the Plan, and advise them of the procedures to be followed to provide coverage of the Dependent child(ren).
4. Enrollment Related to a Valid QMCSO: If the Plan has determined that an order is a valid QMCSO it will accept enrollment of the alternate recipient Dependent child as of the earliest possible date following the date the Plan determined the order was valid, without regard to typical enrollment restrictions.
    a. If the Employee is already a Covered Person, the QMCSO may require the Plan to provide coverage for the Employee's Dependent child(ren) and to accept contributions for that coverage from a parent who is not a Covered Person. The Plan will accept a Special Enrollment of the Dependent child(ren) specified by the QMCSO from either the Employee or the custodial parent. Coverage of the Dependent child(ren) will become effective as of the date the enrollment is received by the Plan, and will be subject to all terms and provisions of the Plan, including the limits

on selection of provider and requirements for authorization of services, as permitted by applicable law.

b. If the Employee is benefits-eligible but is not a Covered Person when the QMCSO is received and if the QMCSO orders the Employee to provide coverage for the alternate recipient Dependent child, the Plan will accept a Special Enrollment of the Employee and the Dependent child specified by the QMCSO. Coverage of the Employee and the alternate recipient will become effective as of the date specified on the QMCSO, or if not specified, the first day of the month after the Special Enrollment request is received. Coverage will be subject to all terms and provisions of the Plan, including limits on selection of provider and requirements for authorization of services, as permitted by applicable law.

5. Contributions for Coverage: No coverage will be provided for any Dependent child under a QMCSO unless the applicable Employee contributions for that Dependent child's coverage are paid, and all of the Plan's requirements for coverage of that Dependent child have been satisfied. Contributions required for coverage under a QMCSO are the total Employer contributions required for coverage of the Employee and all members of the Employee's family who are enrolled in the Plan, minus the contributions otherwise actually being paid by the Employee.

6. Termination of Coverage: Generally, coverage of a Dependent child under a QMCSO will terminate when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the Plan for other Dependent children or when coverage of the Employee-parent terminates for any reason, including failure to pay any required contributions, subject to the Dependent child's right to elect COBRA Continuation Coverage if that right applies.

For information (free of charge) regarding the procedures for administration of QMCSOs, contact the Employer's Benefits Office/Department.

Payment for Coverage

The specific amount a Covered Person must pay for coverage is announced each year. The Employee pays his or her contributions for medical coverage on a before-tax basis. This means that his or her payments for these coverages come from his or her pay before federal, and in most cases, state taxes are withheld. That way, the Employee should pay less in taxes.

Note that if the Employee is an active Employee and enrolled in a HDHP with HSA Plan, the Employer may make a contribution to his or her Health Savings Account (HSA). The amount and frequency of that contribution is determined by the Employer (within permissible government guidelines) and announced on an annual basis.

NOTE: If the Employee elects coverage for a Domestic Partner and that Domestic Partner is not his or her tax-qualified dependent, the contributions the Employee makes toward the cost of this Domestic Partner coverage must be deducted on an after-tax basis, in accordance with IRS regulations. The amount the Employer pays toward the cost of your Domestic Partner coverage must be imputed as income and therefore is taxable to the Employee. Contact the payroll department with any questions about the tax implications of covering a Domestic Partner.

Changing Coverage During the Year (Mid-Year Change of Status)

Government regulations generally require that your Plan coverages remain in effect throughout the Plan Year, but Covered Persons may be able to make some changes during the year (mid-year) if the Plan Administrator or its designee determines that the Covered Person has a qualifying change in his or her status affecting his or her benefit needs. Proof of the change of status event will be required. The following qualifying changes are the general changes permitted mid-year under this Plan unless the Employer cafeteria plan dictates otherwise. If not otherwise specified, these are the acceptable changes:

1. **Change in Employee's legal marital status**, including marriage, divorce, legal separation, annulment or death of a spouse;

2. **Change in number of Employee's Dependents**, including birth, adoption, placement for adoption, or death of a Dependent child;

3. **Change in the Employee, spouse's or Dependent child's employment status or work schedule, if it impairs your or their eligibility for benefits**, including the start or termination of employment by the Employee, the Employee's spouse or any Dependent child, a strike or lock-out, or the start of or return from an unpaid leave of absence. In addition, any change in the employment status of the Employee, the Employee's spouse, or the Employee's Dependent that results in that individual losing or gaining eligibility under this Plan will constitute a change in status affecting the Covered Person's benefit needs;

4. **Change in Dependent status that satisfies or ceases to satisfy the Plan's eligibility requirements,** including changes due to attainment of age or any other reason provided under the definition of Dependent of this document;

5. **Change of residence or worksite that allows or impairs** the ability of the Employee, the Employee's spouse or any Dependent child's eligibility for benefits;

6. **Change required under the terms of a Qualified Medical child Support Order (QMCSO),** including a change to add coverage for the child to provide the coverage specified in the order, or to cancel coverage for the child if the order requires the Employee's former spouse to provide coverage for the child;

7. **Change consistent with a Covered Person's right to Special Enrollment** as described in the paragraph dealing with Loss of Coverage under the Special Enrollment section;

8. **Change consistent with entitlement to or loss of eligibility for Medicaid or Medicare** affecting the Employee, the Employee's spouse or Dependent child (except for coverage solely under the program for distribution of pediatric vaccines) including prospective cancellation of coverage of the person entitled to Medicare/Medicaid following such entitlement or prospective reinstatement or election of coverage following loss of eligibility for Medicare/Medicaid;

9. **Automatic Change in the Cost of Coverage**. If the cost of a qualified benefits plan increases or decrease during the Plan year and under the terms of the Plan Employees are required to make a corresponding change in their payments, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the affected Employees' elective contribution for the Plan;

10. **Significant Change in the Cost of Coverage**. If the cost charged to an Employee for a benefit package significantly increases or significantly decreases during the Plan year, the Plan may permit the Employee to make a corresponding change in election under the Plan. In such a case the Employee may start coverage in the Plan option with the decreased cost; or, revoke coverage in the Plan option with an increased cost and elect, on a prospective basis, coverage under another plan option providing similar coverage, if one is available, or drop the coverage if no other such plan option is available;

11. **Significant curtailment without loss of coverage**. If the Employee or Employee's spouse or Dependent child has a significant curtailment of coverage under a plan during the Plan year that is not a loss of coverage, the Plan may permit the Employee who has been participating in the Plan to revoke his/her election for that coverage and elect to receive, on a prospective basis, coverage under another benefit package option providing similar coverage, or to drop coverage if no similar benefit package option is available. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to Covered Persons under the Plan so as to constitute reduced coverage to participants generally;

12. **Addition or elimination of a benefit package option providing similar coverage**. If during a Plan Year, the Plan adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option) the Covered Person may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage;

13. **Addition or significant improvement of any Plan option under the Employer's health care programs or the spouse's Employer's health care plans or programs**. In such a case, a Covered Person may revoke coverage in the current plan and either elect, on a prospective basis, coverage under a new or improved plan option;

14. **Reduction of Hours**. An Employee who was expected to average at least 30 hours of service per week may prospectively drop group health plan coverage midyear if the Employee's status changes so that the Employee is expected to average less than 30 hours of service, even if the reduction of hours does not result in loss of eligibility for the plan. However, the mid-year change must correspond to the Employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in other minimum essential coverage (MEC). The new MEC coverage must be effective no later than the first day of the second month following the month in which the original coverage is dropped. For example, other minimum essential coverage could mean intended enrollment in Health Insurance Marketplace coverage, minimum essential coverage through the spouse's group health plan, to change to a different medical plan option of the Employee's own Employer or to enroll in Medicaid/CHIP.

The following rules apply to making changes to your benefit coverages during the year:

1. Any change an Employee makes to his or her benefits must be determined by the Plan Administrator or its designee to be necessary, appropriate to and consistent with the change in status; (*For example, if mid-year the Employee and spouse deliver a newborn child, they can add that child to this Plan but it would be inconsistent with the birth event to drop the spouse from coverage at this time*.); and

2. The Employee must notify the Plan Administrator in writing within 31 days of the qualifying change in status. Otherwise, the request will not be considered to have been made on account of the Covered Person's change of status and he or she will have to wait until the next Open Enrollment period to make his or her changes in coverage. (The Employee has 60 days from the loss of eligibility for Medicaid or CHIP to request to enroll in this Plan (if the Employee is benefits-eligible) as discussed under Special Enrollment); and

3. If the Employee has a qualifying change in status, the Employee is only allowed to make changes to his or her coverage that are consistent with the change of status event. Generally only coverage for the individual who has lost eligibility as a result of a change of status (or who has gained eligibility elsewhere and actually enrolled for that coverage) can be dropped mid-year from this Plan; and

4. If the Employee will be adding an individual to the Plan, the individuals must be benefits-eligible, and coverage changes associated with a mid-year qualifying change of status opportunity must be prospective and are therefore effective on the first of the month following the date the Employee submits a completed online benefit change application or a written change form to his or her Employer, except for:

   - Newborns, who are effective on the date of birth; and
   - Children adopted or placed for adoption, who are effective on the date of adoption or placement for adoption.

   If the Employee will be removing an individual from the Plan mid-year, coverage will terminate in accordance with the "When Coverage Ends" provisions described in this section.

A Brief Summary of Common Change of Status Events and the Mid-Year Enrollment Changes Allowed Under the Medical Plan

Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code.

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

This chart should NOT be referenced for a Health FSA or Dependent Care Assistance Plan (DCAP).

If the Employee experiences the following Event...	**The Employee may make the following change(s) within 31 days of the event.** *NOTE: Failure to notify the Plan Administrator within 60 days of the date of a divorce or the date a child loses eligibility will cause the individuals losing coverage to forfeit the right the elect COBRA continuation coverage.*	**THE EMPLOYEE MAY NOT make these types of changes...**
Family Events		
Marriage	• Enroll himself or herself, if applicable • Enroll his or her new spouse and other eligible Dependents • Drop health coverage (to enroll in his or her spouse's plan) • Change health plans, when options are available	• Drop health coverage and not enroll in spouse's plan; if the Employee does, he or she won't receive coverage.
Divorce	• Remove his or her spouse from his or her health coverage • Enroll himself or herself (and his or her children) if he or she or his or her children were previously enrolled in his or her spouse's plan	• Change health plans • Drop health coverage for himself or herself or any other covered individual
Gain a child due to birth or adoption	• Enroll himself or herself, if applicable • Enroll the eligible child and any other eligible Dependents • Change health plans, when options are available	• Drop health coverage for himself or herself or any other covered individuals
Child requires coverage due to a QMCSO	• Add child named on QMCSO to his or her health coverage (enroll himself or herself, if applicable and not already enrolled) • Change health plans, when options are available, to accommodate the child named on the QMCSO	• Make any other changes, except as required by the QMCSO

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This chart should NOT be referenced for a Health FSA or Dependent Care Assistance Plan (DCAP).

If the Employee experiences the following Event...	**The Employee may make the following change(s) within 31 days of the event.** *NOTE: Failure to notify the Plan Administrator within 60 days of the date of a divorce or the date a child loses eligibility will cause the individuals losing coverage to forfeit the right the elect COBRA continuation coverage.*	**THE EMPLOYEE MAY NOT make these types of changes...**
Loss of a child's Dependent's eligibility (*e.g.,* child reaches the maximum age for coverage)	• Remove the Dependent from his or her health coverage • Dependent will be offered COBRA. Employee should check with Employer to see if he or she can pay for Dependent's COBRA coverage on a pre-tax basis.	• Change health plans • Drop health coverage for himself or herself or any other covered individuals
Death of a Dependent (spouse or child)	• Remove the Dependent from his or her health coverage • Change health plans, when options are available	• Drop health coverage for himself or herself or any other covered individuals
Covered Person has become entitled to (or lost entitlement to) Medicaid, CHIP or Medicare	• Drop coverage for the person who became entitled to Medicare or Medicaid. • Add the person who lost Medicare/Medicaid entitlement.	• Drop health coverage for himself or herself or any other covered individuals
Employment Status Events		
Spouse becomes eligible for health benefits in another group health plan	• Remove his or her spouse from his or her health coverage, with proof of spouse's other plan coverage • Remove his or her children from his or her health coverage, with proof of children's other plan coverage • Drop coverage for himself or herself only with proof that spouse added him or her to the spouse's new group health plan	• Change health plans • Add any eligible dependents to his or her health coverage

A Brief Summary of Common Change of Status Events and the Mid-Year Enrollment Changes Allowed Under the Medical Plan Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code. This chart is only a summary of some of the permitted medical plan changes and is not all inclusive. This chart should NOT be referenced for a Health FSA or Dependent Care Assistance Plan (DCAP).		
If the Employee experiences the following Event...	**The Employee may make the following change(s) within 31 days of the event.** *NOTE: Failure to notify the Plan Administrator within 60 days of the date of a divorce or the date a child loses eligibility will cause the individuals losing coverage to forfeit the right the elect COBRA continuation coverage.*	**THE EMPLOYEE MAY NOT make these types of changes...**
Spouse loses employment or otherwise becomes ineligible for health benefits in another plan	• Enroll his or her spouse and, if applicable, eligible children in his or her health plan • Enroll himself or herself in a health plan if previously not enrolled because he or she was covered under his or her spouse's plan • Change health plans, when options are available	• Drop health coverage for himself or herself or any other covered dependents
The Employee loses employment or otherwise become ineligible for health benefits	• Enroll in his or her spouse's plan, if available • Elect temporary COBRA coverage for the Qualified Beneficiaries (the Employee and his or her covered dependents)	
Proof of a status change may be required to make a corresponding change in coverage/enrollment.		

Return to Work and Benefit Continuation Issues

- If the Employee ceases to be a benefits-eligible Employee and then within thirty (30) days return to work, then the Employee will be required to take the same benefit election for the remaining portion of the Plan Year as he or she had before he or she terminated. Participation shall be effective the first of the month following the return to work.
- If the Employee ceases to be a benefits-eligible Employee and returns to work more than thirty (30) days following the termination, his or her Employer will determine if or when he or she will become eligible for benefits in accordance with Affordable Care Act rules.

When Coverage Ends

Employee coverage or coverage for a Board or Council member ends on the earliest of the last day of the month in which:

- His or her board or council position ends; or
- His or her employment contract ends; or
- He or she is no longer are eligible to participate in the Plan; or
- He or she ceases to make any contributions required for his or her coverage; or
- The date the Plan is discontinued.

Retiree coverage ends on the earliest of:

- The last day of the month in which the Retiree becomes enrolled in Medicare (except this provision does not apply to Retirees from the Town of Payson); or
- The last day of the month in which there is failure to make any required contributions for coverage; or
- The last day of the month preceding the month in which the individual no longer meets the definition of a Retiree or is no longer eligible to participate in the Plan; (Note there is no opportunity to rejoin Kairos once the Retiree or COBRA coverage has been terminated unless hired or rehired as an eligible Employee by a participating Employer of Kairos); or
- The date the Plan is discontinued.

Coverage of the Employee's covered Dependents or Domestic Partner ends on the earliest of the last day of the month in which:

- The Employee or Retiree's coverage ends; or
- The Dependent spouse or Domestic Partner of a Retiree becomes enrolled in Medicare; or
- The Employee's covered spouse or Domestic Partner or Dependent child(ren) no longer meet the Plan's definition of spouse or Domestic Partner or Dependent child; or
- The Dependent child(ren) attains age 26; or
- The Employee ceases to make any contributions required for their coverage; or
- The date the Plan is discontinued.

Surviving Lawful Spouse and Surviving Dependents coverage ends on the earliest of the following:

- The last day of the month in which the surviving lawful spouse and Dependents are no longer eligible to participate in the Plan (includes circumstances in which: (1) the surviving spouse remarries, becomes Medicare eligible or dies and (2) the surviving Dependent child no longer meet the definition of Dependent child(ren)); or
- The date the surviving lawful spouse and surviving Dependents cease to make the contributions required for coverage; or
- The date the Plan is discontinued.

See also the COBRA section of this document for information on how to temporarily continue benefits when coverage ends.

NOTE: Kairos intends this Plan to be permanent, but since future conditions affecting the Plan cannot be anticipated or foreseen, Kairos reserves the right to amend, modify or terminate this Plan in any manner at any time, which may result in the termination or modification of the Covered Person's coverage. Expenses incurred prior to the Plan termination will be paid as provided under the terms of the Plan prior to its termination.

Delayed Notification of Termination to the Plan

Late notification means a notice of ineligibility for coverage received by the Plan Administrator more than 60 days after the date of the event causing termination of coverage under this Plan. For example, these are some, but not all of the situations considered to be late notifications:

- Employee terminates employment with a participating Employer (this termination of employment includes the Employee retiring from the participating Employer). Neither the Employee nor the Employer notify the Plan Administrator within 60 days of the date of termination of the Employee's employment.
- Employee and spouse divorce. Neither the Employee, spouse, nor the Employer notify the Plan Administrator within 60 days of the date of divorce.
- Child reaches age 26. Neither the child, the Employee-parent, the other parent or the Employer notifies the Plan Administrator by the end of the month in which the child reaches age 26.
- Disabled child age 26 or older is no longer disabled. Neither the child, the Employee-parent, the other parent or the Employer notifies the Plan Administrator by the end of the month in which the disabled child is no longer disabled.

If the Plan Administrator receives a late notification, the Plan Administrator will:

- Verify that the notice is truly late and then promptly notify all vendors associated with the health benefits in which the individual(s) are currently enrolled, of the date coverage should have terminated. Termination will occur as of the last day of the month in which the actual terminating event occurred (e.g. the divorce, the termination of employment, etc.)
- Determine if COBRA coverage will be permitted to be offered in accordance with the COBRA provisions outlined in this document. If the timeframe for timely notice of a COBRA qualifying event has expired, in which case COBRA will not be offered, the Plan Administrator will notify the COBRA Administrator so the affected individual(s) can be provided with a written notice of the unavailability of COBRA .
- Investigate if health claims including outpatient drugs have been paid by the Plan during the period of time in which the individual(s) were ineligible for coverage. If so, the Plan Administrator will determine, on advice of legal counsel, the method to recoup/remedy payment of claims.

Options When Coverage under this Plan Ends

When coverage under this Plan terminates Covered Persons may have the option to buy temporary continuation of this group health plan coverage by electing COBRA, or Covered Persons can look into options to buy an individual insurance policy for health care coverage from the Health Insurance Marketplace.

Also, in the Marketplace a Covered Person could be eligible for a tax credit that lowers his or her monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit a Covered Person's eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, a Covered Person may qualify for a special enrollment opportunity for another group health plan for which he or she is eligible (such as a spouse's plan), if he or she requests enrollment in that plan within 30 days of losing coverage under this Plan.

When coverage under this Plan terminates, remember that Covered Persons have options to consider in order to avoid the Individual Mandate penalty. For more information on the Individual Mandate, individuals should talk with their tax advisor or visit www.healthcare.gov.

Notice to the Plan (When Rights May End)

An Employee, an Employee's spouse, or any of his or her Dependent children or Domestic Partner **must notify the Plan Administrator preferably within 30 days but no later than 60 days*** after the date of:

- a divorce;
- a Dependent child reaches the Plan's limiting age;
- a Dependent child has any physical or mental Disability or ceases to have any physical or mental Disability;
- a Domestic Partner ceases to meet the Plan's definition of Domestic Partner;

- any individual meets the termination provisions of the Plan.

*Failure to give this Plan a timely notice (notice to the Plan Administrator as noted above) may cause the Employee, the Employee's spouse and/or Dependent child(ren):

a. To lose the right to obtain COBRA Continuation Coverage, or
b. May cause the coverage of a Dependent child to end when it otherwise might continue because of a disability, or
c. May cause claims to not be able to be considered for payment until eligibility issues have been resolved, or
d. May result in the Employee's liability to repay the Plan if any benefits are paid to an ineligible person.

When the Plan Can End Coverage for Cause

A. The Plan Administrator or its designee may end an Employee's coverage and/or the coverage of any of his or her covered Dependents for cause 30 days after it gives the Employee written notice of its finding that the Employee or his or her covered Dependent:

   1. Engaged in an act, practice or omission that constitutes fraud or an intentional misrepresentation of a fact in any enrollment, claim or other form in order to obtain coverage, services or benefits under the Plan; or
   2. Allowed anyone else to use the identification card that entitles you or your covered Dependent to coverage, services or benefits under the Plan; or
   3. Altered any prescription furnished by a physician or other health care practitioner.

   If an Employee's coverage is terminated for any of the above reasons, it may be terminated retroactively to the date that the Employee or his or her covered Dependent performed or permitted the acts described above.

B. The Plan Administrator or its designee may end the Employee's coverage and/or the coverage of any of the Employee's covered Dependents for cause 30 days after it gives the Employee written notice of its finding that the Employee or his or her covered Dependent(s) engaged in conduct that was abusive, obstructive, or otherwise detrimental to a physician or health care practitioner. If coverage is terminated for this reason, it will be terminated on a going forward basis.

C. The Plan Administrator or its designee may end the Employee's coverage and/or the coverage of any of his or her covered Dependents for cause 15 days after it gives the Employee written notice of its finding that the Employee has failed to pay his or her contribution amount. In this instance, the Employee's coverage may be terminated retroactively to the date of the delinquent contribution amount. In addition, the Employee's coverage may be suspended during the 15-day notice period.

Special Circumstances: FMLA and Other Leaves

Family and/or Medical Leave Act (FMLA):

If the Employee has completed 12 months of employment with an Employer participating in Kairos and has completed 1,250 hours of work for that Employer in the year preceding the start of leave, and the Employee works at a location where the company employs 50 or more Employees within 75 miles, the Employee is entitled by law to up to 12 weeks each year (in some cases up to 26 weeks) of unpaid family or medical leave for specified family or medical purposes, such as the birth or adoption of a child, or to provide care of a spouse, child or parent who is seriously ill, or for the Employee's own serious illness (whether FMLA is granted to an Employee for the care of a Domestic Partner depends on the administrative policies of each Kairos Employer).

While the Employee is officially on such a family or medical leave, the Employee can keep his or her coverage for himself or herself and his or her Dependents in effect during that family or medical leave period by continuing to pay his or her contributions during that period. Since the Employee will not be paid while

the Employee is on family or medical leave, he or she may pay his or her contributions as they come due on the dates he or she would have been paid.

For the calculation of the 12-month period used to determine Employee eligibility for FMLA, this Plan uses a rolling 12-month period measured backward in time from the date the Employee uses any FMLA leave.

NOTE: This FMLA provision does not apply to Board/Council members.

Whether or not the Employee keeps his or her coverage while the Employee is on family or medical leave, if the Employee returns to work promptly at the end of that leave, his or her coverage will be reinstated without any additional limits or restrictions imposed on account of his or her leave. This is also true for any of his or her Dependents who were covered by the Plan at the time he or she took his or her leave. Any changes in the Plan's terms, rules or practices that went into effect while the Employee was away on that leave will apply to the Employee and his or her Dependents in the same way they apply to all other Employees and their Dependents.

To find out more about entitlement to family or medical leave as required by federal and/or state law, and the terms on which an Employee may be entitled to it, contact your Employer.

Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA):

If an Employee goes into active military service for up to 31 days, he or she can continue his or her health care coverage during that leave period if he or she continues to pay his or her contributions for that coverage during the period of that leave. If the Employee goes into active military service for more than 31 days, he or she should receive military health care coverage at no cost; however, the Employee may also continue this group health plan coverage under the provisions of USERRA, at his or her own expense, as follows:

If the Employee elects USERRA continuation coverage, the maximum period for this coverage is up to 24 months.

When an Employee's coverage under this Plan terminates because of his or her reduction in hours due to his or her military service, the Employee and his or her eligible dependents may also have COBRA rights. See the COBRA section of this document. Questions regarding entitlement to this leave and to the continuation of medical coverage should be referred to the Employer.

Reinstatement of Coverage After a Leave Of Absence

- If an Employee's coverage ends while the Employee is on an approved leave of absence for family, medical or military leave, his or her coverage will be reinstated on the day he or she returns to active employment status, if he or she returns immediately after his or her leave of absence ends, subject to all accumulated Plan maximum benefits that were incurred prior to the leave of absence.
- If an Employee's coverage ends while the Employee is on an approved leave of absence other than family, medical, or military leave, his or her coverage will be reinstated on the first day of the month following his or her return to active employment status, if he or she returns immediately after his or her leave of absence ends, subject to all accumulated Plan maximum plan benefits that were incurred prior to the leave of absence.
- An Employee who is terminated and rehired will be treated as a new Employee upon rehire only if the Employee was not credited with an hour of service, as defined under the ACA, with the Employer for a period of at least 13 consecutive weeks (26 consecutive weeks for educational institutions) immediately preceding the date of rehire.

Questions regarding entitlement to an approved leave of absence and to the continuation of medical coverage should be referred to the Employer.

Health Insurance Portability and Accountability Act of 1996

HIPAA Title I
Solely to the extent required by the Health Insurance Portability and Accountability Act of 1996 (hereinafter "HIPAA"), an Employee shall be a Covered Person under the Plan no later than such time as required under HIPAA, and the Plan shall be subject to the special enrollment, and nondiscrimination in health status provisions of HIPAA. This Section shall be interpreted and applied to give an Employee only those rights as prescribed under HIPAA and the rulings and regulations issued thereunder.

HIPAA Title II
The Plan shall comply with the privacy and security regulations of HIPAA, in accordance with the provisions set forth in HIPAA Privacy and HIPAA Security Sections. This Section shall be interpreted and applied to give an Employee only those rights as prescribed under the Health Insurance Portability and Accountability Act of 1996, and the rulings and regulations issued thereunder.

The Component Benefit Plans provide each member with a separate Notice of Privacy Practices. This Notice describes how the respective Component Benefit Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Please see the applicable Component Benefit Plan for how to obtain additional copies of the Notice of Privacy Practices.

If you have additional questions please contact the Privacy Officer at:

Kairos Health Arizona, Inc.
333 E. Osborn Road, Ste. 300
Phoenix, AZ 85012
Phone: (888) 331-0222
Website: www.svc.kairoshealthaz.org

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA). Please see the applicable Component Benefit Plan for information regarding disclosures of Electronic Protected Health Information ("Electronic PHI") to the insurance company and/or Plan Sponsor for policy and/or plan administration functions and the applicable procedures related to the security of this information.

Coordination with State Medicaid Programs

The fact that a Covered Person is eligible for coverage by, or is covered by, a State Medicaid program shall not affect the Covered Person's eligibility to participate in the Plan or to receive benefits. The payment of benefits under the Plan with respect to any Covered Person shall be made in accordance with any assignment of rights made by or on behalf of the Covered Person of a beneficiary of the Covered Person as required by any State Medicaid program. To the extent a payment has been made to or with respect to a Covered Person pursuant to a State Medicaid program and the amount so paid is for a medical expense that the Plan has a legal liability to pay, the Plan will pay such expense in accordance with any State law that provides that the State has acquired the right with respect to the Covered Person to receive payment for such expense.

This Section shall be interpreted and applied to give an Employee only those rights as prescribed under State Medicaid Programs, and the rulings and regulations issued thereunder.

Mental Health Parity Act and Mental Health Parity and Addiction Equity Act

Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations to the extent required. For further details, please contact the Plan Administrator.

Women's Health and Cancer Rights Act

Solely to the extent required under the law of the Women's Health and Cancer Rights Act (hereinafter "WHCRA"), the Plan shall provide certain benefits related to benefits received in connection with a mastectomy.

In the case of a Covered Person who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the coverage shall be provided in a manner determined in consultation with the attending physician and the patient for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Such reconstructive benefits are subject to annual plan deductibles and coinsurance provisions such as other medical and surgical benefits covered under the Plan.

This Section shall be interpreted and applied to give an Employee only those rights as prescribed under WHCRA, and the rulings and regulations issued thereunder.

Newborns' and Mothers' Health Protection Act

Solely to the extent required by the Newborns' and Mothers' Health Protection Act (hereinafter "NMHPA"), the Plan shall provide that coverage for childbirth may not be limited to a hospital stay of less than 48 hours for normal delivery, or less than 96 hours for cesarean section, or require the provider to obtain approval for shorter hospital stays. The requirement shall not apply if the attending provider, in consultation with the mother, decides to discharge the mother or newborn earlier than the time prescribed by the NMHPA.

This Section shall be interpreted and applied to give Covered Persons only those rights as prescribed under the NMHPA, and the rulings and regulations issued thereunder.

Genetic Information Nondiscrimination Act of 2008

The Plan shall also comply with the Genetic Information Nondiscrimination Act of 2008 (hereinafter "GINA").

This Section shall be interpreted and applied to give Covered Persons only those rights as prescribed under GINA, and the rulings and regulations issued thereunder.

Children's Health Insurance Program Reauthorization Act of 2009

The Plan shall also comply with the Children's Health Insurance Program Reauthorization Act of 2009 (hereinafter "CHIP").

This Section shall be interpreted and applied to give Covered Persons only those rights as prescribed under CHIP, and the rulings and regulations issued thereunder.

Michelle's Law

The Plan shall also comply with Michelle's Law (P.L. 110-381).
This Section shall be interpreted and applied to give Covered Persons only those rights as prescribed under Michelle's Law, and the rulings and regulations issued thereunder.

BENEFITS

Medical, Prescription Drug, and Employee Assistance Program Benefits

Covered Persons shall have the right to the medical benefits, prescription drug benefits, and Employee Assistance Program benefits described in the applicable Component Benefit Plan. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Component Benefit Plan. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan.

Dental and Vision Benefits

Covered Persons shall have the right to the dental and vision benefits described in the applicable Component Benefit Plan. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Component Benefit Plan. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan.

Cafeteria Plan Benefits

Covered Persons shall have the right to benefits described in the applicable Component Benefit Plan. Such benefits shall be subject to the terms, conditions and limitations set forth in such Component Benefit Plan. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan. Each Cafeteria Plan is intended to qualify under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code"), and which is incorporated as if fully set forth herein. Each participating Employer maintains its own Section 125 plan. Covered Persons should refer to the summary plan description and/or Plan Document for such Employer's Section 125 plan in order to learn what benefits can be elected under the Employer's Section 125 plan.

COORDINATION OF BENEFITS

Coordination of Benefits Provisions

Coordination of benefits provisions are set forth in Component Benefit Plans where applicable. For more information regarding coordination of benefits for a particular Component Benefit Plan, see that Component Benefit Plan.

CONTINUATION COVERAGE

See **Important Updates Regarding COVID-19 Relief – Tolling of Certain Plan Deadlines** in the section "Establishment of Plan; General Plan Information" for important updates regarding COBRA coverage.

Eligibility for Continuation Coverage

The provisions contained in this Section apply only to the following benefits provided under the Plan:

Medical/Prescription Drug/Employee Assistance Program (EAP)
Dental
Vision
Health Care Flexible Spending Account in the Cafeteria Plan

Certain Employees and Dependents shall have the right to purchase continuation coverage under this Plan in accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, Title X (COBRA), provided such individuals were Covered Persons under the Plan on the date immediately preceding the date of a Qualifying Event or become Covered Persons during the continuation period because such Dependent is born to or placed for adoption with the Employee.

COBRA rights are explained in detail here. If you have any questions about your COBRA rights please contact the Plan Administrator for a copy of your COBRA rights.

If coverage for you or your eligible family ceases because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death or a child ceasing to meet the definition of "dependent"), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time.

Members Not Subject to COBRA

The member must notify Kairos if the member is not subject to COBRA, so that non-COBRA continuation coverage is provided instead of COBRA. This is determined each January, based on the number of full time equivalents employed in the prior calendar year. Employers that are subject to COBRA are: non-church entities that employed 20 or more full-time (and/or full-time equivalent) employees on more than 50% of the member's business days during the preceding calendar year.

When an employer terminates from Kairos, and ceases to be a member, but still has active participants with non-COBRA continuation coverage, the member will need to ensure that new insurance carriers will agree to provide coverage for its non-COBRA participants through the end of the offered coverage time periods.

Continuation Coverage Definitions

For purposes of this Section, the following terms have the following meanings:

A. "Employee" means as to a Component Benefit Plan, a person who is (or was) covered under the Plan by virtue of the person's performing services for the Employer on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage.

B. "Dependent" means as to a Component Benefit Plan, with respect to an Employee as defined in this Section, any individual who, on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage, is covered under such Plan as (1) the Dependent spouse of such Employee or (2) the Dependent child of such Employee. The term Dependent shall include any child born to or placed for adoption with the Employee during the continuation period.

C. "Qualified Beneficiary" means an Employee or Dependent as defined in this Section but shall not

mean Dependents defined in the Election Rules, except that the term Qualified Beneficiary shall include Dependents born to or placed for adoption with the Employee during the continuation period.

D. "Qualifying Event" means any of the following, the occurrence of which would result in loss of coverage under the Plan were it not for the right to purchase COBRA continuation coverage:

1. For Employees, termination of employment for any reason other than gross misconduct, or loss of eligibility due to reduction in hours worked by the Employee.

2. For Dependents:

    a. Death of the Employee.
    b. Divorce of the Employee and spouse.
    c. Legal separation of the Employee and spouse.
    d. Reduction in hours worked by the Employee or termination of employment by the Employee for any reason other than gross misconduct.
    e. Entitlement of the Employee to benefits under Title XVIII of the Social Security Act (relating to Medicare).
    f. Ceasing to qualify as a Dependent child under the Plan.

The Qualifying Event shall be deemed to occur on the date of the Qualifying Event, not on the date coverage ends because of the Qualifying Event.

Loss of Eligibility for Continuation Coverage

A Qualified Beneficiary shall not be eligible for COBRA continuation coverage unless both A and B occur:

A. The Employer or Plan Administrator is notified of the election of COBRA continuation coverage, on a form provided for that purpose, within 60 days of the later of:

    1. The date the Qualified Beneficiary's coverage under the Plan would otherwise terminate by reason of an event described in this Section.
    2. The date notice of eligibility is sent to the individual in accordance with the Notice Requirements.

B. The Qualified Beneficiary pays the initial required premium, as set forth in the Required Premium Section below, no later than the date 45 days after the date on which COBRA continuation coverage was elected.

Until expiration of the election period, a Qualified Beneficiary may change or revoke any election. Failure to elect COBRA continuation coverage within the prescribed election period shall result in a waiver of the right to COBRA continuation coverage.

Termination of COBRA Continuation Coverage

COBRA continuation coverage under a Component Benefit Plan shall terminate on the date on which the earliest of the following occurs:

1. The last day of the month preceding the date the Qualified Beneficiary fails to pay a subsequent required premium within 30 days of the date it is due.
2. The date the Qualified Beneficiary first becomes, after the date of making a COBRA election, entitled to Medicare.
3. The date the Qualified Beneficiary first becomes, after the date of making a COBRA election, covered under another group health plan, as defined in Code Section 5000(b)(1), not containing a limitation or exclusion as to any preexisting condition of such individual (other than such an exclusion or limitation which does not apply to, or is satisfied by, such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996).

4. 36 months from the date on which a Qualifying Event described in Continuation Coverage Definitions Sections (D)(2)(a), (D)(2)(b), (D)(2)(c), (D)(2)(e), or (D)(2)(f) occurs.
5. 18 months from the date on which a Qualifying Event described in Continuation Coverage Definitions Sections (D)(1) or (D)(2)(d) occurs. If a Qualifying Event described in Continuation Coverage Definitions Sections (D)(2)(a), (D)(2)(b), (D)(2)(c), or (D)(2)(f) occurs subsequent to a Qualifying Event described in Continuation Coverage Definitions Section (D)(2)(d), an additional period of coverage shall be allowed for Dependents who have properly and timely elected and paid for COBRA continuation coverage; but, in no event shall the sum of the first and second periods of coverage exceed 36 months from the date of the first Qualifying Event giving rise to the Qualified Beneficiary's eligibility for COBRA continuation coverage.
6. The date the Employer terminates all group health plans.
7. In the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled (i) at the time of the Qualifying Event or (ii) at any time during the first 60 days of continuation coverage, the 18-month period set forth in #5 above shall be extended to 29 months; provided that such individual notifies the Plan Administrator of such determination in accordance with the Notice Requirements provision before the end of such 18-month period; and provided further that if the Qualified Beneficiary does not remain disabled during the extended period, coverage shall cease with the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.
8. In the case of a Qualifying Event described in Continuation Coverage Definitions Section (D)(2)(d) that occurs less than 18 months after the date the Employee becomes entitled to Medicare, 36 months from the date the Employee becomes entitled to Medicare.
9. For the Health FSA or Limited-Purpose Health FSA, if COBRA is required to be provided, the last day of the Plan Year in which the Qualifying Event occurs.

Notice Requirements

1. The Employer shall notify the Plan Administrator, or its designee, of the occurrence of an event described in Continuation Coverage Definitions Sections (D)(1), (D)(2)(a), (D)(2)(d), and (D)(2)(e), within 30 days of the date of the described event.
2. The Qualified Beneficiary shall be responsible for notifying the Plan Administrator, or its designee, of the occurrence of an event described in Continuation Coverage Definitions Sections (D)(2)(b), (D)(2)(c), or (D)(2)(f) within 60 days of the date of the described event.
3. The Plan Administrator, or its designee, shall provide notice to Qualified Beneficiaries of their COBRA continuation coverage rights within 14 days of the date it receives the notice described in #1 and #2 above.
4. A Qualified Beneficiary, who is determined under Title II or XVI of the Social Security Act to have been disabled at any time within the first 60 days of the continuation period, shall be responsible for notifying the Plan Administrator, or its designee, of such determination within 60 days after the date of such determination, but in no event later than the end of the 18-month period set forth in Termination of COBRA Continuation Coverage Section above, in provision #5. Such Qualified Beneficiary further shall be responsible for notifying the Plan Administrator, or its designee, of any final determination under such Title(s) that he or she is no longer disabled, within 30 days of the date of such determination.
5. At the commencement of coverage under the Plan, the Plan Administrator, or its designee, shall provide each Employee or spouse who is a Covered Person with notice of their rights under COBRA.
6. The Plan Administrator, or its designee, shall provide notice to each Qualified Beneficiary of any termination of COBRA continuation coverage that takes effect earlier than the end of the maximum period of COBRA continuation coverage applicable to the Qualified Beneficiary.
7. The Plan Administrator, or its designee, shall provide notice to each Employee, spouse or Dependent of the unavailability of COBRA continuation coverage if the Plan Administrator, or its designee, determines after receiving notice of a Qualifying Event that the Employee, spouse or Dependent is not entitled to COBRA continuation coverage.

Coverage Available for Continuation

A Qualified Beneficiary may elect to continue receiving the health care coverage (as defined in COBRA

regulations) that he or she was receiving under a Component Benefit Plan immediately before the event giving rise to the right to elect COBRA continuation coverage. If coverage provided under such Component Benefit Plan to similarly situated active Employees is changed or eliminated, COBRA continuation coverage also shall be changed or eliminated. If the Employer terminates the Component Benefit Plan but continues to maintain one or more other group health plans, as defined in Code Section 5000(b)(l), COBRA continuation coverage recipients may elect coverage under one of those other group health plans. A Qualified Beneficiary may be able to elect to continue to receive coverage for the level of reimbursement, if any, that the individual had in effect under his or her Health FSA or Limited-Purpose Health FSA immediately before the Qualifying Event after reflecting debits for health care reimbursements made up to the Qualifying Event

Election Rules

Scope of Election:
Each affected Qualified Beneficiary generally shall have an independent right to elect or reject COBRA continuation coverage under each Component Benefit Plan that is required to offer COBRA coverage to the Qualified Beneficiary; provided, however, that in the event an Employee or his or her spouse makes an election to continue coverage on behalf of the other or on behalf of any other Qualified Beneficiary, such election shall be binding on such other party; and provided further, that in the event the Qualified Beneficiary is a minor or an incapacitated person, the parent or legal guardian of such minor or the legal representative of such incapacitated person shall have the right to elect or reject continuation coverage on behalf of such minor or incapacitated person, and any such election or rejection of coverage shall be binding on such minor or incapacitated person. Each Qualified Beneficiary is entitled to a separate election with respect to any choice of coverages available under each Component Benefit Plan that is required to offer COBRA coverage to the Qualified Beneficiary.

After Acquired Dependents:
A Qualified Beneficiary eligible for COBRA continuation coverage under a particular Component Benefit Plan may, under such Component Benefit Plan, elect to cover Dependents (as defined in this Section) acquired after the date of eligibility described under the Loss of Eligibility of Continuation Coverage Section to the same extent as Covered Persons, provided the Employer or Plan Administrator, or its designee, is notified of the election to cover such Dependent(s) in the manner and within the time set forth in the applicable Component Benefit Plan, or the time limit required by applicable law, except that in no event shall notice be required within a period of less than 30 days. Such newly acquired Dependent(s), other than Qualified Beneficiaries defined in this Section, shall have no independent right to COBRA continuation coverage. Failure to notify the Employer or Plan Administrator within the prescribed time shall result in a waiver of the right to elect COBRA continuation coverage for such newly acquired Dependent(s).

Open Enrollment Periods:
During an open enrollment period occurring during the COBRA coverage period, a Qualified Beneficiary may elect to cover Dependents not previously covered, subject to the terms and conditions set forth in the applicable Component Benefit Plan; provided, however, that this subsection shall not apply to Health FSA or Limited-Purpose Health FSA benefits.

Required Premium

In order to receive COBRA continuation coverage under a Component Benefit Plan, Qualified Beneficiaries shall agree, on forms furnished by the Plan Administrator, or its designee, to pay any required premiums to the Component Benefit Plan and shall make such premium payments when and as required. All premiums other than the initial premium shall be due on the first day of the calendar month. The amount of the premium shall be no more than 102 percent of the cost of coverage. In the case of a Qualified Beneficiary who is determined under Title I or XVI of the Social Security Act to have been disabled at any time within the first 60 days of continuation coverage, the cost of coverage for the 19th month through the 29th month of coverage shall be no more than 150 percent of the cost of coverage. Notwithstanding the foregoing, the cost of coverage shall not exceed the maximum, nor be changed more frequently than, permitted by law.

Governing Provisions

When the provisions for COBRA continuation coverage are set forth in an applicable Component Benefit Plan, such applicable Component Benefit Plan shall govern except to the extent such language fails to comply with requirements of applicable law or fails to determine the right or liability of the party, in which case the provisions of this Section shall govern.

CONTRIBUTIONS, FUNDING AND PLAN ASSETS

Contributions

Employer Contributions:
The Employer shall pay, as contributions to the Plan, all or a portion, as determined by the Employer, of the cost of the benefits provided under the Plan. The Employer reserves the right to cease payments under the Plan at any time and shall be under no obligation to make any contributions to the Plan after the Plan is terminated.

Employee Contributions:

1. **Amount:** From time to time, the Employer shall determine, on a fixed dollar or percentage basis, the amount, if any, of contributions required from Covered Persons who are Employees to entitle them and their Dependents, if applicable, to be covered by and receive benefits under the Plan. The amount of such contribution shall be as set forth in any election or enrollment materials, whether paper or electronic, issued or posted in conjunction with the Plan or the Employer's Cafeteria Plan (if applicable), as such materials may be changed from time to time. Any such election or enrollment materials are hereby incorporated by reference into the Plan as if set forth in full herein. Employee contributions under the Employer's Cafeteria Plan (if applicable) are subject to maximum contribution limits as established by the Employer and in compliance with Internal Revenue Service contribution limitations.
2. **Payment:** As a condition of receiving benefits under the Plan, eligible Employees shall agree, on forms or materials furnished by the Employer or through a telephone or web-based enrollment process, to make contributions under the Plan in the amount determined as described above and shall make such contributions when and as required. If so provided under the terms of the Employer's Cafeteria Plan contributions by Employees shall be made by salary reduction in accordance with the terms of such plan and a corresponding contribution by the Employer.

Priority of Contributions:
Benefits shall be deemed to come first from amounts contributed by eligible Employees and then from amounts contributed by the Employer.

Funding

Funding Mechanism:
Contributions from the Employer and/or eligible Employees may be held under or paid to one or more of the following vehicles: insurance policies or arrangements, Health Maintenance Organizations or dedicated trust funds established by the Employer. In addition, benefits may be paid directly from the general assets of the Employer.

Plan Assets

Subject, in all cases, to the right of the Employer to terminate its obligation hereunder, the Employer shall pay benefit(s) provided for herein, to the extent not:

1. Provided for by Employee contributions.
2. Payable from an insurance policy held under the Plan.
3. Paid by a dedicated trust fund established by the Employer.

Where an insurance policy provides for payment of premiums directly from the Employer, unless the insurance policy states otherwise, payable dividends, retroactive rate adjustments, or experience refunds are not Plan Assets. These dividends, retroactive rate adjustments, or experience refunds are Employer property, which the Employer may retain to the extent they do not exceed the Employer's aggregate contributions to Plan cost made from its own funds.

ADMINISTRATION

Plan Administrator

The Board of Directors of Kairos Health Arizona, Inc. shall serve as Plan Administrator until such time as it has appointed another person, entity, or committee to serve as Plan Administrator. The Plan Administrator shall be the "named fiduciary".

Plan Administrator's Duties

Except as to those functions reserved within the Plan to the Board of Directors or an Employer, the Plan Administrator shall have the duty to manage the operation and administration of the Plan. The Plan Administrator shall cause to be maintained such records as may be reasonably necessary or desirable for the proper management and administration of the Plan. The Plan Administrator shall also cause to be maintained for inspection by any individual who participates or is eligible to participate in the Plan, a copy of each Component Benefit Plan and this document; and any amendments or changes to these documents. Upon written request, the Plan Administrator shall provide to such participating or eligible individuals a copy of these documents and may impose a reasonable charge, as permitted by law, for such copies.

Plan Administrator's Powers

Except as expressly limited or reserved in the Plan, the Employer, or the Employer's governing Board or Council, the Plan Administrator shall have the right to exercise, in a uniform and nondiscriminatory manner, full discretion with respect to the administration, operation, and interpretation of the Plan. Without limiting the generality of the foregoing rights, the Plan Administrator shall have full power and discretionary authority to:

1. Require any person to furnish such information as Plan Administrator may request from time to time and as often as the Plan Administrator determines reasonably necessary for the purpose of proper administration of the Plan and as a condition to the individual's receiving benefits under the Plan.
2. Make and enforce such rules and prescribe the use of such forms as the Plan Administrator determines reasonably necessary for the proper administration of the Plan.
3. Interpret the Plan and decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.
4. Determine all questions concerning the eligibility of any individual to participate in, be covered by, and receive benefits under the Plan pursuant to the provisions of the Plan.
5. Determine whether objective criteria set forth in the Plan have been satisfied respecting any term, condition, limitation, exclusion, and restriction or waiver thereof.
6. Delegate to other person(s) any duty that otherwise would be a fiduciary responsibility of the Plan Administrator under the terms of the Plan.
7. Engage the services of such person(s) and entity or entities as it deems reasonably necessary or appropriate in connection with the administration of the Plan.
8. Make such administrative or technical amendments to the Plan as may be reasonably necessary or appropriate to carry out the intent of the Employer, including changing the funding arrangement or any other amendments as may be required or appropriate to satisfy the requirements of the Code and the rules and regulations from time to time in effect under any such laws, or to conform the Plan with other governmental regulations or policies.
9. Pay all reasonable and appropriate expenses in connection with the management and administration of the Plan including, but not limited to, premiums or other considerations payable under the Plan and fees and expenses of any actuary, accountant, legal counsel, or other specialist engaged by the Plan Administrator.

Delegation of Duties

The Plan Administrator has the power to delegate all or part of its duties to one or more third parties. The Plan Administrator has delegated its claims adjudication powers to the following entities:

Medical: Blue Cross Blue Shield of Arizona

Prescription Drug: MaxorPlus

Denta PPOl: Delta Dental of Arizona

Dental DHMO: Total Dental Administrators (TDA)

Vision: Vision Service Plan Insurance Company

Cafeteria Plan: The participating Employer sponsoring the plan

Finality of Decisions

The Plan Administrator shall have full power, authority and discretion to enforce, construe, interpret and administer the Plan. All decisions and determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on Covered Persons and all other interested parties.

Compensation and Bonding of Plan Administrator

Unless otherwise agreed to by the Employer, the Plan Administrator shall serve without compensation for services as such, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid by the Employer. Unless otherwise determined by the Employer or unless required by federal or state law, the Plan Administrator shall not be required to furnish bond or other security in any jurisdiction.

Liability Insurance

An Employer or the Plan Administrator may obtain errors and omissions insurance coverage at its expense that insures any of its employees serving as the Plan Administrator, or on a committee that is the Plan Administrator, against legal liability that may arise from such employees' performance of Plan administrative duties.

Reserved Powers

The Plan Administrator reserves the powers, among others:

1. To adopt the Plan.
2. To amend and terminate the Plan according to the Amendment, Termination, or Merger of Plan provisions contained herein.
3. To appoint and remove any claim administrator, Plan Administrator, third party administrator, or insurance company.

Power and Authority Insurance Company(ies) or Third Party Administrator(s)

Benefits under the Plan are provided through the following group policies:

Please refer to Appendix A for a list of all carriers and Component Benefit Plans.

In addition to the provisions outlined above, the insurance companies and/or the Plan Administrators are responsible for determining eligibility for and the amount of any benefits payable under their respective Component Benefit Plans and prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective Component Benefit Plans.

Please contact the participating Employer or the appropriate claim administrator, third party administrator, or insurance company if you have any questions regarding the Plan, your eligibility, or the amount of any benefit payable under a Component Benefit Plan.

PROCEDURES

See **Important Updates Regarding COVID-19 Relief – Tolling of Certain Plan Deadlines** in the section "Establishment of Plan; General Plan Information" for important updates regarding claims and appeals.

General Claims Procedures

Except as hereinafter provided, the provisions of this Section shall apply to every claim for a benefit under the Plan regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred.

These provisions shall not apply to the extent that claims and appeals procedures are set forth differently in a Component Benefit Plan or any associated documents. In addition, the provisions of this Section shall not be interpreted so as to override applicable state laws that are more protective of Covered Persons' rights with respect to claims and appeals.

Claims and Appeals for Self-Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits under the Component Benefit Plans provided through a self-insured benefit plan, the Plan Administrator and/or its delegate is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-insured arrangement.

To obtain benefits from a self-insured arrangement, the Covered Person must complete, execute, and submit to the Plan Administrator and/or its delegate a written claim on the form available from the Plan Administrator and/or its delegate. The Plan Administrator and/or its delegate has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide a claim.

The Plan Administrator and/or its delegate will decide a Covered Person's claim in accordance with reasonable claims procedures. If the Plan Administrator and/or its delegate denies a claim in whole or in part, then the Covered Person will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the Covered Person may appeal to the Plan Administrator and/or its delegate for a review of the denied claim. The Plan Administrator and/or its delegate will decide the appeal in accordance with reasonable claims procedures. If the Covered Person does not appeal on time, then the Covered Person may lose his or her right to file suit in a state or federal court, because he or she will not have exhausted the internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

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

See the documentation with respect to the applicable Component Benefit Plan among the applicable Attachments for more information about how to file a claim and appeal a denied claim, and for details regarding the claims procedures applicable to a claim.

Claims Deadline

Unless specifically provided otherwise in a Component Benefit Plan or pursuant to applicable law, a claim for benefits under this Plan (including the Component Benefit Plans) must be made within one year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the Covered Person or his or her designee to make sure this requirement is met.

Limitations Period for Filing Suit and Venue for Any Suit

Unless specifically provided otherwise in a Component Benefit Plan or pursuant to applicable law, a suit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedures. Any action, suit, or proceeding arising out of or relating to this Plan or any Component Benefit Plan shall be initiated and prosecuted in a state or federal court of competent jurisdiction located in Maricopa County, Arizona.

Legal Remedy

Before pursuing a legal remedy, a Claimant shall first exhaust all claims, review, and appeals procedures required under the Plan.

Other Party Liability Claims, Payment Condition, Subrogation and Other Matters

Other Party Liability:
This Section shall govern with respect to Plan benefits for injuries or illnesses of Covered Persons related to another party's actions or inactions. To the extent that conflicting subrogation or recovery provisions exist in an insurance contract or plan document which is a Component Benefit Plan, such provisions in the insurance contract or plan document shall govern.

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

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

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from

claiming reimbursement for charges incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

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

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

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

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

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

Participant is a Trustee over Plan Assets:
Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he 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 Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
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 Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved. No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability:
The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) ("incurred") prior to the liable party being released from liability. The Participant's/Participants' 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 Participant 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.

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

Wrongful Death:
In the event that the Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations:
It is the Participant's/Participants' 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 sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.

5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
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 Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or 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 Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

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

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

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.

Payment Procedures

Payment of Claim:
Subject to the No Assignment of Benefits provision, benefits shall be payable to the Claimant upon establishment of the right thereto. Notwithstanding the foregoing, if a Claimant is adjudicated bankrupt or purports to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge any benefit payable under the Plan, voluntarily or involuntarily, the Plan Administrator and/or its delegate, in its sole discretion, may hold or cause to be held, or apply such payment of benefit, or any part thereof, to or for the benefit of such Claimant as the Plan Administrator and/or its delegate deems appropriate.

Facility of Payment:
If a Claimant dies before all amounts payable under the Plan have been paid, or if the Plan Administrator and/or its delegate determines that the Claimant is a minor or is incompetent or incapable of executing a valid receipt and no guardian or legal representative has been appointed, or if the Claimant fails to provide the Plan with a forwarding address, the amount otherwise payable to the Claimant may be paid to any other person or institution reasonably determined by the Plan Administrator and/or its delegate to be entitled

equitably thereto and without prejudice therefor. Any payment made in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

Unclaimed Self-Insured Plan Funds:
In the event a benefits check issued by a claim administrator, third party administrator, or insurance company for a self-insured Component Benefit Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to the applicable Component Benefit Plan and applied to the payment of current benefits and administrative fees under the Component Benefit Plan. In the event a Covered Person subsequently requests payment with respect to the voided check, the claim administrator, third party administrator, or insurance company for the self-insured Component Benefit Plan shall make such payment under the terms and provisions of the Component Benefit Plan as in effect when the claim was originally processed. Unclaimed self-insured Component Benefit Plan funds may be applied only to the payment of benefits (including administrative fees) under the Component Benefit Plan pursuant to any applicable State law(s).

MISCELLANEOUS

No Employment Rights

The Plan is a voluntary undertaking of the Employer and does not constitute a contract with any person. The Plan is not an inducement or condition of an Employee's employment with any Employer. Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any Employee or any other person, any legal or equitable rights against his or her Employer or their shareholders, directors, officers, employees or agents, or as giving any person the right to be retained in the employ of the Employer.

Exclusive Rights

No individual shall have a right to benefits under the Plan except as specified herein; and in no event shall any right to benefits under the Plan be or become vested.

No Property Rights

No one has any right, title, or interest in the property of the Employer by virtue of the Plan, nor is any person entitled to interest on any benefit amounts that may be allocated or available to him or her.

No Assignment of Benefits

Except as provided in the Procedures Section, benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void. Notwithstanding the foregoing, a Covered Person may direct, in writing, that benefits payable to him or her be paid instead to an institution in which he or she is or was hospitalized, to a provider of medical, dental, or vision services or supplies furnished or to be furnished to him or her, or to a person or entity that has provided or paid for, or agreed to provide or pay for, any benefits payable under the Plan. The Plan reserves the right to make payment directly to the Covered Person. No payment by the Plan pursuant to such direction and assignment shall be considered as recognition by the Plan of a duty or obligation to pay a provider of medical, dental, or vision services or supplies except to the extent the Plan actually chooses to do so.

Right to Offset Future Payments

In the event a payment or the amount of a payment is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous or excess payment. This right to offset shall not limit the right of the Plan to recover an erroneous or excess payment in any other manner.

Right to Recover Payments

Whenever a payment has been made by the Plan, including erroneous payments, in a total amount in excess of the amount payable under the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from the person to or for whom the payment was made.

Misrepresentation or Fraud

A Covered Person who receives benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator shall decide such matters on a case by case basis.

Legal Action

Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan must first exhaust the Plan's claim, review, and appeal procedures. Unless otherwise provided by law, the

Employer and the Plan Administrator are the only necessary parties to any action or proceeding that involves the Plan or its administration. No Employee, Employer, or other person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.

No action at law or in equity in any court or agency shall be brought to recover benefits under the Plan prior to the exhaustion of the claims and appeals procedures set forth in the Procedures Section, nor may an action be brought after the time limits set forth in the provision entitled, "Limitations Period for Filing Suit and Venue for Any Suit".

Governing Law and Venue

The provisions of the Plan shall be administered, and all questions pertaining to the validity or construction of the Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable federal law and, to the extent not preempted, the laws of the State of Arizona. Any action, suit, or proceeding arising out of or relating to this Plan or any Component Benefit Plan shall be initiated and prosecuted in a state or federal court of competent jurisdiction located in Maricopa County, Arizona.

Governing Instrument

This document, together with the documentation incorporated by reference into it, is the legal instrument governing the Plan.

Savings Clause

If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

Captions and Headings

The captions and headings of a Section or provision of the Plan are for convenience and reference only and are not to be considered in interpreting the terms and conditions of the Plan.

Word Usage

Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

Notices

No notice or communication in connection with the Plan made by a Claimant, an Employee, or a Covered Person shall be effective unless duly executed on a form provided or approved by, and filed with, the appropriate Plan Administrator (or his or her representative).

Waiver

No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in a writing signed by the party to be charged. No written waiver shall be deemed a continuing waiver unless so specifically stated in the writing, and only for the stated period, and such waiver shall operate only as to the specific term, condition, or provision waived.

Parties' Reliance

The Employer, a claim administrator, the Plan Administrator, a third party administrator(s), an insurance company(ies), and anyone to whom the Plan's operation or administration is delegated may rely conclusively on any advice, opinion, valuation, or other information furnished by any actuary, accountant, appraiser, legal counsel, or physician the Plan engages or employs. A good faith action or omission based on this reliance

is binding on all parties, and no liability can be incurred for it except as the law requires. No liability shall be incurred for any other action or omission of the Employer or their employees, except for willful misconduct or willful breach of duty to the Plan.

Disclaimer

The Employer and Plan Administrator make no assertion or warranty about:

1. Health care services and supplies that Covered Persons obtain reimbursement for as Plan benefits, or
2. Whether Plan benefits will be excludable from a covered Person's gross income for federal or state income tax purposes.

Expenses

All expenses of the Plan shall be paid from Employee contributions or by the Plan, unless otherwise paid by the Employer. The Employer may advance expenses to the Plan, subject to reimbursement, without obligating itself to pay such expenses.

Indemnification

NOTE: This provision applies to each individual participating Employer and the Employees enrolled in their plan(s). The Employer, to the extent permitted by law, shall indemnify and hold harmless any employee, officer, or shareholder of the Employer from and against all loss, damages, liability and reasonable costs and expenses incurred in carrying out his or her responsibilities under the Plan, unless due to the bad faith or willful misconduct of such person, provided that such individual's attorney's fees and any amount paid in settlement shall be approved by the Employer.

AMENDMENT, TERMINATION OR MERGER OF PLAN

Right to Amend the Plan

Except as provided in this Section, the Plan Administrator reserves the unlimited right to amend the Plan in any way. Any amendment to the Plan shall be in writing and shall be adopted by the Plan Administrator in accordance with its normal procedures. However, the Plan Administrator shall have the authority to amend the Plan to comply with applicable law or regulation or to reflect the Plan Administrator's intent.

Right to Terminate or Merge the Plan

Notwithstanding that the Plan is established with the intention that it be maintained indefinitely, the Plan Administrator reserves the unlimited right to terminate or merge the Plan. Any decision to terminate or merge the Plan shall be in writing and shall be adopted by the Plan Administrator in accordance with its normal procedures.

Effect of Amendment, Termination or Merger

Any amendment, termination or merger of the Plan shall be effective at such date as the Plan Administrator shall determine except that no amendment, termination or merger shall reduce benefits payable for covered expenses incurred prior to the later of the date the amendment, termination or merger is effective or adopted, except as required or permitted by law.

Change in Funding Mechanism

The Plan Administrator reserves the unlimited right to change, modify, cancel or otherwise terminate any of the funding arrangements available under the Contributions, Funding and Plan Assets Section, including, by way of example and not by way of limitation, the right to change insurance carriers and the right to provide previously insured benefits on a partially insured or fully uninsured basis.

HIPAA PRIVACY

NOTE: For purposes of this section, the term "Plan Sponsor" will mean, when required by applicable law, an applicable participating Employer.

The Plan provides each Covered Person with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Covered Person's personal health information. It also describes certain rights the Covered Person has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling (888) 331-0222.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Covered Persons. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Covered Person's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Covered Person's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.
6. Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information.
3. Other Covered Entities: The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes.
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. Disclosures to Covered Persons: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic

violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Covered Person.

2. Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Covered Person's Rights

The Covered Person has the following rights regarding PHI about him/her:

1. Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Covered Person has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Covered Person is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Officer.
5. Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Covered Person wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must be clearly identified. The Plan must respond to the Covered Person's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.
6. Amendment: The Covered Person has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.

   Other uses and disclosures not described in this section can only be made with authorization from the Covered Person. The Covered Person may revoke this authorization at any time.

Questions or Complaints

If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan

using the following information. The Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:
Privacy Officer
Kairos Health Arizona, Inc.
333 E. Osborn Road, Ste. 300
Phoenix, AZ 85012
Phone: (888) 331-0222
Website: www.svc.kairoshealthaz.org

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
        ii. Individuals described in Appendix B.
        iii. Information Technology Department.
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the Plan Sponsor
The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

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

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance
In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Covered Person's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Any terms not otherwise defined in this Section shall have the meanings set forth in the Security Standards.

APPENDIX A - APPLICABLE COMPONENT BENEFIT PLANS

All of the following attachments to this Plan may be obtained from the Plan Administrator upon written request, at no charge:

Medical Benefits/Prescription Drug Benefits and their corresponding Summaries of Benefits and Coverage (SBC) and benefit grids (5 Plan Options):

Plan Name: $500 Core Plan
Plan Effective Date: July 1, 2017
Funding: Self-Insured
Third Party Administrator: BlueCross BlueShield of Arizona
Phone: (844) 817–4116
Website: https://www.azblue.com/individualsandfamilies
Name of document containing Plan description: Kairos Health Arizona, Inc. BCBSAZ PPO Core $500/80% Benefit Plan

Pharmacy Benefit Manager: MaxorPlus
Phone: (800) 687-0707
Website: https://maxorplus.com

Appeal and Grievance Process:

For information on the Member Appeal and Grievance Process, please visit: https://www.azblue.com/~/media/azblue/files/about/standardappealpacket.pdf?la=en

Precertification/Prior Authorization Requirements:

BCBSAZ may change the services that require precertification at any time without providing notice. Please go to https://www.azblue.com/individualsandfamilies for a current listing of services that require precertification or call the Customer Service number listed above.

'MaxorPlus' list of medications requiring a prior authorization may change at any time without providing notice. Please go to www.maxorplus.com for a current list of medications that require a prior authorization or call the MaxorPlus customer service number (800) 687-0707.

Plan Name: $750 Copay Plan
Plan Effective Date: July 1, 2017
Funding: Self-Insured
Third Party Administrator: BlueCross BlueShield of Arizona
Phone: (844) 817–4116
Website: https://www.azblue.com/individualsandfamilies
Name of document containing Plan description: Kairos Health Arizona, Inc. BCBSAZ PPO Copay $750/80% Benefit Plan

Pharmacy Benefit Manager: MaxorPlus
Phone: (800) 687-0707
Website: https://maxorplus.com

Appeal and Grievance Process:

For information on the Member Appeal and Grievance Process, please visit: https://www.azblue.com/~/media/azblue/files/about/standardappealpacket.pdf?la=en

Precertification/Prior Authorization Requirements:

BCBSAZ may change the services that require precertification at any time without providing notice. Please go to https://www.azblue.com/individualsandfamilies for a current listing of services that require precertification or call the Customer Service number listed above.

'MaxorPlus' list of medications requiring a prior authorization may change at any time without providing notice. Please go to www.maxorplus.com for a current list of medications that require a prior authorization or call the MaxorPlus customer service number (800) 687-0707.

Plan Name: $1,500 High Deductible Health Plan
Plan Effective Date: July 1, 2017
Funding: Self-Insured
Third Party Administrator: BlueCross BlueShield of Arizona
Phone: (844) 817–4116
Website: https://www.azblue.com/individualsandfamilies
Name of document containing Plan description: Kairos Health Arizona, Inc. BCBSAZ HDHP $1,500/80% Benefit Plan

Pharmacy Benefit Manager: MaxorPlus
Phone: (800) 687-0707
Website: https://maxorplus.com

Appeal and Grievance Process:

For information on the Member Appeal and Grievance Process, please visit: https://www.azblue.com/~/media/azblue/files/about/standardappealpacket.pdf?la=en

Precertification/Prior Authorization Requirements:

BCBSAZ may change the services that require precertification at any time without providing notice. Please go to https://www.azblue.com/individualsandfamilies for a current listing of services that require precertification or call the Customer Service number listed above.

'MaxorPlus' list of medications requiring a prior authorization may change at any time without providing notice. Please go to www.maxorplus.com for a current list of medications that require a prior authorization or call the MaxorPlus customer service number (800) 687-0707.

Plan Name: $2,500 High Deductible Health Plan
Plan Effective Date: July 1, 2017
Funding: Self-Insured
Third Party Administrator: BlueCross BlueShield of Arizona
Phone: (844) 817–4116
Website: https://www.azblue.com/individualsandfamilies
Name of document containing Plan description: Kairos Health Arizona, Inc. BCBSAZ HDHP $2,500/80% Benefit Plan
Pharmacy Benefit Manager: MaxorPlus
Phone: (800) 687-0707
Website: https://maxorplus.com

Appeal and Grievance Process:

For information on the Member Appeal and Grievance Process, please visit: https://www.azblue.com/~/media/azblue/files/about/standardappealpacket.pdf?la=en

Precertification/Prior Authorization Requirements:

BCBSAZ may change the services that require precertification at any time without providing notice. Please go to https://www.azblue.com/individualsandfamilies for a current listing of services that require precertification or call the Customer Service number listed above.

'MaxorPlus' list of medications requiring a prior authorization may change at any time without providing notice. Please go to www.maxorplus.com for a current list of medications that require a prior authorization or call the MaxorPlus customer service number (800) 687-0707.

Plan Name: $5,000 High Deductible Health Plan
Plan Effective Date: July 1, 2017
Funding: Self-Insured
Third Party Administrator: BlueCross BlueShield of Arizona
Phone: (844) 817–4116
Website: https://www.azblue.com/individualsandfamilies
Name of document containing Plan description: Kairos Health Arizona, Inc. BCBSAZ HDHP $5,000/80% Benefit Plan

Pharmacy Benefit Manager: MaxorPlus
Phone: (800) 687-0707
Website: https://maxorplus.com

Appeal and Grievance Process:

For information on the Member Appeal and Grievance Process, please visit: https://www.azblue.com/~/media/azblue/files/about/standardappealpacket.pdf?la=en

Precertification/Prior Authorization Requirements:

BCBSAZ may change the services that require precertification at any time without providing notice. Please go to https://www.azblue.com/individualsandfamilies for a current listing of services that require precertification or call the Customer Service number listed above.

'MaxorPlus' list of medications requiring a prior authorization may change at any time without providing notice. Please go to www.maxorplus.com for a current list of medications that require a prior authorization or call the MaxorPlus customer service number (800) 687-0707.

PPO Dental Benefits:
Plan Name: Select Plan
Plan Effective Date: July 1, 2017
Group Number: 050330001
Funding: Self-Insured
Third Party Administrator: Delta Dental
Phone: (800) 352-6132
Website: http://deltadentalaz.com/member/
Name of document containing Plan description: Summary of Benefits Delta Dental of Arizona, Inc. Employer Group Dental Contract Select Plan

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Employer Dental DHMO Plan:
Plan Name: Summit Care Plus Plan
Plan Effective Date: July 1, 2017
Funding: Fully Insured
Carrier: Total Dental Administrators
Phone: (888) 422-1995
Website: www.tda.dental.com/members
Name of document containing Plan description: Summit Care Plus Plan Summary

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Employer Vision Service Plan:
Plan Name: VSP Vision Plan
Plan Effective Date: July 1, 2018
Group Number: 30082772
Third Party Administrator: Vision Service Plan (VSP)
Phone: (800) 877-7195
Website: www.vsp.com
Name of document containing Plan description: VSP Certificate of Coverage

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Cafeteria Plan:
Each participating Employer has adopted its own Cafeteria Plan. Questions about the benefits under such plan should be addressed to the participating Employer.

Pre-tax contributions are available for:
Each participating Employer has adopted its own Cafeteria Plan. Information regarding benefits under such plan, specifically which benefits are subject to pre-tax contributions should be reviewed and confirmed within the Cafeteria plan.
NOTE: This Appendix A shall be subject to modification without formal amendment of the Plan.

APPENDIX B - EMPLOYEES OF THE EMPLOYER APPROVED TO HAVE ACCESS TO PROTECTED HEALTH INFORMATION

NOTE: Each Employer can designate its own list of Employees and/or Employees in certain departments that have access to Protected Health Information (PHI). Contact the participating Employer for a list of these Employees/departments.

APPENDIX C - PARTICIPATING EMPLOYERS

Name of Entity	BCBSAZ Group Numbers
Arizona Fire and Medical Authority	42133
Arlington Elementary School District	42141
Beaver Creek Unified School District	42147
Blue Ridge Fire District	42135
Blue Ridge Unified School District	42143
Bullhead City Elementary School District	42162
Casa Grande Union High School District	42145
Central Arizona Fire & Medical Authority	42102
Chino Valley Unified School District	42150
City of Cottonwood	42103
City of Sedona	42104
Clarkdale Jerome School District	42106
Colorado River Union High School District	42163
Copper Canyon Fire & Medical Authority	42101
Cottonwood-Oak Creek School District #6	42107
Desert Hills Fire District	42105
Double Adobe Elementary School District	42149
East Valley Institute of Technology	42126
Florence Unified School District	42139
Fredonia-Moccasin Elementary	42164
Golden Valley Fire District	42165
Highlands Fire District	42108
Humboldt Unified School District	42161
Kingman Unified School District	42144
Miami Unified School District	42142
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Pearce Elementary School District	42155
Picacho Elementary School District	42166
Pima County JTED #11	42111
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Pinetop Lakeside Sanitary District	42113
Prescott Unified School District	42159
Queen Creek Unified School District	42140
Safford Unified School District	42160
San Carlos Unified School District	42127
San Simon Unified School District	42167

Name of Entity	BCBSAZ Group Numbers
Sedona-Oak Creek Unified School District #9	42115
Sedona Fire District	29114
Show Low Unified School District	42154
Sierra Vista Unified School District	42157
St. Johns Unified School District	42124
Stanfield Elementary School District	42153
Summit Fire & Medical District	42125
Superior Unified School District	42151
Toltec Elementary School District	42168
Topock Elementary School	42130
Town of Camp Verde	42116
Town of Cave Creek	42123
Town of Clarkdale	42117
Town of Fredonia	42138
Town of Gila Bend	42137
Town of Jerome	42118
Town of Payson	42119
Town of Pima	42132
Town of Pinetop Lakeside	42120
Union Elementary School District #62	42131
Valley Academy for Career and Technology Education	42152
Valley Union High School	42148
Verde Valley Fire District	42121
Willcox Unified School District	42122

NOTE: This Appendix C shall be subject to modification without formal amendment of the Plan.

Kairos Health Arizona, Inc. – Pool
PPO –Copay 750

Plan Year Benefits for: 2020-2021	
All Essential Health Benefits	Unlimited

	In-Network Benefit	Out-of-Network Benefit
Deductible Individual Individual +1 Individual +2 or more	 $750 $1,500 $2,250	 $1,500 $3,000 $4,500
Note: *If you have other family members on the Plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.*		
Payment Level (unless otherwise stated)	80%	50%
Maximum Out-of-Pocket Individual Family Unit	 $5,000 $10,000	 N/A N/A
Note: *If you have other family members on the Plan, each family member must meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.* *The maximum out-of-pocket includes the deductible, coinsurance and copayments. The maximum out-of-pocket limit does not include amounts above a benefit maximum, any amounts for balance billing, any amounts for non-covered services, and any charges for lack of precertification.*		

Covered Medical Expenses	In-Network Benefit	Out-of-Network Benefit	Limits
Acupuncture	80% after deductible	50% after deductible	Limited to 8 visits per member per Plan Year.
Allergy Services Office Visit Injections Serum	PCP – $20 copay Specialist – $40 copay	50% after deductible	All other services subject to applicable coinsurance after deductible.
Ambulance	80% after deductible		
Ambulatory Surgical Center	80% after deductible	50% after deductible	
Anesthesia	80% after deductible	50% after deductible	
Behavioral and Mental Health (including chemical dependency or substance abuse) Inpatient Treatment Outpatient Treatment	80% after deductible $20 copay	50% after deductible	Precertification is required for Inpatient.
Birthing Center	80% after deductible	50% after deductible	
Blood & Plasma	80% after deductible	50% after deductible	
Chemotherapy	80% after deductible	50% after deductible	

NOTE: *This benefit grid is intended only as a brief summary of your plan benefits. If there is a conflict between this grid and the wording of plan documents and accompanying component benefit plans, those documents will govern.*

Chiropractic Care	80% after deductible	50% after deductible	Limited to 12 visits per member per Plan Year.
Cochlear Implants	80% after deductible	50% after deductible	
Dialysis	80% after deductible	50% after deductible	
Diagnostic Testing (COVID-19)	100%; Deductible waived	100%; Deductible waived	Limited to two antibody tests. Any subsequent tests must be deemed medically necessary. Tests must be ordered by a provider (MD/DO, NP, PA, Pharmacist).
Durable Medical Equipment	80% after deductible	50% after deductible	Limited to 1 breast pump and breast pump supplies per member per Plan Year. Cost share waived for 1 breast pump and supplies whether In-Network of Out-of-Network.
EAR (Extended Active Rehabilitation) Facility	80% after deductible	50% after deductible	Limited to 60 days per Plan Year. Precertification is required. This limit does not apply for services submitted with a primary mental health or substance abuse diagnosis.
Emergency Room Care	80% after deductible		
Gene Therapy	80% after deductible	Not Covered	Precertification required. Limited to Cellular Immunotherapy only. Services must be performed at a Blue Distinction Center. Travel and lodging is limited to a maximum of $10,000 per member, per lifetime.
Glaucoma, Cataract Surgery and Lenses	80% after deductible	50% after deductible	Limited to one set.
Habilitative Services	80% after deductible	50% after deductible	
Home Health Care	80% after deductible	50% after deductible	Limited to 6 hours of care per member per day.
Hospice Care	80% after deductible	50% after deductible	
Hospital Inpatient Treatment Outpatient Treatment	80% after deductible	50% after deductible	Precertification is required for Inpatient. $500 charge if no precertification for out-of-network stay.

NOTE: *This benefit grid is intended only as a brief summary of your plan benefits. If there is a conflict between this grid and the wording of plan documents and accompanying component benefit plans, those documents will govern.*

Long-Term Acute Care (LTAC)	80% after deductible	50% after deductible	Precertification is required. Limited to 60 days per Plan Year. This limit does not apply for services submitted with a primary mental health or substance abuse diagnosis.
Maternity Expenses Office Visit	80% after deductible, except first prenatal visit subject to copay	50% after deductible	Copays apply to physician visits; deductible applies to all covered services outside of physician's office.
Childbirth delivery – Professional Services Childbirth delivery – Facility Services	80% after deductible		
Newborn Care	80% after deductible	50% after deductible	
Nutritional Counseling and Training	100%; Deductible waived	50% after deductible	Limited to six (6) nutritional counseling and training visits per member, per year. Available for members diagnosed with one or more of the following conditions: Cardiovascular Disease, Coronary Artery Disease, Diabetes, Eating Disorders, Food Allergies, Gastrointestinal Disorders, Heart Failure, High Cholesterol, Hypertension, Mental Health and Substance Abuse Disorders, Obesity, Pre-Diabetes, and Renal Failure/Disease.
Outpatient Diagnostic X-ray and Lab	80% after deductible	50% after deductible	
Physician Services Primary Care Specialist	$20 copay $40 copay	50% after deductible	

NOTE: *This benefit grid is intended only as a brief summary of your plan benefits. If there is a conflict between this grid and the wording of plan documents and accompanying component benefit plans, those documents will govern.*

Kairos Health Arizona, Inc. – Pool
PPO –Copay 750

Preventive Care Well Adult Care Routine Physical Exam Mammograms Pap Smears Routine Immunizations Well Child Care Exam Immunizations	100%; Deductible waived	50% after deductible	For a more comprehensive listing see BCBSAZ benefit booklet.
Prosthetics, Orthotics, Supplies and Surgical Dressings	80% after deductible	50% after deductible	Prosthetics and orthotics limited to 1 pair per year.
Radiation Therapy	80% after deductible	50% after deductible	
Skilled Nursing Facility	80% after deductible	50% after deductible	Limited to 60 days per Plan Year. This limit does not apply for services submitted with a primary mental health or substance abuse diagnosis.
Surgery	80% after deductible	50% after deductible	
Telehealth Consultations (BlueCare Anywhere)	100%; Deductible waived	Not covered	
Telemedicine Services	80% after deductible	50% after deductible	
Therapy Services Autism Spectrum Disorder Treatment Cardiac Therapy Occupational Therapy Physical Therapy Pulmonary Therapy Speech Therapy	80% after deductible	50% after deductible	Occupational Therapy, Physical Therapy, and Speech Therapy are limited to 60 combined visits per Plan Year.
Transplants	80% after deductible	Not Covered	Precertification is required. Services must be performed at a Blue Distinction Center. Travel and lodging limited to a maximum of $10,000 per member, per transplant.
Urgent Care	$40 copay	50% after deductible	
Wigs	80% after deductible	50% after deductible	
All Other Covered Services	80% after deductible	50% after deductible	

NOTE: *This benefit grid is intended only as a brief summary of your plan benefits. If there is a conflict between this grid and the wording of plan documents and accompanying component benefit plans, those documents will govern.*

Kairos Health Arizona, Inc. – Pool
PPO –Copay 750

Covered Prescription Drug Expenses:	In-Network Pharmacy	Out-of- Network Pharmacy
Pharmacy Option 30 day supply:		
Generic	$10 copay	
Preferred	30% ($35 maximum)	
Non-Preferred	50% ($75 maximum)	
Pharmacy Option 90 day supply:		
Generic	$25 copay	Not covered
Preferred	$50 copay	Not covered
Non-Preferred	$90 copay	Not covered
Mail Order Option 90 day supply:		
Generic	$25 copay	Not covered
Preferred	$50 copay	Not covered
Non-Preferred	$90 copay	Not covered
Specialty Drug Option (Precertification is required):		
Specialty	50% ($75 maximum) after deductible	Not covered

NOTE: *This benefit grid is intended only as a brief summary of your plan benefits. If there is a conflict between this grid and the wording of plan documents and accompanying component benefit plans, those documents will govern.*

PPO Design

PPO Copay $750/80%

Benefit Book

Kairos Health Arizona, Inc.

Effective July 1, 2020

azblue.com

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

21324 0720

Kairos Health Arizona, Inc.
PPO Copay $750/80% Benefit Plan

Your employer sponsors a self-funded Employee Health Care Plan ("the Plan") to provide its employees with healthcare coverage. The Plan is established by your employer and is maintained pursuant to a written document called a Plan Document.

Your employer has contracted with Blue Cross® Blue Shield® of Arizona ("BCBSAZ") to provide certain administrative claims processing and utilization management services for this Preferred Provider Organization (PPO) benefit plan. Benefits under the Plan are paid from the general assets of the Plan Sponsor*. BCBSAZ, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

BCBSAZ is an independent contractor and shall not for any purpose be deemed an agent of your employer or the employer's Plan Administrator*, nor shall BCBSAZ and your employer be deemed partners, joint venturers or governed by any legal relationship other than that of independent contractor. In this book, BCBSAZ refers to the administrative services agreement and/or stop loss insurance agreement with your employer as a group master contract.

This benefit book describes the benefits for employees and their dependents that are eligible for and have elected coverage, under the PPO benefit plan. BCBSAZ may distribute a similar benefit book for insured employer groups and self-funded employer groups. This book by itself is not your employer's Summary Plan Description or a Plan Document.

This PPO benefit plan gives you access to a network of providers that have agreed to negotiated discounts with BCBSAZ or a local Blue Cross and/or Blue Shield plan if covered services are rendered outside of Arizona.

Please note: Not all services are covered. As this is a self-funded employer healthcare plan, benefits provided in this PPO plan may not include all benefits required for those healthcare plans which are not self-funded. Read this benefit book carefully to understand the benefits and limitations of the PPO benefit plan.

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CUSTOMER SERVICE INFORMATION

You need to understand your health insurance benefits and the limitations on those benefits before you receive services. If you have any questions, please contact BCBSAZ at one of the phone numbers on the back of your ID card.

MyBlue℠

BCBSAZ also makes information available at www.azblue.com and you may wish to look there before calling. MyBlue is the member area on www.azblue.com that allows you to manage your health insurance plan from anywhere you have Internet access. Go to www.azblue.com/member for more information and to register for a MyBlue account. After you register for MyBlue, you can*:

View claims and benefits information
Track deductible, if applicable to your plan
Update account information
Verify enrollment status
Search for providers
Compare hospitals
Access HealthyBlue® – tools for a healthier life

*Access to MyBlue links and services will vary based on benefit plan type.

BCBSAZ Customer Service

Customer Service phone numbers for your plan are on the back of your member ID card.

Hours:	Monday through Friday, 6:00 a.m. to 6:00 p.m. MST (except holidays) All other services are available Monday through Friday, 8:00 a.m. to 4:30 p.m. MST (except holidays)
If you lose your ID card and need a replacement:	(800) 687-0707
Hearing Impaired (TDD):	(602) 864-4823
For assistance in Spanish (en Español):	(602) 864-4884
Mailing Address:	Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466

Provider Locator & Benefit Vendor Information

Getting care outside of Arizona:	Go to https://www.bcbs.com/ and click on the "Find a Doctor" drop down menu. Or, call us at the numbers listed on the back of your ID card.
Chiropractic Benefits Administrator (CBA)	(800) 678-9133
Pharmacy Benefit Customer Service	(800) 687-0707
Provider Network Status	Check the online provider directory at www.azblue.com or call BCBSAZ Customer Service at the numbers listed on your ID card
Telehealth Services Administrator (TSA):	Log in to MyBlue and click on the BlueCare Anywhere℠ link; download the BlueCare Anywhere app available on Google Play™ store or the App Store®; go to www.BlueCareAnywhereAZ.com; or call (844) 606-1612

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Claim Submissions

Mail New Claims to:	Blue Cross Blue Shield of Arizona, P.O. Box 2924, Phoenix, AZ 85062-2924
Mail claims for out-of-network services to:	Blue Cross Blue Shield of Arizona, P.O. Box 2924, Phoenix, AZ 85062-2924
Claims for Transplant Travel and Lodging:	Attention: Transplant Travel Claim Processor, Mail Stop: A223, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466
Claims for Services Received on a Cruise Ship:	Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466
Claims for Chiropractic Services:	Claims Administration, American Specialty Health Networks, Inc., P.O. Box 509001, San Diego, CA 92150-9001

Disputes

Medical Appeals and Grievances:	Call the Customer Service number on the back of your ID card.
Precertification Denial Appeals:	Call the Customer Service number on the back of your ID card.
Chiropractic Care Disputes:	Call the Chiropractic Care Customer Service number on the back of your ID card, or write: Appeals Coordinator, American Specialty Health Networks, Inc., P.O. Box 509001, San Diego, CA 92150-9001 Telephone (800) 678-9133; Fax (619) 209-6237

Social Media

Like us on Facebook: www.facebook.com/bcbsaz
Follow us on Twitter: www.twitter.com/bcbsaz
Email complaints and concerns to socialcares@azblue.com
Android™ and iPhone® phone users can download our mobile application on Google Play or the App Store.

Android is a trademark of Google LLC.
iPhone is a trademark of Apple Inc., registered in the U.S. and other countries.

DEFINITIONS

"Allowed amount" means the total amount of reimbursement allocated to a covered service and includes both the BCBSAZ payment and the member cost-share payment. BCBSAZ calculates Deductible and coinsurance based on the allowed amount, less any access fees or precertification charges. BCBSAZ uses the allowed amount to accumulate toward any out-of-pocket maximum that applies to the member's benefit plan. The allowed amount does not include any balance bills from noncontracted providers. The allowed amount is neither tied to, nor necessarily reflective of, the amounts providers in any given area usually charge for their services. If the allowed amount is based on a fee schedule, a change to the fee schedule may result in higher member cost share. The table below shows how BCBSAZ determines the allowed amount.

Type of Provider	Type of Claim	Basis for Allowed Amount
Providers contracted with BCBSAZ as Plan Network providers	Emergency and non-emergency	Lesser of the provider's billed charges or the applicable fee schedule, with adjustments for any negotiated contractual arrangements and certain claim editing procedures and pricing guidelines
Providers contracted with a vendor	Emergency and non-emergency	Generally, the lesser of the provider's billed charges or the vendor's fee schedule, with adjustments for any negotiated contractual arrangements
Providers contracted with another Blue Cross or Blue Shield Plan ("Host Blue")	Emergency and non-emergency	Lesser of the provider's billed charges or the price the Host Blue plan has negotiated with the provider
Noncontracted providers in Arizona, including Providers contracted with another BCBSAZ network but not as a Plan Network Provider for this Benefit Plan	Non-emergency claims and emergency ground ambulance claims	Lesser of the provider's billed charges or the applicable BCBSAZ fee schedule, with adjustments for certain claim editing procedures and pricing guidelines. For emergency ground ambulance claims, the allowed amount is based upon the ambulance provider's billed charges.
Noncontracted providers outside Arizona	Non-emergency claims and emergency ground ambulance claims	Lesser of the provider's Billed Charges or the amount the Host Blue would pay the nonparticipating Provider. In the event that the Host Blue has not established an amount it would pay the nonparticipating Provider, the Allowed Amount is based on the applicable fee schedule. For emergency ground ambulance claims, the Allowed Amount is based upon the ambulance provider's billed charges.
Noncontracted providers (in Arizona and out-of-state)	Emergency	The highest of the three following amounts, not to exceed Billed Charges: • The median in-network Provider negotiated rate for the Emergency Services furnished, • The amount for the Emergency Services calculated using the same method BCBSAZ generally uses to determine reimbursement for out-of-network services, or • The amount that would be paid by Medicare Part A or B.

"BCBSAZ" or "We" means Blue Cross Blue Shield of Arizona, when acting as the issuer of insurance coverage or as the administrator of a group benefit plan. Within this benefit book, "BCBSAZ" or "We" may also include contracted vendors, when a contracted vendor is performing functions on behalf of BCBSAZ.

Blue Cross® Blue Shield® of Arizona is an independent licensee of the Blue Cross and Blue Shield Association. BCBSAZ is a not-for-profit corporation organized under the laws of the state of Arizona as a hospital, medical, dental, and optometric services corporation and is authorized to operate a health care services organization as a line of business.

"Bariatric surgery" means a surgical procedure to promote weight loss for the treatment of morbid obesity. Bariatric surgery also includes any revisions to a bariatric surgical procedure.

"Benefit book" means this document.

"Benefit plan" means the document describing the benefits and terms of coverage that the sponsor of a group health plan provides to its group members and their Dependents. Your BCBSAZ plan includes this book and any SBC, your application for coverage, any plan that is issued to replace this plan and any rider,

amendment or modification to this plan, including but not limited to, any changes in deductible, coinsurance or copay amounts. **Changing deductible options within a product does not constitute a new plan.**

"Billed charges" means:

- For a provider that has a participation agreement governing the amount of reimbursement, the amount the provider routinely charges for a service;
- For a provider that has no participation agreement governing the amount of reimbursement, the lowest amount that the provider is willing to accept as payment for a service.

"**Blue Distinction**®" is a national designation awarded by Blue Cross Blue Shield (BCBS) Plans to recognize Providers that demonstrate expertise in delivering quality specialty care—safely, effectively, and cost-efficiently."

"Cancer Treatment Medications" mean prescription drugs and biologicals that are used to kill, slow or prevent the growth of cancerous cells.

"Chiropractic Benefits Administrator (CBA)" means the independent company that administers chiropractic benefits for BCBSAZ. The CBA develops and manages the BCBSAZ network of chiropractic providers, processes chiropractic claims, determines medical necessity and handles utilization management, grievances and appeals related to chiropractic services.

"Contract Holder" means the person to whom the benefit plan is issued. Any other person approved for coverage with the Contract Holder under this plan is a Dependent. Under group coverage, the Contract Holder is the member who is eligible for coverage because of his or her affiliation with a Group.

"Cosmetic" means surgery, procedures or treatment and other services performed primarily to enhance or improve appearance, including but not limited to, and except as otherwise required by state or federal law, those surgeries, procedures, treatments and other services performed in the absence of a functional impairment of a body part or organ as documented in the medical record, even if such services will improve emotional, psychological or mental condition or function.

"Cost-share" means the member's financial obligation for a covered service. Depending on the plan type, cost-share may include one or more of the following: deductible, copay, access fee, coinsurance, pharmacy deductible, and precertification charges.

"Custodial care" means health services and other related services that meet any one or more of the following criteria:

1. Are for comfort or convenience;
2. Do not seek to cure;
3. Are provided to support or assist with activities of daily living, including, for example, personal hygiene, nutrition or other self-care; **or**
4. Are provided when acute care is not required or do not require continued administration by licensed skilled medical personnel, such as a licensed practical nurse (LPN), registered nurse (RN), or licensed therapist.

"Diagnosis Related Grouping" or "DRG" means 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.

"Domiciliary Care" is a supervised living arrangement in a home-like environment for individuals who are unable to live independently and who need assistance with activities of daily living, such as bathing, dressing and food preparation.

"Evidence-based Criteria" means medical, pharmaceutical, dental, and administrative criteria, which are based on industry-standard research and technology. These criteria help BCBSAZ determine whether a Service, procedure, medical device, or drug meets the industry standard for medical necessity and/or is a covered benefit. Criteria may include prescription medication or service limitations. BCBSAZ ensures that Evidence-based Criteria is reviewed regularly and updated in response to changes and advancements in the healthcare industry. Decisions are based on the Evidence-based Criteria in effect at the time of Service. You can obtain additional information by calling the Customer Service number on your ID card. BCBSAZ

contracted vendor(s) may establish evidence-based criteria of their own for services the vendor provides or administers pursuant to the vendor's contract with BCBSAZ.

"FDA" means the federal Food and Drug Administration.

"Fee Schedules" mean proprietary schedules of provider fees compiled by BCBSAZ or BCBSAZ's contracted vendors. BCBSAZ or BCBSAZ's contracted vendors develop proprietary schedules of fees based on annual reviews of information from numerous sources, including, but not limited to: Medicare fee schedules from the Centers for Medicare and Medicaid Services (CMS), BCBSAZ's or the contracted vendor's historical claims experience, pricing information that may be available to BCBSAZ or the vendor, information and comments from providers and negotiated contractual arrangements with providers. **BCBSAZ and/or BCBSAZ's contracted vendors may change their Fee Schedules at any time without prior notice to members. If the allowed amount is based on a Fee Schedule, a change to the Fee Schedule may result in higher member cost-share.**

"Group" means the association, employer, trust, or other entity that sponsors the group benefit plan on behalf of its employees or participants.

"Group Master Contract" means the legal agreement between the Group and BCBSAZ.

"Member" or "You" means an individual, employee, participant or Dependent covered under a benefit plan.

"Pharmacy Coverage Guidelines" means pharmaceutical and administrative criteria that are developed from review of published peer-reviewed medical and pharmaceutical literature and other relevant information and are used to help determine whether a medication is eligible for benefits under the "Pharmacy Benefit." Pharmacy Coverage Guidelines are available by going to www.maxorplus.com. Guidelines are also available by calling the Pharmacy Benefit Customer Service number listed on your ID card.

"Physician," for purposes of classifying benefits and member cost-shares in this benefit plan, means a properly licensed MD, DO, DPM, or DC.

"Plan Network" means the network of Providers contracted to provide services to members of this Benefit Plan. Plan Network Providers are also referred to as in-network Providers. See your SBC and ID card for the name of the Plan Network for this Benefit Plan

"Precertification" is the process BCBSAZ uses to determine coverage for certain benefits.

"Primary Care Provider (PCP)" means a healthcare professional who is contracted with BCBSAZ as a PCP and generally specializes in or focuses on the following practice areas: internal medicine, family practice, general practice, pediatrics or any other classification of provider approved as a PCP by BCBSAZ. Your benefit plan does not require you to have a PCP or to have a PCP authorize specialist referrals.

"Provider" means any properly licensed, certified or registered person or facility furnishing medical care to you, such as a doctor, hospital, laboratory or other health professional.

"Rehabilitation Services" are services that help a person restore skills and functioning for daily living lost due to injury or illness.

"Respite Care" is the provision of short-term, temporary relief of the daily routine and stress to provide those who are caring for family members a personal break from their role as caregiver.

"Service" means a generic term referencing some type of healthcare treatment, test, procedure, supply, medication, technology, device or equipment.

"Specialist" means either a physician or other healthcare professional who practices in a specific area other than those practiced by primary care providers, or a properly licensed, certified or registered individual healthcare provider whose practice is limited to rendering mental health services. For purposes of cost-share, this definition of "specialist" does not apply to dentists. BCBSAZ does not require you to obtain an authorization or referral to see a specialist.

"Summary of Benefits and Coverage (SBC)" means a federally required document in a specified template with information on applicable copays, access fees, coinsurance percentages, deductible amounts, other

cost-sharing amounts, benefits, exclusions, limitations; and other important information. Please keep your current SBC with your benefit book.

“Telehealth Services” means medical and behavioral health services provided online via video using a computer, tablet, smartphone, or other mobile device through the Telehealth Services Administrator.

“Telehealth Services Administrator (TSA)” means Amwell Corporation, an independent company that is contracted with BCBSAZ to provide contracted providers, an interactive web platform allowing members to interact with providers, and technical support for telehealth services covered under this plan.

“Telemedicine Services” means Services delivered through interactive audio-video electronic media to treat certain covered conditions.

UNDERSTANDING THE BASICS

Your Responsibilities

Before you receive services:

- Read your benefit materials.
- Know your coverage.
- Know the limits and exclusions on coverage.
- Know how much cost-share you will have to pay.
- Check your provider's network status and know whether your provider is a network provider with BCBSAZ.

After you receive services:

- Read your explanation of benefits (EOB) and/or monthly health statements.
- Tell BCBSAZ if you see any differences between the member cost share on your claims documents and what you actually paid.

ID Card

Bring your ID card with you each time you seek healthcare services, and have your ID card available for reference when you contact BCBSAZ for information. Your ID card will include some basic information about your coverage:

- Who is covered (Contract Holder and Dependent names)
- Identification numbers
- Important phone numbers and addresses

Changes

You will be notified of any changes to this plan as required by law. You will be provided with sixty (60) days advance written notice of material modifications to this plan.

Covered Services

To be covered, a service must be all of the following:

- A benefit of this plan;
- Medically or dentally necessary as determined by BCBSAZ or BCBSAZ's contracted vendor(s);
- Not excluded under any provision of this plan;
- Not experimental or investigational as determined by BCBSAZ or BCBSAZ contracted vendor(s) (does not apply to covered services as part of an approved clinical trial);
- Precertified where required;
- Provided while this benefit plan is in effect and while the person claiming benefits is eligible for benefits; **and**
- Rendered by an eligible provider acting within the provider's scope of practice, as determined by BCBSAZ or BCBSAZ's contracted vendor(s).

Experimental or Investigational Services

BCBSAZ or BCBSAZ's contracted vendor, in its sole and absolute discretion, decides whether a service is experimental or investigational. A service is considered experimental or investigational unless it meets <u>all</u> of the following criteria:

- The service must have final approval from the appropriate governmental regulatory bodies if applicable;
- The scientific evidence must permit conclusions concerning the effect of the service on health outcomes;
- The service must improve the net health outcome;
- The service must be as beneficial as any established alternative; **and**
- The improvement resulting from the service must be attainable outside the investigational setting.

In addition to classifying a service as experimental or investigational using the above criteria, BCBSAZ or its contracted vendor may also classify the service as experimental or investigational if any one or more of the following apply:

- The service cannot be lawfully marketed or used without full (unrestricted) approval of appropriate governmental regulatory bodies and approval for marketing or use has not been given at the time the service is submitted for precertification or rendered;
- The provider rendering the service documents that the service is experimental or investigational; **or**
- Published reports and articles in authoritative (peer-reviewed) medical and scientific literature show that the prevailing opinion among experts is that further studies or clinical trials are necessary to determine maximum tolerated dose, toxicity, safety, appropriate selection, efficacy or efficacy as compared with the standard treatment for the diagnosis.

Medically Necessary

BCBSAZ, or BCBSAZ's contracted vendor, in its sole and absolute discretion, decides whether a service is medically necessary based on the following definition. A medically necessary service is a service that meets all of the following requirements:

- Is consistent with the diagnosis or treatment of a symptom, illness, disease or injury;
- Is not primarily for the convenience of a member or a provider;
- Is the most appropriate site, supply or service level that can safely be provided; **and**
- Meets BCBSAZ's or its contracted vendor, medical necessity guidelines and criteria in effect when the service is precertified or rendered. If no such guidelines or criteria are available, BCBSAZ or its contracted vendor will base its decision on the judgment and expertise of a medical professional or medical consultant retained by BCBSAZ or the vendor.

Medical Necessity Guidelines and Criteria

BCBSAZ uses Evidence-based Criteria to make medical necessity decisions. Call the Customer Service number on your ID card for additional information on Evidence-based Criteria.

Decisions about medical necessity may differ from your provider's opinion. A provider may prescribe, order, recommend or approve a service that BCBSAZ decides is not medically necessary and therefore is not a covered benefit. You and your provider should decide whether to proceed with a service that is not covered. Also, not all medically necessary services are covered benefits under this plan. All benefit plans have exclusions and limitations on what is covered. A service may be medically necessary and still excluded from coverage.

BCBSAZ contracts with vendors to administer some or all of the benefits covered under this plan. These contracted vendors make medical necessity determinations based on their own medical necessity criteria, which are also available to you on request.

PROVIDERS

Know your provider's network and eligibility status before you receive services.

Provider Directory

The BCBSAZ provider directory is available online at www.azblue.com. If you do not have Internet access, and would like to request a paper copy of the directory, or if you have any questions about a provider's network participation with BCBSAZ, please call Customer Service before you receive services.

Provider Eligibility and Network Status

To be **eligible** for coverage, a service must be rendered by an eligible individual provider acting within his or her scope of practice, and, when applicable, performed at an eligible facility that is licensed or certified for the type of procedure and services rendered.

Eligible Providers

Not all medical professionals are eligible providers. Eligible providers include the properly licensed, certified or registered providers listed below, when acting within the scope of their practice and license. Scope of practice is determined by the regulatory oversight agency for each health profession. It means the procedures, actions, and processes that a licensed or certified medical professional is legally allowed to perform based on the individual's specific education and experience, and demonstrated competency. For example, neurosurgery would not be within the scope of practice for a dentist.

Benefits may also be available from other healthcare professionals whose services are mandated by Arizona state law or federal law or who are accepted as eligible by BCBSAZ. The following are examples of ineligible providers: acupuncturists and doctors of naturopathy and homeopathy. Other provider types may also be ineligible. The fact that a service is rendered by an eligible provider does not mean that the service will be covered. Not all eligible providers are contracted to participate in BCBSAZ networks.

ELIGIBLE PROVIDER LIST	
Professional	**Facility Ancillary**
• Board Certified Applied Behavioral Analyst (BCABA) • Certified Registered Nurse First Assist (CRNFA) • Certified Nurse Midwife • Certified Registered Nurse Anesthetist (CRNA) • Doctor of chiropractic (DC) • Doctor of dental surgery (DDS) • Doctor of medical dentistry (DMD) • Doctor of medicine (MD) • Doctor of optometry (OD) • Doctor of osteopathy (DO) • Doctor of podiatry (DPM) • First Assist (FA) • Licensed clinical social worker • Licensed independent substance abuse counselor • Licensed marriage and family therapist • Licensed nurse practitioner (NP) • Licensed professional counselor • Perfusionist • Physician Assistant (PA) • Psychologist (PhD, EdD and PsyD) • Registered Dietician • Registered Nurse First Assist (RNFA) • Speech, occupational or physical therapist • Surgical Assist (SA) • Surgical Technician (ST)	• Ambulance • Ambulatory Surgical Center (ASC) • Audiology Center • Birthing Center • Clinical Laboratory • Diagnostic Radiology • Dialysis Center • Durable Medical Equipment (DME) • Extended Active Rehabilitation (EAR) • Home Health Agency (HHA) • Home Infusion Therapy • Hospice • Hospital, Acute Care • Hospital, Long-Term Acute Care (LTAC) • Hospital, Psychiatric • Orthotics/Prosthetics • Pain Management Clinics • Rehabilitation Treatment Centers (substance abuse centers) • Retail, mail order and specialty pharmacies • Skilled Nursing Facility • Sleep Lab • Specialty Laboratory • Urgent Care

Choosing a Provider

Your costs will be lower when you use an in-network provider. Before receiving scheduled services, verify the network status of all providers who will be involved in your care, such as assistant surgeons, anesthesiologists and radiologists, as well as the facility where the services will be performed.

Network Status

In-Network Providers (Contracted)

In-network providers are the following: (1) Except as noted in this benefit book, healthcare providers licensed in the United States who have a Plan Network contract with BCBSAZ (or with a vendor that has contracted with BCBSAZ to provide or administer services for members of this Benefit Plan); and (2) Except as noted in this benefit book, out-of-state healthcare providers licensed in the United States who have a PPO contract with a Blue Cross and/or Blue Shield plan other than BCBSAZ.

Except for Emergency Services, if the Provider submitting a laboratory, DME/medical supply, and/or air ambulance claim does not have a Plan Network contract with BCBSAZ (when the claim is submitted to BCBSAZ) or a PPO contract with the out-of-state Blue Cross and/or Blue Shield Plan to which the claim is submitted, the claim will be processed as an out-of-network claim**.** Members are responsible for out-of-network Cost Share and any applicable Balance Bill. See the *"Out-of-Network Providers"* section below.

Claims for services provided by independent clinical laboratory, durable medical equipment/medical supply and air ambulance providers are required to be filed as follows:

- Independent Clinical Laboratory: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the referring provider is located.

- Durable Medical Equipment/Medical Supplies: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state where the member resides.

- Air Ambulance: Claims must be filed with the Blue Cross and/or Blue Shield plan in the state of the member pickup location.

In-network providers will file your claims with BCBSAZ or the applicable out-of-state Blue Cross and/or Blue Shield plan. The provider's contract generally prohibits the provider from charging more than the allowed amount for covered services. However, when there is another source of payment, such as liability insurance, all providers may be entitled to collect their balance bill from the other source, or from proceeds received from the other source. The provider's contract does allow the provider to charge you up to the provider's billed charges for non-covered services. We recommend that you discuss costs with the provider before you obtain non-covered services. BCBSAZ and/or the out-of-state Blue Cross and/or Blue Shield plan directly reimburse in-network providers for your benefit plan's portion of the allowed amount for covered services. **You are responsible to pay your member cost-share directly to the provider.**

Except for emergencies, in-network providers must render covered services in the United States for the services to be considered in-network and subject to in-network member cost-share. If an in-network provider renders covered services outside the United States, the services will be considered out-of-network and subject to out-of-network member cost-share, including balance bills (except for emergencies).

Out-of-Network Providers (Contracted and Noncontracted)

Out-of-network providers are: (1) Providers who are contracted with a Host Blue plan as "Participating" only providers; (2) Providers who are contracted with BCBSAZ but do not have a Plan Network contract (such as BCBSAZ PPO-only Providers); (3) Eligible providers who have no contract with BCBSAZ or a Host Blue plan (Noncontracted providers); (4) Providers who are contracted with Blue Cross Blue Shield Global® Core; and (5) Providers who submit a laboratory, DME/medical supply, or air ambulance, claim to a Host Blue plan and do not have a PPO contract with that plan.

- **Participating-Only Providers**

  Participating-only providers are contracted with a Host Blue plan as "Participating" and are not contracted as PPO or Preferred providers. Participating-only providers are out-of-network providers. Participating-only providers will submit your claims to the Host Blue plan with which they are contracted. If you receive covered services from a Participating-only provider, you will pay out-of-network cost share and access fees. However, you will not have to pay the balance bill because the provider is contracted.

- **Noncontracted Providers**

Eligible providers who have no provider participation agreement with BCBSAZ or any Host Blue plan are noncontracted providers. Noncontracted providers are out-of-network providers.

If you receive covered services from an eligible noncontracted provider, you will pay out-of-network cost share, access fees, and the balance bill. Noncontracted providers may bill you up to their full billed charges. The difference between the noncontracted provider's billed charges and payment under this benefit plan may be substantial. Please check with the noncontracted provider regarding the amount of your financial responsibility before you receive services.

If you have an inpatient or an outpatient admission and both the facility and the primary provider are in-network, you pay in-network cost-share for services received from out-of-network providers.

Unless BCBSAZ agrees to pay the Provider directly, BCBSAZ will send payment to you for whatever benefits are covered under your plan, and you will be responsible for paying the out-of-network provider. A noncontracted provider will not receive a copy of your explanation of benefits (EOB) and will not know the amount this benefit plan paid you for the claim.

- **Providers Contracted with Blue Cross Blue Shield Global® Core**

  Providers who are contracted with Blue Cross Blue Shield Global Core are out-of-network providers. For covered services from these providers, you will pay out-of-network cost share and access fees (except for emergency services), plus the balance bill.

Eligible Provider Status and Payment – Summary Table Subject to all terms and conditions noted in this section.				
Provider Contract Status	**Network Status and Applicable Cost-Share**	**Provider Required to File Claim on Member's Behalf**	**Accept BCBSAZ Allowed Amount and Do Not Balance Bill**	**Payee for Reimbursement**
Providers contracted with BCBSAZ as Plan Network Providers*	In-network	Yes	Yes	BCBSAZ reimburses the **provider** the allowed amount, less any member cost-share
Providers contracted with another Blue Cross or Blue Shield Plan ("Host Blue") as PPO providers*	**In-network**	**Yes**	**Yes**	**The Host Blue, on behalf of BCBSAZ, reimburses the provider the allowed amount less any member cost-share**
Providers contracted with Host Blue as Participating only providers*	Out-of-network	Yes	Yes	The Host Blue, on behalf of BCBSAZ, reimburses the **provider** the allowed amount less any member cost-share
Providers contracted with Blue Cross Blue Shield Global Core	Out-of-network	Yes	No	Blue Cross Blue Shield Global Core reimburses the **provider** the allowed amount less any member cost-share
Noncontracted providers (in Arizona and out-of-state, including providers who are contracted with BCBSAZ but not for your Plan Network) (must be eligible providers)*	Out-of-network	No (provider may elect to do so as courtesy to member)	No. May charge up to full billed charges. Difference between billed charges and BCBSAZ member reimbursement may be substantial.	BCBSAZ reimburses the **member** the allowed amount, less any member cost-share. Provider does not get copy of member's EOB or know reimbursement amount.

Except as noted in this benefit book

Sample Differences in Financial Responsibility Based on Provider Choice

Out-of-pocket expenses can differ depending on the provider you choose. Your savings may vary depending on your benefit plan and your chosen provider. Please refer to your SBC for examples of potential financial responsibility that are specific to your benefit plan

Locating an In-Network Provider

Check the Plan Network Provider Directory at www.azblue.com to locate an in-network Provider who offers the Services you are seeking, and contact the Provider for an appointment. If you cannot get an appointment with an in-network Provider, contact Customer Service at the number on your ID card.

Precertifications for Out-of-Network Providers

BCBSAZ does not guarantee that every specialist or facility will be in your Plan Network. Not all providers will contract with health insurance plans. If you believe or have been told there is no in-network provider available to render covered services that you need, you may ask your treating provider to request precertification of in-network cost-share for services from an out-of-network provider. BCBSAZ will not issue this precertification if we find that an in-network provider is available to treat you. The section on precertification explains how to make this request.

Continuing Care from an Out-of-Network Provider

You may be able to receive benefits at the in-network level for services from an out-of-network provider, under the circumstances described below. Continuity of care benefits are subject to all other applicable provisions of your benefit plan. To request continuity of care, call the Customer Service number on your ID card.

Continuity of care only applies to otherwise covered services rendered by providers. Continuity of care is not available for facility services. If the hospital or other facility at which your provider practices is not an in-network facility, the out-of-network provisions of coverage will apply to covered facility services.

New Members	**Current Members**
A new member may continue an active course of treatment with an out-of-network physician during the transitional period after the member's effective date if: The member has: 1. A life-threatening disease or condition, in which case the transitional period is not more than thirty (30) days from the effective date of coverage; **or** 2. Entered the third trimester of pregnancy on the effective date of coverage, in which case the transitional period includes the covered physician services for the delivery and any care related to the delivery for up to six (6) weeks from the delivery date; **and**	A current member may continue an active course of treatment with an out-of-network physician if BCBSAZ terminates the physician from the network for reasons other than medical incompetence or unprofessional conduct if: The member has: 1. A life-threatening disease or condition, in which case the transitional period is not more than thirty (30) days from the effective date of the physician's termination; **or** 2. Entered the third trimester of pregnancy on the effective date of the physician's termination, in which case the transitional period includes the covered physician services for the delivery and any care related to the delivery for up to six (6) weeks from the delivery date; **and**
The member's physician agrees in writing to do all of the following: 1. Accept the BCBSAZ allowed amount applicable to covered services as if provided by an in-network physician, subject to the cost-share requirements of this benefit plan; 2. Provide BCBSAZ with any necessary medical information related to your care; **and** 3. Comply with BCBSAZ's policies and procedures, as applicable, including precertification, network referral, claims processing, quality assurance and utilization review.	

Out-of-Area Services

Overview

BCBSAZ has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association. Whenever you access healthcare services outside the geographic area BCBSAZ serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of BCBSAZ's service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield

Plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") do not contract with the Host Blue. We explain below how BCBSAZ pays both kinds of providers.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits (except when paid as medical claims/benefits), and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by BCBSAZ to provide the specific service or services. Vision care benefits are available through VSP, if elected.

BlueCard® Program

Under the BlueCard Program, when you receive covered services within the geographic area served by a Host Blue, BCBSAZ will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive covered services outside BCBSAZ's service area and the claim is processed through the BlueCard Program, the amount you pay for covered services is calculated based on the lower of:

- The billed charges for covered services; or
- The negotiated price that the Host Blue makes available to BCBSAZ.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSAZ has used for your claim because they will not be applied after a claim has already been paid.

Special Cases: Value-Based Programs

BlueCard Program

If you receive covered services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying the provider for any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to BCBSAZ through average pricing or fee schedule adjustments. Additional information is available upon request. Provider incentives, risk-sharing and care coordinator fees are incorporated into the premium and/or contribution percentage members pay for coverage.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured and/or self-funded accounts. If applicable, BCBSAZ will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside BCBSAZ's Service Area

1. Liability Calculation

When covered services are provided outside of BCBSAZ's service area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment BCBSAZ will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of- network Emergency Services.

2. Exceptions

In certain situations, BCBSAZ may use other payment methods, such as billed charges for covered services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount BCBSAZ will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment BCBSAZ will make for the covered services as set forth in this paragraph.

Blue Cross Blue Shield Global Core Program

If you are outside the United States (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core program when accessing covered services. Blue Cross Blue Shield Global Core program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core program assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Service Center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, 7 days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services:** In most cases, if you contact the Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claims to the Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered services. You must contact BCBSAZ to obtain precertification for non-emergency inpatient services.

- **Outpatient Services:** Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services.

- **Submitting A Blue Cross Blue Shield Global Core Claim:** When you pay for covered services outside the BlueCard service area, you must submit a claim to obtain reimbursement. for institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSAZ, the Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Service Center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, 7 days a week.

Services Received on Cruise Ships

If you receive healthcare services while on a cruise ship, you will pay in-network cost-share, and the allowed amount will be based on billed charges. A cruise ship claim is not considered an out-of-country claim. Claims should be submitted and processed through BCBSAZ, not through the Blue Cross Blue Shield Global Core program. Please call the BCBSAZ Customer Service number on the back of your ID card for more information, or mail copies of your receipts to the BCBSAZ general correspondence address listed at the front of this book.

PRECERTIFICATION

When Is Precertification Required

Not all services require precertification. Precertification is not required for Emergency Services or Urgent Care Services. If it is required, your treating provider must obtain it on your behalf before rendering services. Precertification may be required for services to be covered when provided in certain settings..

How to Obtain Precertification

Ask your treating provider to contact BCBSAZ for precertification before you receive services and medications that require precertification. Your provider must contact BCBSAZ because he or she has the information and medical records we need to make a benefit determination. BCBSAZ will rely on information supplied by your provider. If that information is inaccurate or incomplete, it may affect the decision on your request or claim.

Factors BCBSAZ Considers in Evaluating a Precertification Request for Services or Medications

- Applicability of other benefit plan provisions (limitations, exclusions and benefit maximums);
- If the treating provider is in-network;
- Whether the service is medically necessary or investigational;
- Whether the service is dispensed in the appropriate care setting; **and**
- Whether your coverage is active.

Some of these factors may not be readily identifiable at the time of precertification, but will still apply if discovered later in the claim process and could result in denial of your claim.

Prescription Medication Exception

If a covered medication requires precertification, but you must obtain the medication outside of BCBSAZ's precertification hours, you may have to pay the entire cost of the medication when it is dispensed. In such cases, you can file a reimbursement claim with BCBSAZ and have your treating provider request precertification on the next business day. Your claim for the medication will not be denied for lack of precertification, but all other exclusions and limitations of your plan will apply. Coverage is not guaranteed unless the prior authorization is completed.

Precertification of In-Network Cost-Share for Services from an Out-of-Network Provider

If there is no in-network provider available to deliver covered services, your treating provider may contact BCBSAZ and ask BCBSAZ to precertify the in-network cost-share for services from an out-of-network provider. BCBSAZ will evaluate whether there is an in-network alternative. If BCBSAZ determines that an in-network provider is available to treat you, BCBSAZ will not precertify in-network cost-share for services from your out-of-network provider of choice.

Precertification of in-network cost-share for services from an out-of-network provider is a process separate from precertification of services. If you want an out-of-network provider to render services that require precertification, and you also want to be eligible for the in-network cost-share, you must ensure that your provider makes two separate precertification requests: one for the service itself and one for use of the out-of-network provider. If BCBSAZ precertifies you for the in-network cost-share, your services will be subject to the in-network cost-share. You will still be responsible for any balance bill, plus your in-network cost-share.

If BCBSAZ Precertifies Your Service

- Except as otherwise required by applicable law, Precertification is not a pre-approval or a guarantee of payment. Precertification made in error by BCBSAZ is not a waiver of BCBSAZ’s right to deny payment for noncovered services.
- You and your provider will receive a letter explaining the scope of the precertification.

If BCBSAZ Denies Your Precertification Request

Denial of precertification is an adverse benefit determination. As explained in the next section on Claims, BCBSAZ will send you a notice explaining the reason for the denial, and your right to appeal the BCBSAZ decision. Information on where to file an appeal is in the BCBSAZ Appeal and Grievance Guidelines.

If your request for precertification of a service is denied because BCBSAZ decides that the service is not medically necessary, remember that BCBSAZ's interpretation of medical necessity is a benefits determination made in accordance with the provisions of this plan. Your provider may recommend services or treatment not covered under this plan. You and your provider should decide whether to proceed with the service or procedure if BCBSAZ denies precertification.

CLAIMS INFORMATION

Filing Claims

In most cases, in-network providers will file claims for you. Noncontracted providers may file your claims for you, but have no obligation to do so. Make sure you or your providers file all your claims so BCBSAZ can track your covered expenses and properly apply them toward applicable deductibles, coinsurance, out-of-pocket maximums and benefit maximums.

If you choose to pay a provider on a direct pay basis and submit a receipt to BCBSAZ, BCBSAZ will credit your deductibles and out-of-pocket maximums as required by applicable law. You must submit a receipt that includes the amount paid, the procedure and diagnosis codes for the services rendered and a notation indicating direct payment. If you choose to pay a contracted provider for a covered service on a direct pay basis, the provider will not submit the claim to BCBSAZ for processing under this benefit plan.

Time Limit for Claim Filing

A complete claim, as described below, must be filed within one year from the date of service. Any claim not filed with all required content within the one year period is an untimely claim. BCBSAZ will deny untimely claims from contracted providers based on the terms of the provider's contract. BCBSAZ will deny untimely claims from members except for the following situations:

- Medicare or another carrier was the primary payer on a claim where BCBSAZ was secondary payer, and the delay was caused by the need to coordinate benefits with the primary payer.
- The member can show good cause for delay. BCBSAZ determines good cause in its sole discretion. Examples of good cause:
    - BCBSAZ gave the member wrong information about the filing date;
    - The member had an extended illness that prevented the member from filing the claim; or
    - Other similar situations outside the member's reasonable control.

Complete Claims

Claim forms are available from BCBSAZ. Go to the "Forms" section of the "Member" area of www.azblue.com or call the Customer Service number on your ID card. BCBSAZ may reject claims that are filed without complete information needed for processing. If BCBSAZ rejects a submitted claim due to lack of information, BCBSAZ will notify you or the provider who submitted the claim. Lack of complete information may also delay processing. A complete claim includes, at a minimum, the following information:

- Billed charges
- Date of service(s)
- Diagnosis code
- Group number
- Member ID number
- Member name
- Name of provider
- Patient name
- Patient's birth date
- Procedure code
- Provider ID number

Medical and Dental Records and Other Information Needed to Process a Claim

Even when the claim has all information listed above, BCBSAZ may need to request medical or dental records or coordination of benefits information to make a coverage determination. If BCBSAZ has requested medical records or other information from a third party, BCBSAZ will suspend claim processing while the request is pending. BCBSAZ may deny a claim for lack of timely receipt of requested records.

Explanation of Benefits (EOB) Form and Monthly Member Health Statement

After your claim is processed, BCBSAZ and/or any contracted vendors that process claims will send you an EOB. Most EOBs are consolidated and sent to you in a monthly Member Health statement rather than as single EOBs. Your BCBSAZ EOBs also will be available through the member portal on www.azblue.com. An

EOB shows services billed, whether the services are covered or not covered, the allowed amount and the application of cost-sharing amounts. Carefully review your EOB for any discrepancies or inconsistencies with the amounts your provider actually collects from you or bills to you. If you paid more cost share than required for a covered service, BCBSAZ may refund that amount to a network provider, and the provider will be responsible for refunding you. Your EOB will show any refunds for cost-share overpayments. BCBSAZ and/or any contracted vendors will also send your in-network provider the information that appears on your EOB. This information is not sent to out-of-network providers. Out-of-network providers do not receive any written information on how much was paid on a claim or the reasons for how the claim processed. Save the EOB for your personal records. BCBSAZ or any contracted vendor may charge a fee for duplication of claims records.

Notice of Determination

If your request for precertification is denied, or your claim is denied in whole or in part, you will receive a notice of adverse benefit determination. In most cases, your EOB or monthly statement will serve as the notice, and will:

- State the specific reason(s) for the adverse benefit decision (e.g., not covered because the provider is ineligible or because services are not covered under this benefit plan),
- Reference the specific plan provision on which the determination is based,
- Describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary,
- Describe applicable grievance/appeal procedures,
- Disclose any internal rule, guideline or protocol relied on in making the adverse determination (or state that such information is available free of charge upon request)
- If the denial is based on medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state the information will be provided free of charge upon request).

Pharmacy Prescriptions; Submission of Claims by Members

When you submit a prescription to a retail, mail order, or specialty pharmacy, it is possible that the pharmacy could tell you that you are not eligible for coverage, that your medication is not covered, or that you have to pay more for the medication than you think you should pay. If this happens, you can:

- Call the Pharmacy Benefits Customer Service number on your ID card for assistance, or
- Pay the pharmacy for the medication, and then submit a claim to MaxorPlus for reimbursement.

If you submit a claim to MaxorPlus, MaxorPlus will review your request to determine if you should be reimbursed for some or all of the money you paid to the pharmacy, and will send you an EOB. If MaxorPlus denies your claim, you will receive a document describing your appeal rights along with the EOB. Submitting a prescription to a pharmacy is not considered to be a claim and will not result in an EOB.

Coupons, patient assistance programs, and other discount programs are occasionally used by members, providers, and pharmacies to reduce out-of-pocket member costs associated with prescription medications. Coupons, patient assistance programs, and other discount programs do not count toward your deductible and out-of-pocket maximum. Your deductible and out-of-pocket maximum balances may be adjusted at any time to reflect the actual amount paid for that prescription after discounts have been applied.

Time Period for Claim Decisions:

Post-Service Claims

Within thirty (30) days of receiving your claim for a service that was already rendered, BCBSAZ will send you an EOB adjudicating the claim, or a notice that BCBSAZ has requested records needed to make a decision on your claim.

If BCBSAZ cannot make a decision on your claim within thirty (30) days, BCBSAZ may extend the initial processing time by fifteen (15) days by notifying you, within the initial 30-day period, of the need for an extension, the expected decision date, and any additional information that may be needed for the decision. You or your provider will have at least forty-five (45) days to submit any requested information.

Pre-Service Claims

When you request coverage for a service that has not yet been rendered (precertification), BCBSAZ will make a precertification decision within a reasonable time period considering the medical circumstances, but not later than ten (10) business days from receipt of the precertification request.

If BCBSAZ requires more time to make a precertification decision, BCBSAZ may extend the time by an additional fifteen (15) days by notifying you, within the initial ten (10)-day period of need for an extension, the expected decision date, and any additional information needed for the decision. You and your provider will have at least forty-five (45) days to submit any requested information.

Concurrent Care Decisions

BCBSAZ may require that your provider submit a plan of care. Based on that plan, BCBSAZ may precertify a certain number of visits or services over a certain period of time. You may request precertification for additional periods of care. If your request involves urgent care and is made at least 24 hours prior to the expiration of the existing plan of care, BCBSAZ will make a determination as soon as possible in accordance with medical exigencies, but no later than 24 hours after receipt of the request. If your request is not made at least 24 hours prior to the expiration of the existing plan of care, BCBSAZ will make a determination as soon as possible in accordance with medical exigencies, but no later than 72 hours after receipt of the request. If precertification is denied, you may appeal the denial in the same way you appeal any other coverage denial.

Urgent Claims

When your provider requests coverage for an urgent care claim, a determination will be made as soon as possible in accordance with medical exigencies, but no later than seventy-two (72) hours after receipt of the request. Federal law defines an “urgent” medical situation as the following: (a) one in which application of the “non-urgent” time periods could seriously jeopardize the member’s life, health or ability to regain maximum function **or** (b) one which, in the opinion of a physician with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

GENERAL PROVISIONS

Appeal and Grievance Process

Members may participate in BCBSAZ's appeals and grievance processes, which are described in detail in the BCBSAZ Appeal and Grievance Guidelines, a separate document provided to you. You do not have to pay any fees or charges to file or pursue an appeal or grievance with BCBSAZ. You may obtain another copy of the BCBSAZ Appeal and Grievance Guidelines by visiting us at www.azblue.com or by calling Customer Service at the number on your ID card.

If you receive a bill from an out-of-network provider for services provided at an in-network facility and want to dispute the amount of the bill, you may be able to initiate a dispute resolution process defined under Arizona law. This process is not available for all balance bills. To initiate the dispute resolution process or to appeal a denial of precertification for urgently needed services you have not yet received, please call Customer Service at the number on your ID card.

Billing Limitations and Exceptions

When there is another source of payment such as a liability insurer, in-network providers may be entitled to collect any difference between the allowed amount and the provider's billed charges from the other source or from proceeds received from the other source, pursuant to A.R.S. § 33-931.

A.R.S. § 33-931 may give providers medical lien rights independent of this benefit plan or any contract with BCBSAZ. BCBSAZ is not a party to any collection dispute that may arise under the provisions of A.R.S. § 33-931.

Blue Cross and Blue Shield Association

You hereby expressly acknowledge and agree to the following:

I. This benefit plan constitutes a contract between the Group and BCBSAZ, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("Association"), an association of independent Blue Cross and Blue Shield Plans, permitting BCBSAZ to use the Blue Cross and/or Blue Shield service marks in the state of Arizona;
II. BCBSAZ is not contracting as the agent of the Association;
III. In accepting the benefits of this plan, you are not relying on any representations by the Association or any other Blue Cross or Blue Shield plan, other than BCBSAZ; **and**
IV. You will not seek to hold the Association or any Blue Cross and Blue Shield plan other than BCBSAZ, accountable or liable for BCBSAZ's obligations herein.

Claims Editing Procedures and Pricing Guidelines

BCBSAZ uses systems to verify benefits, eligibility, claims accuracy, and compliance with BCBSAZ coding and pricing guidelines and Evidence-based Criteria. BCBSAZ uses claims coding and editing logic to process claims and determine allowed amounts. BCBSAZ regularly updates its systems, claims and pricing guidelines and edits, and Evidence-based Criteria.

Confidentiality and Release of Information

BCBSAZ takes confidentiality very seriously. We have processes and systems to safeguard sensitive or confidential information and to release such information only in accordance with state and federal law. If you wish to authorize someone to have access to your information, you can download the Confidential Information Release Form (CIRF) from www.azblue.com or call BCBSAZ Customer Service and request a hard copy of the CIRF form.

Court or Administrative Orders Concerning Dependent Children

When a member is not the custodial parent of a child, but is required by a court or administrative order to provide health benefits to that child, BCBSAZ will provide benefit information to the custodial parent, permit the custodial parent to submit claims for the child and make payments directly to the custodial parent, provider or state agency as applicable.

Access to Information Concerning Dependent Children

BCBSAZ is not a party to domestic disputes. Parental disputes over Dependent coverage and information must be resolved between the parents of the Dependent child. Under Arizona law, both parents have equal rights of access to information about their children, unless there is a court order denying such access. Absent a copy of such order and subject to the confidentiality provisions described above, BCBSAZ provides equal parental access to information.

Discretionary Authority

BCBSAZ has discretionary authority to determine extent of coverage under the terms of this benefit plan.

Provider Treatment Decisions and Disclaimer of Liability

While rendering services to you, in-network providers are independent contractors and not employees, agents or representatives of BCBSAZ. Their contracts with BCBSAZ address reimbursement and administrative policies. Each provider exercises independent medical judgment in deciding what services to provide you, and how to provide them. BCBSAZ's role is limited to administration of the benefits under this benefit plan. Your provider may recommend services or treatment not covered under this benefit plan. You and your provider should decide whether to proceed with a service that is not covered.

BCBSAZ has no control over any diagnosis, treatment, care or other services rendered by any provider and disclaims any and all liability for any loss or injury to you caused by any provider by reason of the provider's negligence, failure to provide treatment or otherwise.

Lawsuits

There is an appeal process for resolving certain types of disputes with members. You are encouraged to use the appeal process before filing a lawsuit, as issues can often be resolved when you provide more information through the appeal process.

By providing this notice BCBSAZ does not waive, but expressly reserves all applicable defenses available under Arizona and federal law.

Legal Action and Applicable Law

This contract is governed by, construed and enforced in accordance with applicable federal law and the laws of the state of Arizona, without regard to conflict of laws principles. This benefit book and the contract between BCBSAZ and the sponsor of your group health plan were issued in Arizona to a group headquartered in Arizona.

Any dispute arising directly or indirectly out of the plan must be resolved by binding arbitration to the fullest extent permitted by applicable law. You agree that neither class or collective claims, nor class action or collective action procedures, will be asserted in, or will apply to, any dispute that arises out of this benefit plan. You irrevocably and unconditionally waive, to the fullest extent permitted by applicable law, any right to a trial by jury in any dispute arising out of or relating to this benefit plan.

<u>Jurisdiction and Venue</u>

Jurisdiction and venue for any Legal Action or other proceeding that arises out of or relates to the contract or this Benefit Plan shall be in any court of competent jurisdiction in the state of Arizona.

<u>Lawsuits by BCBSAZ</u>

Sometimes, BCBSAZ has an opportunity to join class action lawsuits, where third party payers (insurance companies) assert that an entity's conduct resulted in higher payments by the insurance company than otherwise would have been required. BCBSAZ reviews these cases and makes a good faith decision based on the unique facts of each case whether to join the case. BCBSAZ may also bring lawsuits against vendors or other entities to recover various economic damages. When BCBSAZ participates as a plaintiff and recovers damages, those funds are not returned to individual members, but are instead retained by BCBSAZ to reduce overall administrative costs. This paragraph is not intended to limit or waive any claims BCBSAZ may have against any person or entity.

Non-Assignability of Benefits

The benefits contained in this plan, and any right to reimbursement or payment arising out of such benefits, are not assignable or transferable, in whole or in part, in any manner or to any extent, to any person or entity. You shall not sell, assign, pledge, transfer or grant any interest in or to, these benefits or any right of reimbursement or payment arising out of these benefits, to any person or entity. Any such purported sale, assignment, pledge, transfer, or grant is not enforceable against BCBSAZ and imposes no duty or obligation on BCBSAZ.BCBSAZ will not honor any such purported sale, assignment, pledge, transfer or grant.

Medicaid Reimbursement

Member acknowledges that state Medicaid agencies, including the Arizona Health Care Cost Containment System ("AHCCCS"), (collectively referred to as "Medicaid Agencies") are considered payers of last resort for healthcare expenses of individuals who are Medicaid beneficiaries. Member further acknowledges that AHCCCS does, and other state Medicaid Agencies may, have a legal right to reimbursement of expenditures that the Medicaid Agencies have made on behalf of a member who was also a Medicaid Beneficiary, not to exceed the lesser of the member's benefits under this plan or the Medicaid Agencies' payment. Member acknowledges and agrees that BCBSAZ shall reimburse Medicaid Agencies or their designees, for the health claims of a member who was also a Medicaid Beneficiary on the date of service, to the extent required by law.

Member Notices and Communications

BCBSAZ sends notices and other communications to members by U.S. mail to the last address on file with BCBSAZ Customer Service. BCBSAZ may also elect to send some notices and communications electronically if the member has consented to electronic receipt. Notice is deemed complete when sent to the member's last address of record, as follows: (1) on delivery, if hand-delivered; (2) if mailed, on the earlier of the day actually received by the member or five days after deposit in the U.S. mail, postage prepaid; or (3) if transmitted electronically, on the earlier of the day of actual receipt or 24 hours after electronic transmission to the member's email address of record.

Payments Made in Error

If BCBSAZ erroneously makes a payment or over-payment to you or on your behalf, BCBSAZ may obtain reimbursement from you or the provider or BCBSAZ may offset the amount owed against a future claim arising from any covered service. Payments made in error by BCBSAZ do not constitute a waiver concerning the claim(s) at issue or of any right of BCBSAZ to deny payment for noncovered services.

Plan Amendment

There is no guarantee of continued benefits as outlined in this plan. This plan may be amended and benefits may be added, deleted or changed upon notice to the Group and/or Contract Holder and/or participant or as required to comply with state or federal laws. Some mandated benefits or other plan provisions may be required or unavailable based on the size of the group. At the time of renewal, if your Group changes size, it may result in loss of a benefit that is currently available, or inclusion of a benefit not currently available. Please review and retain this book, any replacement books, any SBCs, all riders and amendments, and other communications concerning your coverage.

Retroactive Changes

BCBSAZ reserves the right to make certain retroactive amendments to this benefit plan, as may be permitted under applicable federal and state law. You will receive notice of any such amendments.

Prescription Medication Rebates

BCBSAZ participates in contracts with pharmaceutical companies to receive rebate payments based on the volume and/or market share of pharmaceutical products utilized by BCBSAZ members. These rebate contracts are subject to renegotiation and/or termination from time to time at BCBSAZ's sole discretion.

The rebates BCBSAZ receives are not reimbursable to you. Your group receives: (a) a credit against administrative costs/fees or (b) the prescription medication rebate dollar amount attributable to your group. Rebates received by BCBSAZ may result in the overall cost of a particular medication falling below the amount you pay for such medication pursuant to the coverage described in this benefit plan. Other discount

programs offered by a pharmacy may result in members of the public paying a lower cost for some medications than you pay under this benefit plan.

Provider Contractual Arrangements

The BCBSAZ allowed amount reflects any contractual arrangements negotiated with a provider. Contractual arrangements vary based on many factors. For that reason, BCBSAZ network providers have varying compensation levels based on the provider's agreement to accept a certain reimbursement rate. This means that your in-network cost-share for a particular service can vary based on the network provider you choose because not all providers have the same negotiated reimbursement rate for the same service. For information on your estimated Cost Share for a particular Service, please call Customer Service at the number on your ID card. You will need to provide the name of the Provider and the diagnosis and procedure code to receive an estimated Cost Share. The estimated Cost Share is only an estimate and the actual Cost Share may vary from the estimated Cost Share based on factors such as the services actually performed and the place where the services are actually rendered.

Release of Records

Subject to Arizona or federal law, the member agrees that BCBSAZ may obtain, from any provider, insurance company or third party, all records or information relating to the member's health, condition, treatment, prior health insurance claims or health benefit program. A failure to provide records needed to adjudicate a claim can result in denial of the claim.

Rescission of Coverage

In the event of fraud or intentional misrepresentation of material fact, coverage for any person ineligible to be on the benefit plan as described in the Group Master Contract will be rescinded, that is, as never having been in effect. Premiums paid for the coverage for the ineligible person will be refunded, minus any claims paid for that person. BCBSAZ is entitled to recover claim payments that exceed the amount of premium paid. Such rescission does not affect the coverage of those persons on the benefit plan who remain eligible for coverage.

BCBSAZ will give 30 days' written notice of its intent to rescind, during which time the person may protest the decision by writing to BCBSAZ at the address indicated in the notice and explaining why a rescission is not appropriate or allowable.

A member's eligibility to enroll in the group's health plan is not based on the member's health status. An omission or misrepresentation of health information in your application for group coverage is not a basis for rescission of your group coverage.

Cost of Records

In order to process your claims, BCBSAZ may need to obtain copies of your health records from your provider. In-network providers generally cannot charge you for providing BCBSAZ with health records. Noncontracted providers have no contractual obligation to provide records to BCBSAZ free of charge. If you receive services from a noncontracted provider who charges for record preparation or the cost of copies, you will need to arrange with your provider to obtain any records required by BCBSAZ and pay any applicable fees.

Third-Party Beneficiaries

The provisions of this benefit plan are only for the benefit of those covered under this plan. Except as may be expressly set forth in this book, no third party may seek to enforce or benefit from any provisions of this benefit plan.

Your Right to Information; Availability of Notice of Privacy Practices

You have the right to inspect and copy your information and records maintained by BCBSAZ, with some limited exceptions required by law. If you choose to review your medical records in person, BCBSAZ will require a reasonable amount of time to research and retrieve the records before scheduling a time with you to review the records.

The BCBSAZ "Notice of Privacy Practices" describes how BCBSAZ may use and disclose your information to administer your health plan. It also describes some of your individual rights and BCBSAZ's responsibilities

under federal privacy regulations. BCBSAZ mails a copy of this Notice of Privacy Practices to your address shortly after you enroll for coverage with BCBSAZ.

You can also view the “Notice of Privacy Practices” by visiting the BCBSAZ website, www.azblue.com, and clicking on the Legal link at the bottom of the home page.

If you would like BCBSAZ to mail you another copy of the “Notice of Privacy Practices,” please call the Customer Service telephone number listed on the back of your BCBSAZ identification card, or call (602) 864-4400 or (800) 232-2345 to make your request.

MEMBER COST-SHARING

Members pay part of the costs for benefits received under this plan. Depending on your particular benefit plan, the service you receive and the provider you choose, you may have an access fee, balance bill, coinsurance, copay, deductible or some combination of these payments. Each cost-share type is explained below. This section, the benefit descriptions in this book and your SBC will explain which cost-share types apply to each benefit.

BCBSAZ uses your claims to track whether you have met some cost-share obligations. We apply claims based on the order in which we process the claims and not based on date of service.

Access Fee

An access fee is a fixed fee you pay to a provider for certain covered services, usually at the time of service. If an access fee applies to a particular service, you must pay the access fee plus any other applicable cost-share for the service. Access fees do not count toward meeting your plan-year deductible.

Balance Bill

The balance bill refers to the amount you may be charged for the difference between a noncontracted provider's billed charges and the allowed amount.

Noncontracted providers have no obligation to accept the allowed amount. You are responsible to pay a noncontracted provider's billed charges, even though BCBSAZ will reimburse your claims based on the allowed amount. Depending on what billing arrangements you make with a noncontracted 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 BCBSAZ reimburses you on a claim.

Any amounts paid for balance bills do not count toward deductible, coinsurance or the out-of-pocket maximum.

Benefit Maximums

Some benefits may have a specific benefit maximum or limit based on the number of days or visits, type, timeframe (plan year or benefit plan), age, gender or other factors. If you reach a benefit maximum, any further services are not covered under that benefit and you may have to pay the provider's billed charges for those services. However, if you reach the benefit maximum on a particular line of a claim, you will be responsible for paying only up to the allowed amount for the remaining charges on that line of the claim. All benefit maximums are included in the applicable benefit description.

Coinsurance

Coinsurance is a percentage of the allowed amount that you pay for certain covered services after meeting any applicable deductible. BCBSAZ subtracts any applicable access fees and precertification charges from the allowed amount before calculating coinsurance. Coinsurance applies to every covered service unless the specific benefit section says it does not apply.

BCBSAZ normally calculates coinsurance based on the allowed amount. There is one exception. If a hospital provider's billed charges are less than the hospital's DRG reimbursement, BCBSAZ will calculate your coinsurance based on the lesser billed charge.

Copay

A copay is a specific dollar amount you must pay to the provider for some covered services. If a copay applies to a covered service, you must pay it when you receive services. Different services may have different copay amounts and are shown on your SBC. Usually, if a copay does not apply, you will pay applicable deductible and coinsurance.

Out-of-Pocket Maximum (Individual and Family)

An out-of-pocket maximum is the amount each member must pay each plan year before the plan begins paying 100 percent of the allowed amount on covered services, for the remainder of the plan year. The

payments listed below do not count toward the out-of-pocket maximum. You must keep paying them even after you reach your out-of-pocket maximum:

- Amounts above a benefit maximum
- Any amounts for balance billing
- Any amounts for noncovered services
- Any charges for lack of precertification

If you have family coverage, there is an out-of-pocket maximum for your family. Amounts applied to each member's out-of-pocket maximum also apply to the family out-of-pocket maximum. The family maximum is applied in the same way as the individual maximum described above and is subject to the same rules. When the family has met its family out-of-pocket maximum, it also satisfies the out-of-pocket maximum requirements for all the individual members.

Plan-year Deductible (Individual and Family)

A deductible is the specified amount of money a member must pay each plan year before the plan begins to pay a percentage for covered services.

The member must meet separate deductibles for in-network and out-of-network services.

If you have individual coverage, you must meet your deductible before the plan will pay benefits (except for Preventive Services).

If you have family coverage, on an embedded deductible plan, each family member has an individual deductible. Only when an individual family member reaches his/her deductible will the plan begin to pay benefits for that individual regardless of whether the total family deductible has been met. Once the family deductible is met, the plan pays benefits for all.

Precertification Charges

You must make sure that your out-of-network provider obtains precertification from BCBSAZ for any service that requires it. If your out-of-network provider does not obtain required precertification from BCBSAZ, you are subject to a precertification charge or complete loss of your benefit. Applicable precertification charges are shown on your SBC. Amounts applied as precertification charges do not count toward the plan-year deductible or out-of-pocket maximum.

DESCRIPTION OF BENEFITS

Please review this section for an explanation of covered services and benefit-specific limitations and exclusions. Also be sure to review the information about Covered Services in "*Understanding the Basics*" and refer to *"What is Not Covered"* for general exclusions and limitations that apply to all benefits. BCBSAZ does not determine whether a service is covered under this benefit plan until after services are provided, and BCBSAZ receives a complete claim describing the services actually provided. The SBC shows the actual cost-share amounts for the cost-share types shown for each benefit, such as deductible amounts, copays, and coinsurance percentages.

A. ACUPUNCTURE SERVICES

Your Cost-Share: You pay applicable deductible, coinsurance and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Maximum: There is a benefit maximum of eight (8) visits per member, per plan year.

Benefit Description: Benefits are available for acupuncture services when provided by a chiropractor, MD, or DO who is a licensed acupuncturist.

B. AMBULANCE SERVICES

Your Cost-Share: You pay in-network deductible and coinsurance.

Benefit Description: All factors for coverage are determined by BCBSAZ at its sole and absolute discretion. Benefits are available for:

- Air or water ambulance transportation to the nearest facility capable of providing appropriate treatment when the emergency, accident, or acute illness occurs in an area inaccessible by ground vehicles, or transport by ground ambulance would be harmful to the member's medical condition; or
- Ground ambulance transportation from the site of an emergency, accident, or acute illness to the nearest facility capable of providing appropriate treatment; or
- Interfacility ground, water, or air ambulance transfer for admission to a facility when the transferring facility is unable to provide the level of service required.

Benefit-Specific Exclusions:

- Air ambulance transfers to any facility that is not an acute care facility, such as a skilled nursing facility or an extended active rehabilitation facility.
- All other expenses for travel and transportation are not covered, except for the benefits described in *"Transplant and Gene Therapy Travel and Lodging."*

C. BEHAVIORAL AND MENTAL HEALTH SERVICES (including chemical dependency or substance abuse treatment)

C.1.1 Inpatient Hospital

Your Cost-Share: You pay applicable deductible and coinsurance for inpatient facility and professional charges. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for:

- Diagnostic testing
- Intensive care units and other special care units
- Medications, biologicals and solutions
- Room and board in a semi-private room or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is medically necessary
- Treatment and recovery rooms and equipment for covered services

C.1.2 Subacute Inpatient Behavioral Health Hospitalization (Including Residential Treatment)

Your Cost-Share: You pay applicable deductible and coinsurance for inpatient facility and professional charges. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for:

- Diagnostic testing
- Medications, biologicals and solutions
- Room and board in a semi-private room or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is medically necessary
- Treatment and recovery rooms and equipment for covered services

Benefits are available for inpatient behavioral and mental health services that meet all the following criteria:

- The facility is licensed to provide behavioral health services to patients who require 24-hour skilled care and have the ability to achieve treatment goals in a reasonable period of time.
- The facility's designated medical director is a physician or registered nurse practitioner and provides direction for physical health services provided at the facility;
- A physician or registered nurse practitioner is present on the premises of the facility or on-call at all times;
- The facility's designated clinical director is a behavioral health professional and provides direction for the behavioral health services provided at the facility;
- The facility has 24/7 onsite RN coverage;
- The facility has sufficient behavioral or mental health professional staff to provide appropriate treatment; **and**
- The services meet the BCBSAZ medical necessity criteria for inpatient level of care.

Changing Types of Inpatient Care (applicable to C.1.1 and C.1.2 above): Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, Inpatient Rehabilitation, and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.**

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

Benefit-Specific Exclusions (applicable to C.1.1 and C.1.2 above):

- Domiciliary Care
- Medications dispensed at the time of discharge from an inpatient facility
- Private Duty Nursing
- Respite Care

C.2 Behavioral and Mental Health Services (Outpatient Facility and Professional Services)

Your Cost-Share:

In-Network: You pay a PCP copay per member, per provider, per day for services provided during an office, home or walk-in clinic visit. You pay in-network deductible and coinsurance for outpatient services delivered in locations other than the provider's office, the member's home or a walk-in clinic.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Non-emergency outpatient behavioral and mental health services are available. Those services include psychotherapy, outpatient therapy for chemical dependency or substance abuse, diagnostic office visits, certain office visits for monitoring of behavioral health conditions or medications, intensive outpatient services, counseling for personal and family problems, electroconvulsive therapy (ECT) and partial hospitalization.

C.3 Behavioral Therapy Services For The Treatment Of Autism Spectrum Disorder

Your Cost-Share:

In-Network: You pay a PCP copay per member, per provider, per day for services provided during an office, home or walk-in clinic visit. You pay in-network deductible and coinsurance for outpatient services delivered in locations other than the provider's office, the member's home or a walk-in clinic.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definitions: **"Autism Spectrum Disorder"** means Autistic Disorder, Asperger's Syndrome, or Pervasive Developmental Disorder (not otherwise specified), as defined in current Evidence-based Criteria and referenced in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Behavioral Therapy" means interactive therapies derived from evidence-based research, including applied behavior analysis, which includes discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

Benefit Description: Behavioral therapy services for the treatment of Autism Spectrum Disorder are available for members who have been diagnosed with Autism Spectrum Disorder. Covered behavioral therapy services must be delivered by a provider who is licensed or certified as required by law.

Benefit-Specific Exclusions (applicable to all Behavioral and Mental Health Services):

- Activity therapy, milieu therapy and any care primarily intended to assist an individual in the activities of daily living
- Biofeedback and hypnotherapy
- Custodial Care
- Development of a learning plan and treatment and education for learning disabilities (such as reading and arithmetic disorders)
- Inpatient and outpatient facility charges for services provided by the following facilities: group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters, or foster homes.
- IQ testing
- Lifestyle and work-related education and training, and management services
- Neurofeedback
- Sensory integration and music therapy
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

D. CARDIAC AND PULMONARY REHABILITATION – OUTPATIENT SERVICES

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for outpatient Phase I and II cardiac rehabilitation programs and pulmonary rehabilitation services.

E. CATARACT SURGERY AND KERATOCONUS

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for the removal of cataracts, including placement of a single intraocular lens at the time of the cataract removal. Benefits are also available for the first pair of external contact lenses or eyeglasses post-cataract surgery and for the first pair of contact lenses for treatment of keratoconus.

Benefit-Specific Exclusion: Procedures associated with cataract surgery that are not included in the benefit description, including replacement, piggyback or secondary intraocular lenses and any other treatments or devices for refractive correction.

F. CHIROPRACTIC SERVICES

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Maximum: There is a combined in- and out-of-network limit of twelve (12) chiropractic visits per member, per plan year.

Benefit Description: Benefits are available for chiropractic services.

Benefit-Specific Exclusion: Maintenance or preventive treatment consisting of routine, long-term or non-medically necessary care provided to prevent reoccurrences or to maintain the patient's current status.

G. CLINICAL TRIALS

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: "Approved Clinical Trial" means a Phase 1, 2, 3, or 4 clinical trial conducted for the prevention, detection, or treatment of cancer or other life-threatening disease or condition and also approved or funded by at least one of the following:

- The National Institutes of Health (NIH), including a NIH health cooperative group or center or a qualified research entity that meets the criteria established by NIH for grant eligibility
- Food and Drug Administration (FDA) reviewed investigational new drug application
- The U.S. Department of Defense
- The U.S. Department of Veterans Affairs
- A panel of qualified, recognized clinical research experts within an Arizona academic health institution

Benefit Description: Benefits are available for Covered Services directly associated with an Approved Clinical Trial meeting all requirements specified by applicable federal and Arizona law. Benefits are limited to those services covered under this plan that would be required if you received standard, non-investigational treatment. Services may include laboratory, radiology, Physician Services, medical diagnostic, and/or surgical procedures.

For services associated with an Approved Clinical Trial to be covered, you or your Provider must inform BCBSAZ that you are enrolled in a clinical trial, that the trial meets the requirements of Applicable Law, and that the services to be rendered are directly associated with the trial. Otherwise, BCBSAZ only covers Clinical Trials as required by law and will administer your benefits according to the other terms of your Benefit Plan, which may result in a denial of benefits. If you have any questions about whether a particular Service is covered, please call Customer Service at the number on your ID card.

Benefit-Specific Exclusions:

- Investigational medications (except as stated in *"Prescription Medications for the Treatment of Cancer")* and devices
- Any item, device or service that is the subject of the clinical study, or which is provided solely to meet the need for data collection and analysis
- Clinical Trials not required by law to be covered

- Costs and services customarily paid for by government, biotechnical, pharmaceutical and medical device industry sources
- Costs related to Clinical Trials that do not meet the applicable requirements
- Costs to manage the clinical trial research
- Non-health services that might be required for treatment or intervention, such as travel and transportation and lodging expenses
- Services not otherwise covered under this plan

H. DENTAL SERVICES BENEFIT – MEDICAL

Not all dentists who are contracted with BCBSAZ are contracted to provide medical-related dental services. Call BCBSAZ Customer Service at the number on your ID card with questions.

H.1 Dental Accident Services

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definitions: **"Accidental dental injury"** is an injury to the structures of the teeth that is caused by an external force or element such as a blow or fall. An injury to a tooth while chewing is not considered an accidental dental injury, even if the injury is due to chewing on a foreign object.

A **"sound tooth"** is a tooth that is:

- Whole or virgin; **or**
- Restored with amalgam (silver filling) or composite resin (tooth-colored filling) or restored by cast metal, ceramic/resin-to-metal or laboratory processed resin/porcelain restorations (crowns); **and**
- Without current periodontal (tissue supporting the tooth) disease or current endodontal (tooth pulp or root) disease; **and**
- Not in need of the treatment provided for any reason other than as the result of an accidental dental injury.

Benefit Description: Benefits are available only for the following services to repair or replace sound teeth damaged or lost by an accidental dental injury:

- Extraction of teeth damaged as a result of accidental dental injury
- Original placement of fixed or removable complete or partial dentures
- Original placement, repair or replacement of crowns
- Original placement, repair or replacement of veneers
- Orthodontic services directly related to a covered accidental injury

Benefit-Specific Exclusions:

- Gold foil restorations or inlays
- Occlusal rehabilitation and reconstruction
- Original placement, repair or replacement of dental implants and any related services
- Repair and replacement of fixed or removable complete or partial dentures
- Routine dental care
- Routine extractions

H.2 Dental Services Required for Medical Procedures

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for dental services required to perform the medical services listed in this benefit. These dental services may either be part of the medical procedure or may be performed in conjunction with and made medically necessary solely because of the medical procedure:

- Diagnostic services prior to planned organ or stem cell transplant procedures
- Removal of teeth required for covered treatment of head and neck cancer or osteomyelitis of the jaw
- Restoration of teeth made medically necessary because of the covered treatment of head and neck cancer or osteomyelitis of the jaw

Benefit-Specific Exclusions:

- Dental implants and any related services
- Gold foil restorations and inlays
- Occlusal rehabilitation and reconstruction
- Orthodontic services
- Repair and replacement of fixed or removable complete or partial dentures
- Routine dental care
- Routine extractions

H.3 Medical Services Required for Dental Procedures (Facility and Professional Anesthesia Charges)

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for facility and professional anesthesiologist charges incurred to perform dental services under anesthesia in an inpatient or outpatient facility for a patient having one or more of the following concurrent or co-morbid conditions:

- Children 5 years or younger who, in the opinion of the treating dental provider, cannot be safely treated in the dental office
- Dental extractions due to cancer related conditions
- Diabetes
- Heart problems
- Hemophilia
- Malignant hypertension
- Mental retardation
- Other conditions that could increase the danger of anesthesia
- Probability of allergic reaction
- Senility or dementia
- Uncontrolled seizure disorder
- Unstable cardiovascular condition
- **Other conditions for which these services are required by state or federal law to be covered**

I. DURABLE MEDICAL EQUIPMENT (DME), MEDICAL SUPPLIES AND PROSTHETIC APPLIANCES AND ORTHOTICS

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. Your cost-share is waived for one FDA-approved manual or electric breast pump and breast pump supplies (obtained from an in-network provider) per member, per plan year. The cost-share amount will depend on the provider's network status and the place you receive services. You also pay the balance bill for services provided by noncontracted providers.

Benefit-Specific Maximums:

- Benefits are limited to one unit or one pair of prosthetic appliances and orthotics per member, per plan year. This limit does not apply to claims submitted with a primary mental health and/or substance abuse diagnosis.
- Benefits are limited to one (1) breast pump and breast pump supplies per member, per plan year. This limit does not apply to claims submitted with a primary mental health and/or substance abuse diagnosis.

I.1 Durable Medical Equipment (DME)

Benefit Description: To be eligible for coverage, DME must meet all of the following criteria:

- Be designed for appropriate medical use in the home setting;
- Be specifically designed to improve or support the function of a body part; **and**
- Cannot be primarily useful to a person in the absence of an illness or injury

Benefits are available for DME rental or purchase, as determined by BCBSAZ, and for DME repair or replacement, as determined by BCBSAZ, due to normal wear and tear caused by use of the item in accordance with the manufacturer's instructions or due to growth of a child. Benefits are limited to the allowed amount for the DME item base model. BCBSAZ determines what is covered as the base model. Deluxe or upgraded DME items may be eligible for coverage based upon BCBSAZ medical necessity criteria.

Benefit-Specific Exclusions:

- Charges for continued rental of a DME item after the allowed amount is reached
- Repair costs that exceed the allowed amount of the DME item
- Repair or replacement of DME items lost or damaged due to neglect or use that is not in accordance with the manufacturer's instructions or specifications

I.2 Medical Supplies

Benefit Description: Benefits are available for the following medical supplies:

- Any device or supply required by applicable law or as otherwise permitted under current Evidence-based Criteria
- Blood glucose monitors
- Blood glucose monitors for the legally blind and visually impaired
- Diabetic injection aids and drawing-up devices (including drawing-up devices for the visually impaired)
- Diabetic syringes and lancets, including automatic lancing devices
- Insulin cartridges, including insulin cartridges for the legally blind
- Insulin preparations and glucagon
- Insulin pumps and insulin pump supplies
- Ostomy and urinary catheter supplies
- Peak flow meters
- Prescribed oral agents for controlling blood sugar that are included on the plan
- Supplies associated with oxygen or respiratory equipment
- Test strips for glucose monitors and visual reading and urine test strips
- Volume nebulizers
- **Other medical supplies required by federal or state law to be covered**

Benefits are limited to the allowed amount for the medical supply base model. BCBSAZ determines what is covered as the base model. Deluxe or upgraded medical supplies may be eligible for coverage based upon BCBSAZ medical necessity criteria.

I.3 Prosthetic Appliances and Orthotics

Benefit Description: Benefits are available for the following:

- Cochlear implants
- External or internal breast prostheses when needed as a result of a medically necessary mastectomy
- External and internal prosthetic devices which are used as a replacement or substitute for a missing body part and are necessary for the support or function of a body part or for the alleviation or correction of illness, injury, or congenital defect. External prosthetic appliances shall include artificial arms and legs, wigs, hairpieces, and terminal devices such as a hand or hook. Wigs and hairpieces are covered:
    - For individuals diagnosed with alopecia (absence of hair) caused by chemotherapy, radiation therapy, or second- or third-degree burns
    - For individuals diagnosed with a substance abuse or a behavioral or mental health condition
    - For individuals with any other condition for which coverage is required under federal or state law

- Orthopedic shoes that are:
  - Attached to a brace; and
  - Depth inlay or custom-molded, along with inserts, for individuals with diabetes; and
  - Covered in accordance with BCBSAZ medical necessity criteria.
- Podiatric appliances for prevention of complications associated with diabetes, including foot orthotic devices and inserts (therapeutic shoes: including depth shoes or custom-molded shoes, as defined below.) Custom-molded shoes will only be covered when the member has a foot deformity that cannot be accommodated by a depth shoe. Therapeutic shoes are covered only for diabetes mellitus and any of the following complications of diabetes involving the foot: peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation. Depth shoes and custom-molded shoes are defined as follows:

  - **"Depth Shoes"** shall mean the shoe has a full length, heel-to-toe filler that, when removed, provides a minimum of 3/16th inch of additional depth used to accommodate custom-molded or customized inserts; are made of leather or other suitable material of equal quality; have some sort of shoe closure; and are available in full and half sizes with a minimum of 3 widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard sizing schedule or its equivalent.

  - **"Custom-Molded Shoes"** shall mean constructed over a positive model of the member's foot; made from leather or other suitable material of equal quality; have removable inserts that can be altered or replaced as the member's condition warrants; and have some sort of shoe closure. This includes a shoe with or without an internally seamless toe.

- **Other prosthetic appliance and orthotics required by federal or state law to be covered**

Benefits are limited to the allowed amount for the prosthetic appliance or orthotic base model. BCBSAZ determines what is covered as the base model. Deluxe or upgraded prosthetic appliances or orthotics may be eligible for coverage based upon BCBSAZ medical necessity criteria.

Benefit-Specific Exclusions for all DME, Medical Supplies and Prosthetic Appliances and Orthotics:

- Certain equipment and supplies that can be purchased over-the-counter, as determined by BCBSAZ. Examples include: adjustable beds, air cleaners, air-fluidized beds, air conditioners, air purifiers, assistive eating devices, atomizers, bathroom equipment, biofeedback devices, Braille teaching texts, bed boards, car seats, corsets, cushions, dentures, diatherapy machines, disposable hygienic items, dressing aids and devices, elastic/support/compression stockings, (except TED hose), elevators, exercise equipment, foot stools, garter belts, grab bars, health spas, hearing aid batteries, heating and cooling units, helmets, humidifiers, incontinence devices/alarms, language and/or communication devices (except artificial larynx and trach speaking valve) or teaching tools, massage equipment, mineral baths, portable and permanent spa and whirlpool equipment and units, reaching and grabbing devices, recliner chairs, saunas, and vehicle or home modifications.
- Hair transplants
- Hospital grade breast pumps and hospital grade breast pump supplies
- Items used primarily for help in daily living, socialization, personal comfort, convenience or other nonmedical reasons
- Replacement of external prosthetic devices due to loss or theft
- Strollers of any kind
- Supplies used by a provider during office treatments
- Tilt or inversion tables or suspension devices
- Wigs and hair pieces for alopecia caused by anything other than chemotherapy, radiation therapy, second- or third-degree burns, or a behavioral or mental health or substance abuse diagnosis

J. EDUCATION AND TRAINING

J.1 Diabetes and Asthma Education and Training

Your Cost-Share: Cost-share is waived for services provided by in-network providers. You pay out-of-network deductible and coinsurance for services provided by out-of-network providers. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for diabetes and asthma education and training from providers whose services are:

- Provided in an outpatient setting (outpatient hospital, physician office or other provider (excluding home health));
- Conducted in person; **and**
- Prescribed by a patient's healthcare provider as part of a comprehensive plan of care to enhance therapy compliance and improve self-management skills and knowledge for a patient diagnosed with diabetes or asthma.

J.2 Nutritional Counseling and Training

Your Cost-Share: Cost-share is waived for services provided by in-network providers. You pay out-of-network deductible and coinsurance for services provided by out-of-network providers. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Maximum: Benefits are limited to six (6) nutritional counseling and training visits per member, per plan year.

Benefit Description: Nutritional counseling and training is available for members diagnosed with one or more of the following conditions:

- Cardiovascular Disease
- Coronary Artery Disease
- Diabetes
- Eating Disorders
- Food Allergies
- Gastrointestinal Disorders
- Heart Failure
- High Cholesterol
- Hypertension
- Mental Health and Substance Abuse Disorders
- Obesity
- Pre-Diabetes
- Renal Failure/Renal Disease

K. EMERGENCY SERVICES

Your Cost-Share: You pay your in-network cost-share for emergency services, even for services from out-of-network providers.

Emergency Room: You pay in-network deductible and coinsurance.

Admission to the Hospital from the Emergency Room: You pay in-network deductible and coinsurance for facility and ancillary services related to the emergency, including facility and ancillary services provided while you were in the emergency room. You will also pay your cost-share for the inpatient admission and any professional services provided while you are an inpatient in the hospital. See the "Physician Services" and "Inpatient Hospital" sections of this benefit book.

If you receive emergency services from a noncontracted facility or professional provider, BCBSAZ will base the allowed amount used to calculate your cost-share on the highest of the three following amounts, not to exceed the applicable provider's billed charges:

- The median in-network provider negotiated rate for the emergency service furnished,
- The amount for the emergency service calculated using the same method BCBSAZ generally uses to determine reimbursement for out-of-network services, **or**
- The amount that would be paid by Medicare Part A or B.

The provider's billed charges often exceed the above amounts, which leaves a balance bill. You pay the balance bill plus your in-network cost-share for emergency services provided by a noncontracted provider. The balance bill may be substantial.

For all non-emergency services following the emergency treatment and stabilization, you pay applicable cost-share. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive non-emergency services from a noncontracted provider, you also pay the balance bill, which may be substantial.

Benefit-Specific Definition: **"Emergency Medical Condition"** means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that failing to get immediate medical attention would result in serious jeopardy to the patient's life, health or ability to completely recover, serious impairment to a bodily function or part, or permanent disability.

Benefit Description: Benefits are available for services needed to treat an Emergency Medical Condition.

L. EOSINOPHILIC GASTROINTESTINAL DISORDER

Your Cost-Share: You pay deductible, then 20 percent of the Cost for Formula.

Benefit-Specific Definitions: **"Cost"** is defined as either billed charges, if the Formula is purchased from an out-of-network provider, or the allowed amount, if purchased from an in-network provider.

"Formula" is amino-acid based formula.

Benefit Description: Benefits are available for Formula for members who are:

- At risk of mental or physical impairment if deprived of the Formula;
- Diagnosed with eosinophilic gastrointestinal disorder; **and**
- Under the continuous supervision of a physician or a registered nurse practitioner.

M. FAMILY PLANNING (CONTRACEPTIVES AND STERILIZATION)

Your Cost-Share:

In-Network:

Implanted Devices: Your cost-share is waived for professional charges for implantation and/or removal (including follow-up care) of FDA-approved female implanted contraceptive devices when the purpose of the procedure is contraception, as documented by your provider on the claim.

Sterilization Procedures: Your cost-share is waived for professional and facility charges from in-network providers for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim. You pay in-network deductible and coinsurance for FDA-approved male sterilization procedures.

Hormonal Contraceptive Methods: Your cost-share is waived for female oral contraceptives, patches, rings and contraceptive injections. See the "Physician Services" and "Pharmacy Benefit" sections for benefits.

Emergency Contraception: Your cost-share is waived for FDA-approved over-the-counter emergency contraception when prescribed by a physician or other provider. See the "Physician Services" section for benefits.

Barrier Contraceptive Methods: Your cost-share is waived for diaphragms, cervical caps, cervical shields, female condoms, sponges, and spermicides. See the "Physician Services" and the "Pharmacy Benefit" sections for benefits.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for FDA-approved contraceptive methods and devices and sterilization procedures when prescribed by the member's provider.

Benefit-Specific Exclusion: All prescription and over-the-counter contraceptive medications and devices for male members.

N. HOME HEALTH SERVICES

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: "Sole source of nutrition" is defined as the inability to orally receive more than 30 percent of daily caloric needs.

Benefit-Specific Maximum: Benefits are limited to any combination of skilled nursing services necessary to provide home infusion medication administration, enteral nutrition and/or other services requiring skilled nursing care, up to a maximum of six (6) hours per member, per day. The home health visit limit does not apply to home health services provided in lieu of hospitalization or hospital outpatient services, or to claims for home health services submitted with a primary mental health and/or substance abuse diagnosis.

Benefit Description: Benefits are available for the following services:

- Enteral nutrition (tube feeding) when it is the sole source of nutrition
- Home infusion medication administration therapy, including:
    - Blood and blood components
    - Hydration therapy
    - Intravenous catheter care
    - Intravenous, intramuscular or subcutaneous administration of medication
    - Specialty medications, as defined by BCBSAZ and not covered under the *"Pharmacy Benefit"* benefit
    - Total parenteral nutrition
- Physical therapy, occupational therapy, and speech therapy
- Skilled nursing services necessary to provide home infusion medication administration therapy, enteral nutrition, and other services that require skilled nursing care.
- Other home health services required by federal or state law to be covered

Each service must meet all of the following criteria:

- A healthcare provider must order the service pursuant to a specific plan of home treatment;
- A licensed home health agency must provide the service in the member's residence;
- The healthcare provider must review the appropriateness of the service at least once every 30 days or more frequently, if appropriate under the treatment plan; and
- The service must be provided by an LPN, RN, or another eligible provider.

Benefit-Specific Exclusions:

- All services in excess of the 6 hour per member, per day maximum, except as stated in this section
- Custodial care
- Domiciliary care
- Private duty nursing
- Respite care

O. HOSPICE SERVICES

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you pay the balance bill.

Benefit-Specific Definition: **"Hospice services"** are an alternative multi-disciplinary approach to medical care for the terminally ill. No curative or aggressive treatments are used.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, Inpatient Rehabilitation, and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.**

Benefit Description: When a member elects to use the hospice benefit, it is in lieu of other medical benefits available under this plan, except for care unrelated to the terminal illness or related complications.

The hospice agency determines the required level of care, which is subject to the medical necessity provisions of this benefit plan. Once the member selects the hospice benefit, the hospice agency coordinates all of the member's healthcare needs related to the terminal illness.

The member's physician must certify that the member is in the later stages of a terminal illness and prescribe hospice care, which must be provided by a state-licensed hospice agency. The member must meet the requirements of the hospice.

Benefits are available for the following services:

- ***Continuous Home Care:*** 24-hour skilled care provided by an RN or LPN during a period of crisis, as determined by the hospice agency, in order to maintain the member at home, if the member is receiving services in his or her home
- ***Home Health Services***
- ***Individual and Family Counseling*** provided by a psychologist, social worker, or family counselor
- ***Inpatient Acute Care:*** Inpatient admission for pain control or symptom management, which cannot be provided in the home setting
- ***Outpatient Services***
- ***Respite Care:*** Admission of the member to an approved facility to provide rest to the member's family or primary caregiver
- ***Routine Care:*** Intermittent visits provided by a member of the hospice team

P. INPATIENT AND OUTPATIENT DETOXIFICATION SERVICES

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: **"Detoxification services"** mean the initial medical treatment and support provided to a chemically dependent or addicted individual during acute withdrawal from a drug or substance.

Benefit Description: Benefits are available for medical observation and detoxification services needed to stabilize a member who has developed substance intoxication due to the ingestion, inhalation or exposure to one or more substances.

Q. INPATIENT HOSPITAL

Your Cost-Share: You pay applicable deductible and coinsurance for all inpatient admissions. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Your cost-share is waived for facility charges from in-network providers for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, Inpatient Rehabilitation, and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.**

Benefit Description:

- Blood transfusions, whole blood, blood components and blood derivatives
- Diagnostic testing, including radiology and laboratory services
- General, spinal and caudal anesthetic provided in connection with a covered service
- In-network benefits are available for covered gene therapies only when administered in a contracted Blue Distinction Center.
- Intensive care units and other special care units
- Medications, biologicals and solutions
- Operating, recovery and treatment rooms and equipment for covered services
- Radiation therapy or chemotherapy, except in conjunction with a noncovered transplant
- Room and board in a semi-private room or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is medically necessary
- Other inpatient services required by state or federal law to be covered

Benefit-Specific Exclusion: Medications dispensed at the time of discharge from a hospital.

R. INPATIENT REHABILITATION – EXTENDED ACTIVE REHABILITATION (EAR) SERVICES

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Maximum: Benefits are limited to Sixty (60) in- and out-of-network combined days of EAR services per member, per plan year. This limit does not apply to claims for EAR services submitted with a primary mental health and/or substance abuse diagnosis.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, Inpatient Rehabilitation, and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.**

Benefit Description: Benefits are available for an intense therapy program which is provided in a facility licensed to provide EAR and which meets the following criteria:

- A physician or registered nurse practitioner is present on the premises of the facility or on-call at all times;
- Room and board in a semi-private room or a standard private room (not deluxe) is covered if the hospital only has private rooms or if a private room is medically necessary;
- Services must be for patients who require 24-hour rehabilitation nursing and have the ability to achieve rehabilitation goals in a reasonable period of time;
- The facility has 24/7 onsite RN coverage;
- The facility has sufficient professional staff to provide appropriate treatment;
- The facility's designated medical director is a physician or registered nurse practitioner and provides direction for services provided at the facility; **and**
- The services meet the BCBSAZ medical necessity criteria for inpatient level of care.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- Custodial Care
- Domiciliary Care

- Medications dispensed at the time of discharge from a facility
- Private Duty Nursing
- Respite Care
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

S. LONG-TERM ACUTE CARE (INPATIENT)

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Maximum: Benefits are limited to Sixty (60) in- and out-of-network combined days of long-term acute care services per member, per plan year. This limit does not apply to claims for long-term acute care services submitted with a primary mental health and/or substance abuse diagnosis. If you have questions about the benefit maximum, contact BCBSAZ Customer Service at the number on your ID card.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, Inpatient Rehabilitation, and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.**

Benefit Description: Benefits are available for specialized acute, medically complex care for patients who require extended hospitalization and treatment in a facility that is licensed to provide long-term acute care and which offers specialized treatment programs and aggressive clinical and therapeutic interventions. Room and board is only covered in a semi-private room or a standard private room (not deluxe) if the hospital only has private rooms or if a private room is medically necessary.

Benefit-Specific Exclusions:

- Custodial Care
- Domiciliary Care
- Medications dispensed at the time of discharge from a facility
- Private Duty Nursing
- Respite Care

T. MATERNITY

Your Cost-Share:

Inpatient Services: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Outpatient Services:

In-Network: You pay a physician visit copay only for your first prenatal office or home visit. You pay a physician visit copay for any maternity services not included in the delivering provider's Global Charge and provided by a physician during an office or home visit. You pay in-network deductible and coinsurance for other covered maternity services.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Professional services provided in the member's home must be rendered by an eligible provider. Your cost-share will vary depending on the type of provider and the provider's network status.

Applicable cost-share is waived for maternity services covered under the "*Preventive Services*" benefit and delivered by an in-network provider. If you receive these services from an out-of-network provider, the services will be covered through your maternity benefit and

you will pay the out-of-network cost-share. If you receive services from a noncontracted provider, you also pay the balance bill.

Your cost-share obligations may be affected by the addition of a newborn or adopted child, as described in the **Plan Administration** section of this book. If you have coverage only for yourself and no Dependents, addition of a child will result in a change from individual coverage to family coverage, and you will be required to pay additional premium. If you currently have individual coverage, when a child is added to your plan, you will also be required to meet a family deductible and out-of-pocket maximum.

Benefit-Specific Definition: **"Global Charge"** is defined as a fee charged by the delivering provider that may include certain prenatal, delivery and postnatal services.

Benefit Description: Maternity benefits are available for covered services related to pregnancy. This includes certain screening tests such as prenatal ultrasounds, alpha-fetoprotein (AFP), rubella immunity, Hepatitis B and HIV exposure, blood type, anemia, urinary tract disease or infections, sexually transmitted diseases and others as determined by BCBSAZ. Certain tests, including some genetic screening, may not be covered. For a complete listing of covered prenatal screening, please call BCBSAZ Customer Service at the number on your ID card.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours for the mother and newborn child following a normal vaginal delivery or 96 hours for the mother and newborn child following a cesarean section delivery. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, call the Customer Service number on your ID card.

U. MEDICAL FOODS FOR INHERITED METABOLIC DISORDERS

Your Cost-Share: You pay deductible, then 20 percent of the Cost for Medical Foods.

Benefit-Specific Definitions: **"Cost"** is defined as either billed charges, if the member buys the Medical Foods from an out-of-network provider or the allowed amount, if the member buys the Medical Foods from an in-network provider.

"Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry that meets all of the following requirements:

- The disorder is one of the diseases tested under the newborn screening program required under Arizona law (A.R.S. § 36-694);
- The disorder is such that an afflicted individual will need to consume Medical Foods throughout life in order to avoid serious mental or physical impairment; **and**
- The disorder must involve amino acid, carbohydrate or fat metabolism and have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues, as determined by BCBSAZ.

"Medical Foods" mean modified low protein foods and metabolic formulas that are all of the following:

- Administered for the medical and nutritional management of a member who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation;
- Essential to the member's optimal growth, health and metabolic homeostasis;
- Formulated to be consumed or administered through the gastrointestinal tract under the supervision of an MD or DO physician or a registered nurse practitioner;
- Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs (metabolic formula only); **and**
- Processed or formulated to contain less than one gram of protein per unit of serving (modified low protein foods only).

Benefit Description: Benefits are available for Medical Foods to treat Inherited Metabolic Disorders.

Benefit-Specific Exclusions:

- Foods and beverages that are naturally low in protein or galactose
- Foods and formulas available for purchase without a prescription or order from an MD or DO physician or registered nurse practitioner
- Foods and formulas that do not require supervision by an MD or DO physician or a registered nurse practitioner
- Food thickeners, baby food or other regular grocery products
- Medical foods and formulas for any condition not included in the newborn screening program, such as lactose intolerance without a diagnosis of Galactosemia
- Nutrition for a diagnosis of anorexia
- Nutrition for nausea associated with mood disorder, end stage disease etc.
- Spices and flavorings
- Standard oral infant formula

Claim submission for Medical Foods

You may buy Medical Foods from any source. If you buy Medical Foods from an out-of-network provider, you must submit a claim form with the following information:

- Member's diagnosis for which the Medical Foods were prescribed or ordered;
- Member's name, identification number, group number and birth date;
- Prescribing or ordering physician or registered nurse practitioner;
- The amount paid for the Medical Foods;
- The dated receipt or other proof of purchase; **and**
- The name, telephone number and address of the Medical Food supplier.

Medical Foods claim forms are available from BCBSAZ. Submit the completed Medical Foods Claim Form and the dated receipt to the address for claims submission at the front of this book.

Medical Foods also may be covered under the *"Home Health Services"* benefit. Medical Foods are not covered under the *"Pharmacy Benefit.*"

V. NEUROPSYCHOLOGICAL AND COGNITIVE TESTING

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Services are available for the evaluation of decreased mental function or developmental delay.

W. OUTPATIENT SERVICES

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill. Your cost-share is waived for diagnostic mammography services from an in-network provider.

Your cost-share is waived for facility charges from in-network providers for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim.

Professional services provided by a radiologist or pathologist, including a dermapathologist, are always subject to applicable deductible and coinsurance, even when the services are provided in a physician's office. You pay applicable deductible and coinsurance and balance bill for sleep studies, regardless of where the sleep study is performed.

Benefit Description: Benefits are available for the following outpatient services and include, but are not limited to, any services that would be covered if performed as an inpatient service:

- Allergy testing, antigen administration, and desensitization treatment
- Blood transfusions, whole blood, blood components, and blood derivatives
- Diagnostic testing, including laboratory and radiology services
- Dialysis
- End-stage renal disease services
- Epidural and facet injections and radio frequency ablation for pain management
- Infusion/IV therapy in an outpatient setting
- In-network benefits are available for covered gene therapies only when administered in a contracted Blue Distinction Center.
- Maternity services provided in birthing centers
- Medications, and the administration of medications, in an outpatient setting
- Orthognathic treatment and surgery, including but not limited to dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral)
- Outpatient and ambulatory cardiac testing, angiography, sleep testing (including sleep studies and polysomnography), and video EEG
- Pre-operative testing
- Radiation therapy or chemotherapy, unless performed in conjunction with a noncovered transplant
- Surgery and other invasive procedures
- Treatment of Temporomandibular Joint Disorders (TMJ)

X. PHARMACY BENEFIT

MaxorPlus is an independent company and does not provide Blue Cross or Blue Shield products or services. MaxorPlus is solely responsible for the products and services it provides.

Information About This Benefit

Contact MaxorPlus Member Services to request any of the following:

- A list of covered medications that require precertification;
- A list of covered vaccines;
- Information on the assigned cost-share Tier of a covered medication;
- Information regarding Maintenance Medications;
- A list of Specialty Medications;
- Other information about this Pharmacy Benefit.

MaxorPlus Copay Assistance Program

- MaxorPlus Specialty Pharmacy Patient Care Advocates can assist members with enrollment with manufacture copay assistance programs, call MaxorPlus Specialty Pharmacy at 1-866-629-6779. *Please note that not all specialty medications will have copay assistance available. Those medications that do have assistance available are subject to availability and may be discontinued at any time.
- Any portion known to have been paid by a secondary payer (i.e. patient assistance, copay cards, or other insurance) will not be considered as true member out-of-pocket and will not apply to deductible and out-of-pocket maximums for prescriptions filled at MaxorPlus Specialty Pharmacy.

Your Cost-Share:

In-Network Medications Obtained From Pharmacies:
Please see the benefit schedules for your cost shares dependent upon the plan you have chosen. These cost shares may vary depending upon which tier your medication falls.
Tiers are as follows:

Tier 1 – Generics
Tier 2 – Preferred
Tier 3 – Non-Preferred
Tier 4 – Specialty

Your cost-share may be waived for preventive medications and for covered vaccines.

Your cost-share is waived for all FDA-approved contraceptive methods when prescribed by your provider and obtained from an in-network pharmacy, including the following:

- Condoms (female and male)
- FDA-approved diaphragms, cervical caps and cervical shields
- FDA-approved emergency contraception for members of any age
- FDA-approved generic oral, patch, vaginal ring and injectable contraceptives
- FDA-approved brand oral, patch, vaginal ring and injectable contraceptives with no generic equivalent components
- Sponges and spermicides

Contraceptives must be prescribed for or include the purpose of contraception and not be prescribed solely for some other medical reason to be covered with no member cost-share.

For certain covered preventive medications and items obtained from an in-network pharmacy, your cost-share is waived for the generic version of the medication or item and you pay applicable cost share for the brand-name version of the medication or item. Contact MaxorPlus on whether a drug is considered a preventive medication.

You may obtain up to a 90-day supply of medications from retail pharmacies.

Oral chemotherapy medications will be covered at a generic copay once approved through the prior authorization process.

Benefit-Specific Definitions: **"Compounded Medications"** are medications that contain at least one FDA-approved component and are custom-mixed by a pharmacist.

"Designated Prescription Network Program" is a program that requires certain members taking certain medications to obtain prescriptions for all covered medications from one designated eligible provider and to obtain all medications designated by MaxorPlus from one network pharmacy or provider.

"Generic medications" are medications defined as generic by the national database system used by MaxorPlus to pay prescription claims.

"PBM" means the independent pharmacy benefit manager that contracts with Kairos to administer the prescription medication benefits covered under this benefit plan.

"Medication Synchronization" is defined as the coordination of medication refills for a patient taking two or more medications for a chronic condition that are being dispensed by a single network pharmacy to facilitate the synchronization of the patient's medications for the purpose of improving medication adherence.

Benefit Description: Benefits are available for prescription medications that meet the following criteria:

- The medication is not excluded by a different provision in this plan;
- The medication must be approved by the FDA for the diagnosis for which the medication has been prescribed; **and**

- The medication must be dispensed by a pharmacy located in the U.S. and by a pharmacist licensed in the U.S., unless the medication is needed for an urgent or emergency medical situation while the member is traveling outside the U.S. Claims for medications dispensed outside the U.S will be subject to the U.S. dollar exchange rate on the date the claim is paid.

You may obtain most prescription medications from retail pharmacies or the in-network mail order pharmacy. Compounded medications must be obtained from retail pharmacies that have been credentialed by MaxorPlus to dispense compound medications. Please contact MaxorPlus Member Services at the number listed in your benefit plan materials for a list of pharmacies credentialed to dispense compound medications.

Certain vaccines are covered when obtained from in-network retail pharmacies and administered by a certified, licensed pharmacist.

The following medical devices are covered under this benefit: diabetic test strips, lancets, diabetic syringes/needles for insulin, Freestyle brand continuous glucose monitors, and spacer devices for asthma medications.

Covered medications are subject to limitations, including but not limited to, quantity, age, gender, dosage, and frequency of refills. Medications may be subject to limitations. Medication limitations are subject to change at any time without prior notice.

If a medication is not processing at the pharmacy, you or your physician/provider may request a reconsideration by calling the MaxorPlus Member Services at (800) 687.0707 twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. There is no guarantee that MaxorPlus will authorize a reconsideration. Reasons for requesting a reconsideration include but are not limited to the following: quantity, age, gender, dosage and/or frequency of refill limitations, requests for waiver of cost-share for brand name medications or devices taken or used for a preventive purpose.

If you are currently obtaining a covered medication from the network mail order pharmacy, you have the option to receive that medication from a network retail pharmacy. Please call Pharmacy Benefit Customer Service at the number on your ID card if you need assistance with this issue. Also, if you are currently obtaining a Specialty Medication from a Specialty Pharmacy and need to receive that medication from a retail pharmacy instead, please contact Pharmacy Benefit Customer Service. MaxorPlus will determine whether you are eligible to receive the Specialty Medication from a retail pharmacy instead of a Specialty Pharmacy.

Benefit-Specific Exclusions:

- Abortifacient medications
- Administration of a covered medication
- Biologic serums
- Blood and blood factors
- Certain categories of injectable medications
- Compounded medications obtained from a mail order pharmacy
- Designated medications prescribed by an ineligible provider or dispensed by an unapproved pharmacy or provider to members enrolled in the Designated Prescription Network Program
- Nutritional supplements, including infant formula
- Medications, devices, equipment and supplies lawfully obtainable without a prescription, except as stated in this benefit plan
- Medical devices, except as stated in this benefit
- Medical foods
- Medication delivery implants
- Medications designated as clinic packs
- Medications dispensed to a member who is an inpatient in any facility
- Medications for athletic performance
- Medications for lifestyle enhancement
- Medications labeled "Caution – Limited by Federal Law to Investigational Use" or words to that effect and any experimental medications as determined by MaxorPlus, except as stated in this benefit
- Medications packaged with one other or multiple other prescription products

- Medications packaged with over-the-counter medications, supplies, medical foods, vitamins or other excluded products
- Medications that exceed limitations, including, but not limited to, quantity, age, gender and refill limits
- Medications used for any cosmetic purpose, including but not limited to, Tretinoin for members age 26 and older
- Medications used to treat a condition not covered under this plan
- Medications with primary therapeutic ingredients that are sold over the counter in any form, strength, packaging or name
- Prescription medications dispensed in unit-dose packaging, unless that is the only form in which the medication is available
- Prescription refills for medications that are lost, stolen, spilled, spoiled or damaged
- Medications designed for weight gain or loss, including but not limited to, Xenical® and Meridia®, regardless of the condition for which it is prescribed
- Medications obtained from an out-of-network mail order pharmacy
- Medications to improve or achieve fertility or treat infertility
- Medications for sexual dysfunction

Y. PHYSICAL THERAPY (PT), OCCUPATIONAL THERAPY (OT), SPEECH THERAPY (ST) AND HABILITATION SERVICES

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Maximum: PT, OT, and ST services are limited to a combined in- and out-of-network maximum of sixty (60) visits per member, per plan year. Evaluations apply to the sixty (60) visit limit.

Benefit Description: Benefits are available for PT, OT, ST and habilitation services.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration and home independence
- Any care for comfort and convenience
- Cognitive therapy
- Computer speech training and therapy programs and devices
- Custodial Care
- Domiciliary Care
- Massage therapy, except in limited circumstances as described in current Evidence-based Criteria
- Occupational therapy for any purpose other than training the member to perform the activities of daily living
- Phase III cardiac rehabilitation programs
- Physical or occupational therapeutic services performed in a group setting of 2 or more individuals
- Services rendered after a member has met functional goals
- Services rendered when no objectively measurable improvement is reasonably anticipated
- Services to prevent regression to a lower level of function
- Services to prevent future injury
- Services to improve or maintain posture
- Strength training, cardiovascular endurance training, fitness programs, strengthening programs and other services designed primarily to improve or increase strength
- Work re-entry therapy, services or programs

Z. PHYSICIAN SERVICES

Your Cost-Share:

In-Network: You pay one copay, per member, per provider, per day for office, home and walk-in clinic visits. If you receive preventive services during one of these visits, your copay may be waived, as described in the *"Preventive Services"* section of this benefit book.

Allergy injections: You pay a PCP or Specialist copay for injections received from in-network providers, even if no office visit is billed. If you receive any allergy related services or testing, You pay in-network deductible and coinsurance.

Your copay will be waived if you receive only the following services and no other covered service during your visit:

- Covered immunizations
- Covered laboratory services
- Covered physical therapy, speech therapy, occupational therapy (PT, OT, ST); these services are subject to in-network deductible and coinsurance

You pay in-network deductible and coinsurance for non-preventive physician services provided in locations other than an office, home, or walk-in clinic, including but not limited to, inpatient and outpatient facilities. If you receive preventive physician services that are billed separately from inpatient or outpatient facility charges, your cost-share for those services may be waived as described in the *"Preventive Services"* section of this benefit book.

Out-of-Network: You pay out-of-network deductible and coinsurance for services rendered by an out-of-network physician. If you receive services from a noncontracted provider, you also pay the balance bill.

See the "Emergency" section for cost-share for emergency professional services.

Professional services provided by a radiologist or pathologist, including a dermapathologist, are always subject to applicable deductible and coinsurance, regardless of where the radiologist or pathologist performs the services.

You pay applicable deductible and coinsurance, and balance bill for sleep studies, regardless of where the sleep study is performed.

Benefit Description: Benefits are available for the following:

- Abortifacient medications for the abortions covered under this plan, including oral medications as described in current Evidence-based Criteria
- Allergy testing, antigen administration, and desensitization treatment
- Office, home, or walk-in clinic visits (urgent care facilities are not walk-in clinics) for the diagnosis and treatment of a sickness or injury
- Orthognathic treatment and surgery
- Inpatient medical visits
- Medications, and the administration of medications in a physician's office
- Second diagnostic surgical opinions
- Services for FDA-approved patches, rings, and contraceptive injections; FDA-approved diaphragms, cervical caps, cervical shields, female condoms, sponges, and spermicides; and FDA-approved emergency contraception. See the "Guidance Regarding Preventive Medications" section on www.azblue.com for a list of contraceptive methods covered as preventive services under the pharmacy benefit.
- Services for FDA-approved sterilization procedures
- Services for fitting, implantation, and/or removal (including follow-up care) of FDA-approved female contraceptive devices
- Services for FDA-approved implanted contraceptive devices
- Sleep studies
- Surgical procedures (including assistance at surgery). Call customer service at the number on your ID card to verify that the surgical assistant chosen by your physician is eligible and to determine whether the surgical assistant and anesthesiologist selected by your physician are in-network providers.
- Treatment of TMJ

The following circumstances may impact member cost-share for physician services:

- If multiple surgical procedures are performed during a single operative session, the secondary procedures are usually reimbursed at reduced amounts. Noncontracted providers may bill the full

amount for secondary, incidental or mutually exclusive procedures, in addition to the primary surgical procedure.

- You may receive services in a physician's office that incorporate services or supplies from a provider other than your physician. If the other provider submits a separate claim for those services or supplies, you will pay the cost-share for the other provider plus the cost-share for your office visit. Examples of services or supplies from another provider include durable medical equipment from a medical supply company, an X-ray reading by a radiologist, or tissue sample analysis by a pathologist.

AA. POST-MASTECTOMY SERVICES

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available, to the extent required by applicable state and federal law, for breast reconstruction following a medically necessary mastectomy. Benefits include all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance, including postoperative implanted or external prostheses; and treatment of physical complications for all stages of the mastectomy, including lymphedema.

Notice of Rights Under the Women's Health and Cancer Rights Act of 1998 (WHCRA): If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving the mastectomy-related benefits described above under "Benefit Description," coverage will be provided in a manner determined in consultation between the attending physician and the member being treated. These benefits are subject to the same cost-share generally applicable to other medical and surgical benefits provided under this plan, as described in the "Member Cost-share" section of your SBC. If you would like more information on WHCRA benefits, call BCBSAZ Customer Service at the number listed on your ID card.

BB. PREGNANCY, TERMINATION

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for abortions that meet the following requirements:

- The treating provider certifies in writing the abortion is medically necessary in order to save the life of the mother or to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion.

Benefits are also available for abortifacient medications for the abortions covered under this plan, including some oral medications, as described in current Evidence-based Criteria.

Benefit-Specific Exclusion: Abortions, except as stated in this benefit.

CC. PREVENTIVE SERVICES

Your Cost-Share:

In-Network:

Your cost-share is waived, regardless of the location where services are provided, if:

- You receive one of the services listed in the Benefit Description subsection of this Preventive Services section; **and**
- The diagnosis codes, procedure codes, or combination of procedure and diagnosis codes billed by your provider on the line of the claim indicates the service is preventive.

For certain covered preventive medications and items obtained from an in-network pharmacy, your cost-share is waived for the generic version of the medication or item and you pay applicable cost-

share for the brand-name version of the medication or item. You may request an exception for waiver of cost-share for the brand name version of a preventive medication or item obtained from an in-network pharmacy. See the **"Benefit Description"** section below for information about the exception process.

Out-of-Network: You pay out-of-network deductible and coinsurance. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: **"Preventive Services"** are those services performed for screening purposes when you do not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the member has a condition or an active symptom of a condition, which is determined by the procedure codes, diagnosis codes, or combination of procedure and diagnosis codes your provider submits on the claim.

Benefit-Specific Maximum: Benefits are limited to one (1) manual or electric (not hospital grade) breast pump and breast pump supplies per member, per plan year. These limits do not apply to claims for preventive services submitted with a primary mental health and/or substance abuse diagnosis.

Benefit Description: Benefits are available for the following services recommended by your provider and as appropriate for the member's age and gender, and as recommended by:

- Advisory Committee on Immunization Practices (ACIP) routine immunization recommendations at www.cdc.gov/vaccines/hcp/acip-recs/index.html
- Health Resources and Services Administration (HRSA) guidelines for pediatric and adolescent preventive care and screening at https://mchb.hrsa.gov/maternal-child-health-topics/child-health/bright-futures.html
- HRSA guidelines for women's healthcare services at www.hrsa.gov/womens-guidelines/index.html
- U.S. Preventive Services Task Force (USPSTF) A or B graded services at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations

Benefits are also specifically available for the following services:

- Mammograms for routine breast cancer screening, including:
  - A single baseline mammogram for members ages 35-39; and
  - One mammogram per year for members age 40 and older
  - More frequent mammograms based on the physician's recommendation
- Prostate specific antigen (PSA) testing and digital rectal examination (DRE) for members age 40 and older, or for members under age 40 who are at high risk due to:
  - Family history (such as multiple first-degree relatives diagnosed at an early age);
  - African-American race; or
  - Previous borderline PSA levels
- Well-baby/child care up to 47 months; childhood immunizations

Benefits will be provided for any other preventive service required by federal or state law. For a list of covered preventive medications, go to the "Guidance Regarding Preventive Medications" section on www.azblue.com. For questions about preventive services covered under this benefit, call Customer Service at the number on your ID card or log in to your MyBlue account on www.azblue.com for more preventive health information and links.

In order to request an exception for waiver of cost share for the brand name version of a preventive medication or item obtained from an in-network pharmacy, you or your physician/provider can call the Pharmacy Benefit Customer Service number on your ID card 24 hours per day, 7 days per week, 365 days per year. There is no guarantee that BCBSAZ and/or the PBM will authorize an exception.

If a preventive service has been denied due to your gender on file with BCBSAZ, and you are undergoing or have undergone gender transition, please contact Customer Service at the number on your ID card for assistance. BCBSAZ covers all gender-specific preventive services that are deemed medically necessary for a member, as determined by the member's attending provider, without regard to the member's gender identity, gender assigned at birth, or gender that is on file with BCBSAZ.

Services or tests included under this benefit and provided to a member with a specific diagnosis, signs, or symptoms of a condition or disease for which the test is being performed may be covered through another benefit section of this plan. Certain maternity services covered under this benefit also are available through the *"Maternity"* benefit.

Benefit-Specific Exclusions:

- Abortifacient medications
- All prescription and over-the-counter contraceptive medications and devices for male members

Services or tests listed under this benefit and provided to a member with a specific diagnosis, signs or symptoms of a condition or disease for which the test is being performed may be covered through another benefit section of this plan. Certain maternity services covered under this benefit are also available through the "Maternity" benefit.

DD. RECONSTRUCTIVE SURGERY AND SERVICES

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit Description: Benefits are available for reconstructive surgery, which is surgery performed to improve or restore the impaired function of a body part or organ resulting from one of the following:

- Congenital defects;
- Illness and disease;
- Injury and trauma;
- Surgery; **or**
- Therapeutic intervention

Benefit-Specific Exclusion: Cosmetic surgery and any related complications, procedures, treatment, office visits, consultations, and other services for Cosmetic purposes. This exclusion does not apply to:

- Breast reconstruction following a Medically Necessary mastectomy, to the extent required by federal and state law
- Other services required by federal or state law to be covered

EE. SKILLED NURSING FACILITY (SNF) SERVICES

Your Cost-Share: You pay applicable deductible and coinsurance. The cost-share amount will depend on the provider's network status. If you receive SNF services at a noncontracted provider, you also pay the balance bill, in addition to deductible and applicable coinsurance.

Benefit-Specific Maximum: Benefits are limited to Sixty (60) in- and out-of-network combined days of SNF services per member, per plan year. This limit does not apply to claims for SNF services submitted with a primary mental health and/or substance abuse diagnosis.

Changing Types of Inpatient Care: Some inpatient facilities provide different levels of care within the same facility (for example, acute inpatient, Inpatient Rehabilitation, and other inpatient care). If you move or transfer between different levels of inpatient care, even within the same facility, your cost-share obligation will change to match your level of care. **If you are moving to a level of care that requires precertification, you will also need to obtain a new precertification for the different level of care.**

Benefit Description: Benefits are available for inpatient skilled nursing facility services which are provided in a facility licensed to offer 24-hour skilled nursing services and which meet the following criteria:

- A physician or registered nurse practitioner is present on the premises of the facility or on-call at all times;
- Room and board in a semi-private room or a standard private room (not deluxe) is covered if the hospital only has private rooms or if a private room is medically necessary;

- Services must be provided to patients who require 24-hour skilled care and have the ability to achieve treatment goals in a reasonable period of time;
- Skilled nursing services must be provided by and under the supervision of qualified and licensed professionals, such as an LPN or RN, and provided at a level of complexity and sophistication requiring assessment, observation, monitoring, and/or teaching or training to achieve the medically desired outcome;
- The facility has 24/7 onsite RN coverage;
- The facility has sufficient professional staff to provide appropriate treatment;
- The facility's designated medical director is a physician or registered nurse practitioner and provides direction for services provided at the facility; and
- The services meet the BCBSAZ medical necessity criteria for inpatient level of care.

Benefit-Specific Exclusions:

- Activity therapy and milieu therapy including community immersion or integration, home independence and work re-entry therapy or any care intended to assist an individual in the activities of daily living or for comfort and convenience
- Custodial Care
- Domiciliary Care
- Medications dispensed at the time of discharge from a facility
- Private Duty Nursing
- Respite Care
- Services rendered after a member has met functional goals and no objectively measurable improvement is reasonably anticipated, as determined by BCBSAZ

FF. TELEHEALTH SERVICES

Your Cost-Share: No charge.

Benefit Description: Remote medical and behavioral health consultations between a Provider and a patient are available through the Telehealth Services Administrator (TSA), including:

- Medical consultations with a Physician, Physician's assistant, or nurse practitioner
- Psychiatry consultations with a psychiatrist
- Counseling with a psychologist or other licensed therapist

Benefit-Specific Exclusions:

- Emergency services
- Preventive services
- Services covered under the "*Telemedicine Services"* benefit
- Services not provided through the TSA

GG. TELEMEDICINE SERVICES

Your Cost-Share: You pay the cost-share amount applicable to the service being provided via telemedicine. Your location when receiving the service and the provider's network status determines the type and amount of your cost-share. See the specific benefit section(s) for information regarding whether you will pay deductible, coinsurance, copays and/or access fees. You will always pay in-network cost-share for emergency services provided via telemedicine.

Benefit Description: Benefits are available for telemedicine services delivered by an in-network provider through interactive audio-video electronic media to treat the following conditions:

- Burns
- Cardiologic conditions
- Dermatologic conditions
- Infectious diseases
- Mental health disorders
- Neurologic diseases, including strokes
- Pain medicine
- Pulmonary diseases
- Substance abuse
- Trauma

- Urology
- Other conditions for which coverage is required by federal or state law

Benefits are also available for emergency or urgent telemedicine services from out-of-network providers to treat one of the covered conditions.

Benefit-Specific Exclusions:

- Non-emergency and non-urgent telemedicine services from an out-of-network provider
- Services delivered through the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail
- Services provided through the "*Telehealth Services*" benefit

HH. TRANSPLANTS – ORGAN – TISSUE – BONE MARROW TRANSPLANTS AND STEM CELL PROCEDURES

Your Cost-Share: You pay applicable deductible, coinsurance, and copays. The cost-share amount will depend on the provider's network status and the place you receive services. If both a donor and a transplant recipient are covered by a BCBSAZ plan or a plan administered by BCBSAZ, the transplant recipient pays the cost-share related to the transplant.

Benefit-Specific Definition: **"Bone Marrow Transplant"** is a medical or surgical procedure comprised of several stages, including:

- Administration of high dose chemotherapy and high dose radiotherapy as prescribed by the treating physician;
- Harvesting of stem cells from the bone marrow or the blood of a third-party donor (allogeneic transplant) or the member (autologous transplant) and all component parts of the procedure;
- Hospitalization and management of reasonably anticipated complications;
- Infusion of the harvested stem cells; **and**
- Processing and storage of the stem cells after harvesting.

Benefit Description: In-network benefits are available for covered transplant Services from Blue Distinction Centers for Transplants. The following transplants are eligible for coverage if they meet current Evidence-based Criteria:

- Allogeneic and autologous bone marrow or stem cell
- Autologous islet cell transplant (AICT)
- Cornea
- Heart; heart-lung; kidney; kidney-liver; kidney-pancreas; liver; lung (lobar, single and double lung); pancreas; small bowel; small bowel-multivisceral

Benefits are available for the following services in connection with, or in preparation for, a covered transplant:

- Air and ground transportation of a medical team to and from the site in the contiguous states of the United States to obtain tissue that is subsequently transplanted into a member
- Bone marrow search and procurement of a suitable bone marrow donor when a member is the recipient of a covered allogeneic transplant and in accordance with customary transplant center protocol as identified by that specific transplant center
- Chemotherapy or radiation therapy associated with transplant procedures
- Harvest and reinfusion of stem cells or bone marrow
- Inpatient and outpatient facility and professional services
- Medical expenses incurred by a donor when the recipient is covered by BCBSAZ. Covered donor expenses include complications and follow-up care related to the donation for up to six (6) months post-transplant, as long as the recipient's coverage with or administered by BCBSAZ remains in effect
- Pre-transplant testing and services

Benefit-Specific Exclusions:

- Expenses related to a noncovered transplant
- Expenses related to donation of an organ to a recipient who is not covered by BCBSAZ

- Transplants that do not meet current Evidence-based Criteria

II. TRANSPLANT AND GENE THERAPY TRAVEL AND LODGING

Your Cost-Share: Waived.

Benefit-Specific Maximums: Benefits are limited to a maximum of $10,000 per member, per transplant or gene therapy treatment. Covered expenses incurred by a Caregiver or donor accumulate toward the member's $10,000 per transplant maximum.

Benefit-Specific Definition: **"Caregiver"** is the individual primarily responsible for providing daily care, basic assistance and support to a member who is eligible for transport lodging and reimbursement. Caregivers may perform a wide variety of tasks to assist the member in his or her daily life, such as preparing meals, assisting with doctors' appointments, giving medications or assisting with personal care and emotional needs.

Benefit Description: Coverage is available for reimbursement of the transplant and gene therapy travel and lodging expenses as listed below during evaluation, transplant, post-transplant care, and complications directly related to the transplant when all the following criteria are met:

- BCBSAZ has precertified the transplant or, if BCBSAZ did not precertify the transplant, the transplant met the requirements of this Benefit Plan;
- The distance from the member's, donor's or caregiver's residence must be more than 60 miles from the transplant facility
- The expenses are incurred by the member, donor or the member's caregiver; and
- The expenses are for any of the following:
  - Meal expenses;
  - Mileage for travel in a personal vehicle (at the rate set by the Internal Revenue Service for medical purposes in effect at the time of travel); car rental charges; bus; train or air fare; **and**
  - Room charges from hotels, motels and hostels or apartment rental.

In-network benefits are available for covered transplant services and gene therapies only when administered in a contracted Blue Distinction Center.

Benefit-Specific Exclusions:

- Alcoholic beverages; in-room movies; items from in-room mini-bars or refrigerators; laundry, cleaning or valet services; telephone or Internet service charges; spa services; gym facilities; or other hotel or motel amenities
- All travel and lodging expenses in excess of the benefit-specific maximums stated above
- Ambulance transportation (ground or air)
- Caregiver salary, stipend and compensation for services
- Cleaning fees
- Expenses for travel or lodging incurred in connection with transplant services that do not qualify for coverage under this Benefit Plan
- Food preparation services
- Furniture or supplies for a rental apartment
- Home modifications
- Security deposits
- Travel and lodging expenses for transplants other than a covered solid organ, bone marrow or stem cell transplant, even if such a transplant is a covered service
- Travel and lodging expenses for members, donors or Caregivers when the member, donor or Caregiver does not travel more than sixty (60) miles for an authorized transplant or transplant-related services
- Vehicle maintenance or services (such as tires, brakes, oil change)

Claims for Reimbursement:

To request reimbursement of eligible transplant travel and lodging expenses, you must submit a Transplant Travel and Lodging claim form along with dated receipts to BCBSAZ. The address for claims submission is listed in the Customer Service section at the front of this book. To request a claim form, call the Customer Service number on your ID card.

JJ. URGENT CARE

Your Cost-Share: You pay one urgent care copay per member, per provider, per day for services from a provider who is contracted with BCBSAZ to render urgent care services. You pay applicable cost-share if you receive urgent care services from an in-network provider who is not specifically contracted for urgent care services. You pay out-of-network deductible and coinsurance if you receive services from an out-of-network urgent care provider. If you receive services from a noncontracted provider, you also pay the balance bill.

Benefit-Specific Definition: "Urgent care" means treatment for conditions that require prompt medical attention, but which are not emergencies.

Benefit Description: Benefits are available for urgent care services rendered by an urgent care provider. Contracted providers are listed on the BCBSAZ website at www.azblue.com under "Urgent Care Centers."

Please be aware that the Plan Network includes some providers, such as hospitals, that offer urgent care services, but which are not specifically contracted with the Plan Network as urgent care providers. No matter what the circumstances, if you obtain urgent care services at a hospital or a hospital's on-site urgent care department, you will be responsible for the applicable emergency room cost-share.

KK. VISION EXAMS (ROUTINE)

This benefit plan does not provide a routine vision exam benefit. Contact your group benefit administrator for information.

WHAT IS NOT COVERED

NOTWITHSTANDING ANY OTHER PROVISION IN THIS PLAN, NO BENEFITS WILL BE PAID FOR EXPENSES ASSOCIATED WITH THE FOLLOWING:

Abortions, except as stated in this plan

Activity Therapy – Activity therapy and milieu therapy, including community immersion, integration, home independence and work re-entry therapy; and any care intended to assist an individual in the activities of daily living; and any care for comfort and convenience, except for limited hospice benefits

Alternative Medicine – Non-traditional and alternative medical therapies; interventions; services and procedures not commonly accepted as part of allopathic or osteopathic curriculum and practices; naturopathic and homeopathic medicine; diet therapies; aromatherapy

Bariatric Surgeries

Benefit-specific exclusions and limitations listed in this book under particular benefit sections

Biofeedback

Blood Administration for the purpose of general improvement in physical condition

Body Art, Piercing and Tattooing – Services related to body piercing, cosmetic implants, body art, tattooing and any related complications. This exclusion does not apply to services required by federal or state law to be covered.

Care for health conditions that are required by state or local law to be treated in a public facility

Care required by state or federal law to be supplied by a public school system or school district

Certain Types of Facility Charges – Inpatient and outpatient facility charges for treatment provided by the following facilities are not covered: Group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters or foster homes.

Charges associated with the preparation, copying or production of health records

Cognitive and Vocational Therapy – Services related to improving cognitive functioning (i.e., higher brain functions), reinforcing or re-establishing previously learned thought processes, compensatory training, sensory integrative activities and services related to employability

Complications of Noncovered Services – Complications and consequences, whether immediate or delayed, arising from any condition or service not covered under this plan. Medical complications arising from an abortion are covered under this plan. This exclusion does not apply to services required by federal or state law to be covered.

Computer Speech Training, Therapy Programs and Devices

Consumable Medical Supplies, including but not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as stated in this plan

Cosmetic Services and any Related Complications – Surgery and any related complications, procedures, treatment, office visits, consultations, and other services for Cosmetic purposes. This exclusion does not apply to breast reconstruction following a Medically Necessary mastectomy, Medically Necessary surgery to improve or restore the impaired function of a body part or organ, Services required by federal or state law to be covered, or Surgery to correct a congenital defect.

Cosmetics and health and beauty aids

Counseling – Counseling and behavioral modification services, except as stated in this plan

Court-Ordered Services – Court-ordered testing, treatment and therapy, unless such services are otherwise covered under this plan as determined by BCBSAZ or as otherwise required under applicable law

Custodial Care

Dental – Except as stated in this plan, dental and orthodontic services; placement or replacement of crowns, bridges or implants; any fixed dental reconstruction of the teeth; orthodontics; extractions of teeth; dentures; vestibuloplasty and surgical orthodontics; and any procedures associated with the services listed in this exclusion, including but not limited to procedures associated with dental implants and fitting of dentures

Dietary and Nutritional Supplements – All dietary, caloric and nutritional supplements, such as specialized formulas for infants, children or adults or other special foods or diets, even if prescribed, except as stated in this plan

Domiciliary Care

Expenses for services that exceed benefit limitations

Experimental or Investigational Services, except as stated in this plan

Fees that are –

- Associated with the collection or donation of blood or blood products
- Other than for medically necessary, in-person, direct member services, except as stated in this plan
- For concierge medicine services, **or**
- For direct primary care

Fertility and Infertility Services – Services to improve or achieve fertility (ability to conceive) or to diagnose and treat infertility (inability to conceive)

Flat Feet – Services for treatment of flat feet, weak feet and fallen arches. This exclusion does not apply to arch supports when medically necessary for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg.

Foot Care – Services for foot care, including trimming of nails or treatment of corns or calluses. This exclusion does not apply when medically necessary for diabetes, neurological involvement, or peripheral vascular disease of the foot or lower leg.

Free Services – Services you receive at no charge or for which you have no legal obligation to pay

Genetic and Chromosomal Testing, Screening and Therapy – Genetic and chromosomal testing, screening and therapy for an individual who is asymptomatic, unaffected or not displaying signs or symptoms of a disorder for which the test, screening or therapy is performed, except as stated in this plan

Government Services – Services provided at no charge to the member through a governmental program or facility

Growth Hormone – Growth hormone, except as specified in current Evidence-based Criteria. Growth hormone to treat Idiopathic Short Stature (ISS) is expressly excluded.

Hearing Aids and Associated Services – Hearing aids, including external, semi-implantable middle ear and implantable bone conduction hearing aids, and any associated services. Hearing screenings are covered as part of a preventive physical exam, except as stated in this plan.

Hypnotherapy

Inpatient or Outpatient Long-Term Care

Laboratory Services Provided Without an Order From an Eligible Provider

Lifestyle and work-related education and training, and management services

Lodging and Meals – Lodging and meals, except as stated in this plan

Maintenance Services – Services rendered after a member has met functional goals; services rendered when no objectively measurable improvement is reasonably anticipated, services to prevent regression to a lower level of function, services to prevent future injury and services to improve or maintain posture, except as stated in this plan

Manipulation of the Spine Under Anesthesia

Marijuana – Medical marijuana, marijuana and any costs or fees associated with obtaining medical marijuana, such as obtaining an initial or renewal registry identification card, even when prescribed and obtained in compliance with state law(s)

Massage Therapy – Massage therapy, except in limited circumstances as described in current Evidence-based Criteria

Medical equipment, supplies, and medications sold on or through unregulated distribution channels as determined by BCBSAZ, including online sources such as eBay, Craig's List or Amazon.com; or at garage sales, swap meets, and flea markets

Medications – Medications which are:

- Not FDA approved
- Not required by the FDA to be obtained with a prescription, except as stated in this plan
- Not used in accordance with current Evidence-based Criteria
- Used to treat a condition not covered by BCBSAZ
- Off-label, unlabeled and orphan medications, except as stated in this plan

Medications Dispensed in Certain Settings – Prescription medications given to the member, for the member's future use, by any person or entity that is not a licensed pharmacy, home health agency, specialty pharmacy or hospital emergency room

Member Costs or Fees associated with health clubs and weight loss programs.

Neurofeedback

Non-Medically Necessary Services – Services that are not medically necessary as determined by BCBSAZ or BCBSAZ's contracted vendor. BCBSAZ and/or the contracted vendor may not be able to determine medical necessity until after services are rendered

Non-Medical Ancillary Services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy

Over-the-Counter Items – Medications, devices, equipment and supplies that are lawfully obtainable without a prescription, except as stated in this plan

Payments for exclusions imposed by any certification requirement

Payments for services that are unlawful in the location where the person resides at the time the expenses are incurred

Personal Comfort Services – Services intended primarily for assistance in daily living, socialization, personal comfort and convenience, homemaker services and services primarily for rest, domiciliary or convalescent care, costs for television, telephone, newborn infant photographs, meals other than meals provided to a member by an inpatient facility while the member is a patient in the inpatient facility, birth announcements, and other services and items for other non-medical reasons

Phase 3 Cardiac Rehabilitation

Private Duty Nursing

Refills or Replacements – Refills or replacements for medications covered under this benefit plan that are lost, stolen, spilled, spoiled or damaged

Reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic, or custodial evaluations.

Reproductive Services – Procedures, treatment, office visits, consultations and other services related to the genetic selection and/or preparation of embryos and implantation services including, but not limited to, pre-implantation genetic diagnosis and in vitro fertilization and related services

Respite Care, except as covered in the Hospice Services benefit

Reversal of Surgical Procedures, except as stated in current Evidence-based Criteria and other criteria as determined by BCBSAZ

Screening Tests – Any testing performed on an individual who does not have a specific diagnosis or acute signs or symptoms of a condition or disease for which the test is being performed, regardless of whether the individual has a family history or other risk factors for the disease or condition, except as stated in this plan

Sensory Integration and Music Therapy

Service Animals and related costs, including but not limited to food, training and veterinary costs

Services for Children of a Dependent, unless the child is also eligible as a Dependent.

Services for Idiopathic Environmental Intolerance – Services associated with environmental intolerance from unknown causes (idiopathic), multiple chemical sensitivity, the diagnosis or treatment of environmental illness (clinical ecology), such as chemical sensitivity or toxicity from exposure to atmospheric or environmental contaminants, pesticides or herbicides

Services for Weight Loss and Gain, except as stated in this plan

Services from Ineligible Providers

Services For Conditions Medicare Identifies as Hospital-Acquired Conditions (HACs), and/or National Quality Forum (NQF) "Never Events"

Services Paid for by Other Organizations; Services Required By Law to be Paid for by Other Organizations – Services paid for by other organizations and/or services required by law to be paid for by other organizations. Other organizations include, but are not limited to, the government, a school, and/or biotechnical, pharmaceutical, medical or dental device industry organizations. Examples of services that are paid for or required by law to be paid for by other organizations are services that are part of a child's individual education program and/or worksite and ergonomic evaluations.

Services Prior to Member's Coverage Effective Date

Services Provided After the Member's Coverage Termination Date, except as stated in this plan

Services Related to or Associated with Noncovered Services. This exclusion does not apply to services required by federal or state law to be covered.

Services Without A Prescription – Services and supplies that are required by this plan to have a prescription and are not prescribed by a physician or other provider licensed to prescribe

Sexual Dysfunction – Services for sexual dysfunction, regardless of the cause, and medications for the treatment of sexual dysfunction

Spinal Decompression or Vertebral Axial Decompression Therapy (VAX-D)

Strength Training – Services primarily designed to improve or increase fitness, strength or athletic performance, including strength training, cardiovascular endurance training, fitness programs and strengthening programs, except as stated in this plan

Telephonic and Electronic Consultations – Telephonic and electronic consultations, except as stated in this plan

Therapy Services, except as stated in this plan

Therapy to Improve General Physical Condition including, but not limited to, inpatient and outpatient routine long-term acute care

Training and Education – Training and education, except as stated in this plan

Transportation – Transport services and travel expenses, except as stated in this plan

Vision – Routine vision exams, except for preventive vision screenings for members under age 5; vision therapy; eye exercises; all types of refractive keratoplasties including but not limited to radial keratotomy and/or lasik surgery; any other procedures, treatments and devices for refractive correction; eyeglass frames and lenses, contact lenses and other eyewear; vision examinations for fitting of eyeglasses and contact lenses, except as stated in this plan

Vitamins – All vitamins, minerals and trace elements that are lawfully obtainable without a prescription, except as stated in this plan

Wigs and hairpieces, except as stated in this plan

Workers' Compensation – Services to treat illnesses and injuries which are (1) covered by Workers' Compensation; and (2) expressly identified as workers' compensation claims when submitted to BCBSAZ. This exclusion does not apply if the member has made a statutory opt-out election and/or is exempt from Workers' Compensation coverage.

PLAN ADMINISTRATION

Changes to Your Information

If you do not tell your Plan Administrator about changes, correspondence from BCBSAZ may not reach you in a timely manner. Also, you may have to reimburse BCBSAZ for claims payments we make on behalf of you or your Dependents, if you or your Dependents became ineligible but incurred claims before you gave us notice. You may also have to pay costs incurred by BCBSAZ for collection of claims payments made after you or your Dependents became ineligible.

Please see your Plan Administrator if you have changes to the following:

- A disabled Dependent age 26 or older who is no longer disabled
- Eligibility of you or your Dependents for Arizona Health Care Cost Containment System (AHCCCS) or other Medicaid coverage during the term of this contract
- Eligibility of you or your Dependents for basic health plan (BHP) coverage during the term of this contract
- Eligibility of you or your Dependents for individual coverage purchased through a state or Federal Exchange.
- Eligibility of you or your Dependents for Medicare during the term of this contract
- Eligibility of you or your Dependents for the Children's Health Insurance Program (CHIP) coverage during the term of this contract
- Individuals being added to the benefit plan: Spouse, newborns, adopted children, children placed for adoption, stepchildren
- Individuals removed from the benefit plan due to divorce or death
- Other medical coverage that you or your Dependents add or lose, including any changes in benefits
- Your mailing address or phone number

Coordination of Benefits (COB)

If you are eligible for benefits under another group health plan, and the other group plan is the primary payer, then the combined benefit payments from all coverages will not exceed the greater of the primary payer's or BCBSAZ's allowed amount.

If your other group health insurance does not include a coordination of benefits provision, the other group coverage pays first. If your other group health insurance provides for coordination of benefits, the following rules will be used to determine which coverage will pay first:

- If the person who received care is covered as an active employee under one benefit plan and as a dependent under another, the employee coverage pays first.
- If the person who receives care is covered as an active employee under one benefit plan and as an inactive employee under another, the coverage through active employment pays first.
- If the person who receives care is a dependent child, then the plan benefits of the parent whose birthday occurred earlier in a calendar year shall cover the child first.
- If both parents have the same birthday, the benefits of the plan that covered a parent longer shall cover a dependent child first.
- If one of the plans determines the order of benefits based upon the gender of a parent and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rule shall determine the order of benefits.
- If the dependent child's parents are legally separated or divorced, the following applies:
  - If a court decree specifies the parent who is financially responsible for the child's healthcare expenses, the specified parent's coverage pays first.
  - If there is no applicable court decree, the custodial parent's coverage pays first. If the custodial parent has remarried, the stepparent's coverage pays second. The non-custodial parent's coverage pays last.
  - If the parents have joint custody, the plan benefits of the parent whose birthday occurred earlier in a calendar year pays first.

When none of the above applies, the coverage you have had for the longest continuous period of time pays first (see *"Non-Duplication of Benefits"*).

If you have coverage under Medicare, Medicare guidelines will be used to determine the primary payer. If the provider accepts assignment from Medicare, the combined payments by Medicare and BCBSAZ will not exceed the Medicare Allowed Amount. If the Provider does not accept assignment from Medicare the

combined payments by Medicare and BCBSAZ will not exceed the Provider's Billed Charges. If the Provider opts-out of Medicare, BCBSAZ is the primary payer.

Non-Duplication of Benefits

If services are covered under this benefit plan and one or more other group benefit plans that are issued or administered by BCBSAZ, the rules described above in *"Coordination of Benefits"* will be used to determine which coverage pays first. Payment of the claim will be subject to all applicable deductibles, coinsurance and copays. The combined benefit payments will not exceed the amount that BCBSAZ would have paid if you had no other coverage.

If services are covered under this benefit plan and one or more BCBSAZ individual contracts, benefits will be paid first under the individual contract. Payment of the claim will be subject to all applicable deductibles, coinsurance and copays. The combined benefit payments will not exceed 100 percent of the amount BCBSAZ would have paid if you had no other coverage. BCBSAZ does not coordinate benefits with non-group coverage provided by an insurance plan other than BCBSAZ.

Definitions Related to Plan Administration

Please refer to the Plan Document and Summary Plan Description regarding Eligibility provisions.

Eligibility Requirements

Please refer to the Plan Document and Summary Plan Description regarding Eligibility provisions.

Effective Date of Coverage

Please refer to the Plan Document and Summary Plan Description regarding Eligibility provisions.

Loss of Eligibility

Please refer to the Plan Document and Summary Plan Description regarding Eligibility provisions.

Retiree Eligibility

Please refer to the Plan Document and Summary Plan Description regarding Eligibility provisions.

Special Enrollment Periods

Please refer to the Plan Document and Summary Plan Description regarding Eligibility provisions.

Termination of Coverage

Please refer to the Plan Document and Summary Plan Description regarding Eligibility provisions.

Leave of Absence

Please refer to the Plan Document and Summary Plan Description regarding Eligibility provisions.

Medical Support Orders

Coverage is available to a child of the Contract Holder in accordance with any court order or administrative order issued by a court of competent jurisdiction that requires the Contract Holder to provide health benefits coverage for such child. The order must clearly specify the name of the Contract Holder, the name and birth date of each child covered by the order and the time period to which the order applies.

Following receipt of the above information from the Group, BCBSAZ will add the child to the Contract Holder's coverage, subject to BCBSAZ's guidelines for adding Dependent children, as outlined above. If the Contract Holder does not have family coverage, the Contract Holder is required to enroll for family coverage and pay any additional required amounts due.

Benefit-Specific Eligibility

Under the following limited circumstances, a nonmember may be eligible to receive benefits under this plan:

- If a transplant recipient is covered under this plan and the donor is not a member, the donor may be eligible for limited benefits (see benefit descriptions for Transplants – Organ – Tissue – Bone Marrow Transplants and Stem Cell Procedures).

Nondiscrimination Statement

BCBSAZ complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to enable people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call (602) 864-4884 for Spanish and (877) 475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, (602) 864-2288, TTY/TDD (602) 864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance, BCBSAZ's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington, DC 20201, (800) 368-1019, TDD (800) 537-7697. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

MULTI-LANGUAGE INTERPRETER SERVICES

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe’é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit’éego bína’ídíłkidgo éí doodago Háida bíjá anilyeedígíí t’áadoo le’é yína’ídíłkidgo beehaz’áanii hólǫ díí t’áá hazaadk’ehjí háká a’doowołgo bee haz’ą doo bąąh ílínígóó. Ata’ halne’ígíí kojį’ bich’į’ hodíilnih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة .للتحدث مع مترجم اتصل ب .877-475-4799

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d’aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید 877-475-4799
.]تماس حاصل نمایید.

Assyrian:
ܟܝܢܐ ܕܡܬܟܠܡܝܢܘܬܐ ܥܠܬܟ ܐܘ ܕܡܢ ܐܢܬ ܡܣܥܪܝܢܘܬܐ ܠܗ، ܐܝܬ ܠܟ ܙܟܘܬܐ ܕܡܬܚܠܨܐ ܡܢ ܫܘܠܛܢܐ ܕܐܪܝܙܘܢܐ Blue Cross Blue Shield of Arizona، ܐܝܬ ܠܟ ܙܟܘܬܐ ܕܡܬܝܠܦܐ ܘܡܕܥܐ ܒܠܫܢܟܘܢ ܒܠܝܬܐ ܕܡܚܝܪܐ. ܠܡܡܠܠܐ ܥܡ ܡܬܪܓܡܢܐ، ܩܪܘܠܘܢ ܠܗܘܢ ܠܟܘܢ ܒܡܠܬܐ 877-475-4799.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคณ หรอคนทคณกาลงชวยเหลอมคาถามเกยวกบ Blue Cross Blue Shield of Arizona คณมสทธทจะไดรบความชวยเหลอและขอมลในภาษา ของคณไดโดยไมมคาใชจาย พดคยกบลาม โทร 877-475-4799