Northern Arizona Public Employees Benefit Trust (NAPEBT)

Administrative Manual

documenting the
Eligibility Provisions for Medical, Dental, Vision, and Life Insurance Benefits,
Outpatient Prescription Drug Benefits,
COBRA Continuation Coverage and Required Health Compliance Notices applicable to the Health and Life Benefits sponsored by NAPEBT.

Amended, restated, and effective July 1, 2024

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INTRODUCTION

Northern Arizona Public Employees Benefit Trust, hereafter referred to as "NAPEBT," is providing this Administrative Manual to document how each NAPEBT Employer administers eligibility under the Plan. Additionally, this document describes the self-funded outpatient prescription drug benefits that are provided to individuals enrolled in a NAPEBT-sponsored medical plan, COBRA continuation of coverage benefits and required health compliance notices. The self-funded NAPEBT-sponsored medical plans, and the insured dental, vision and life insurance plans and other voluntary benefit plans are not outlined in this Administrative Manual and are instead described in a separate document(s). Contact your Employer's Department using the Quick Reference Chart for information on medical plan, dental plan, vision plan, life insurance and voluntary benefits.

All provisions of this document contain important information. If an individual has any questions about their coverage or their obligations under the terms of the Plan, they should seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears in this chapter.

NAPEBT is committed to maintaining health care coverage for employees and their families at an affordable cost; however, because future conditions cannot be predicted, the Plan reserves the right to amend or terminate coverages at any time and for any reason. As the Plan is amended from time to time, Plan Participants will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, the Participant should rely on the later information.

This Plan **is not established** under or subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA.

The medical benefits of the Plan are self-funded with contributions from each participating Employer and from eligible Plan Participants held in a Trust administered by NAPEBT. Independent Claims Administrators pay benefits (e.g. medical and prescription drug claims) out of Trust assets. The Dental Plan, Vision Plan and Life Insurance benefits are fully insured with insurance companies whose names are listed on the Quick Reference Chart in this document, and these insured benefits are not outlined in this Administrative Manual and are instead described in separate insurance company documents.

A Quick Reference Chart follows this introductory text**.** The Quick Reference Chart is a handy resource for the names, addresses and phone numbers of the key contacts for NAPEBT benefits such as the Medical Plan Claims Administrator, Prescription Drug Benefits Administrator, or COBRA Administrator.

IMPORTANT NOTICE

Participants must promptly furnish to their Employer's Department listed in the Quick Reference Guide, information regarding:

- change of name or address,
- marriage, divorce, or legal separation,
- birth or death of any covered family member (including Domestic Partner or a Child of a Domestic Partner),
- change in status of a Dependent Child or Child of a Domestic Partner such as reaching the Plan's limiting age, or no longer meeting the definition of a Dependent or Domestic Partner,
- Medicare enrollment or disenrollment,
- the existence of other coverage.

Failure to timely notify this Plan may cause an individual to lose certain rights (e.g. COBRA continuation rights) under the Plan or may result in a liability to the Plan, or to the individual, if any benefits are paid for an ineligible person.

- Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment. Receipt of this document does not guarantee eligibility for Plan benefits.
- No individual shall have accrued or vested rights to benefits under this Plan. A vested right refers to a benefit that an individual has earned the right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed.

IMPORTANT TERMS USED IN THIS MANUAL

Certain terms used in this document to describe the individuals eligible or covered for benefits, are **important.** These terms are defined in the Definitions Article of this document and outlined below:

- **"Participant(s)"** refers to Active Employees, non-Medicare eligible Retirees, and COBRA Qualified Beneficiaries.
- **"Dependent(s)"** refers only to an eligible Spouse and Dependent Child(ren). a Dependent includes a Domestic Partner and Child of a Domestic Partner.

FOR HELP OR INFORMATION

The following Quick Reference Chart has important helpful information about the administrators of benefits of the NAPEBT Plan.

QUICK REFERENCE CHART	
Information Needed	**Provider**
Plan Sponsor	**Board of Trustees for NAPEBT** 2800 S. Lone Tree Road Flagstaff, AZ 86005 Phone: (928) 226-4209 Website: www.napebt.org
Plan and Benefit Administrator • Third Party Plan Administrator • Benefit Consulting • Accounting Service Provider	**Risk Program Administrators (RPA)** 333 E. Osborn Road, Suite 300 Phoenix, AZ 85012 Phone (833) 917-7205 Email: napebtservice@rpadmin.com For accounting services: NAPEBTAccounting@rpadmin.com
Online Benefits Center and COBRA Administration The online benefits center available to employees and their families for all NAPEBT Employers to enroll in and make updates to their benefit enrollment. COBRA Administration includes the following services: • Information About COBRA Coverage • Adding or Dropping COBRA Qualified Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments • Second Qualifying Event and Disability Notification	**Vimly Benefit Solutions** For Online Benefits Center: 12121 Harbour Reach Drive Mukilteo, WA 98275 Phone: (833) 917-7205 Email: napebtservice@rpadmin.com For COBRA Administration: PO Box 6 Mukilteo, WA 98275-0006 Phone: (206) 859-2697 Email: cobra@vimly.com

QUICK REFERENCE CHART	
Information Needed	**Provider**
Medical Plan Claims Administrator • Claim Forms (Medical and Behavioral Health) • Plan Benefit Information • Questions about the No Surprises Act and Transparency Regulations including the Qualifying Payment Amount (QPA) for emergency services. • Summary of Benefits and Coverage (SBC)	**Blue Cross Blue Shield of Arizona (BCBSAZ)** All correspondence to: P.O. Box 2924 Phoenix, AZ 85062-2924 Phone: (928) 526-7211 or (855) 845-1875 Statewide Website: www.azblue.com
Medical Plan Utilization Management (UM) Program **(Your Doctor must contact BCBSAZ)** • Precertification of coverage • Medical Coverage Guidelines	**Blue Cross Blue Shield of Arizona (BCBSAZ)** Precertification Phone: Maricopa County (602) 864-4320 or (800) 232-2345 ext 4320 Statewide Website: www.azblue.com – Resource Center, Resources Medical Coverage Guidelines Phone: Maricopa County (602) 864-4614 or (800) 232-2345 ext 4614 Statewide
Medical Plan Chiropractic Benefit Program • Additions/Deletions of Providers • General Questions and Information • Claim Issues • Provider Network Participation Verification • Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price.	**Chiropractic Benefits Administrator (CBA)** Claims Administration, American Specialty Health Networks P.O. Box 509001 San Diego, CA 92150-9001 Phone: (800) 678-9133
Medical Appeals and Grievances • Precertification Denial Appeals • Medical Appeals and Grievances • Behavioral Health Appeals and Grievances • External Review for certain claim appeals	**Blue Cross Blue Shield of Arizona (BCBSAZ)** Medical Appeals and Grievances, Mail Stop: A116 P.O. Box 13466 Phoenix, AZ 85002-3466 Phone: (602) 544-4938 or (866) 595-5998 Statewide Fax: (602) 544-5601

QUICK REFERENCE CHART	
Information Needed	**Provider**
Medical PPO Network • General Questions and Information • Nutritional Counseling and Training • Claim Issues • Provider Network Participation Verification • Additions/Deletions of Providers • Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price • Mental Health and Substance Abuse Services and Providers • Confidential Release of Information (Form) Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross and Blue Shield Association, provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. **No network access is available from Blue Cross and Blue Shield of Arizona outside of Arizona**. However, coverage may be available by using AZBlue, check for listings and verify with service provider before a visit. When traveling outside of Canada or the United States for authorized follow-up care or emergent situations contact Blue Cross Blue Shield of Arizona customer service department for precertification. **CAUTION:** Use of a **non**-PPO network hospital, facility or Health Care Provider could result in you having to pay a substantial balance of the provider's billing. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the plan's payment for a covered service. **Your lowest out of pocket costs will occur when you use In-Network PPO providers**.	**Blue Cross Blue Shield of Arizona (BCBSAZ)** All correspondence except claims to: P.O. Box 13466 Phoenix, AZ 85002-3466 Phone: (928) 526-7211 or (855) 845-1875 Statewide Website: www.azblue.com **BlueCard Program (getting care outside of Arizona)** Phone: (800) 810-2583 Website: www.bcbs.com

QUICK REFERENCE CHART	
Information Needed	**Provider**
Medical Plan Chiropractic Appeals and Grievances • Chiropractic disputes • Chiropractic Appeals and Grievances	**American Specialty Health Networks, Inc.** Appeals Coordinator P.O. Box 509001 San Diego, CA 92150-9001 Phone: (800) 678-9133 Fax: (619) 209-6237
24 Hour Nurse Assistance • For confidential assistance with health issues at any time, 24 hours a day, call the nurses at this hotline.	**Blue Cross Blue Shield of Arizona (BCBSAZ)** Phone: (866) 422-2729 Website: www.azblue.com/NurseOnCall
Disease Management (DM) Program • For confidential information and assistance managing these health conditions, Diabetes, Asthma, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Congestive Heart Failure, Arthritis, Low Back Pain & Depression, please call this program's health professionals.	**Blue Cross Blue Shield of Arizona (BCBSAZ)** Phone: (800) 232-2345 ext 5135 or (602) 864-5135

QUICK REFERENCE CHART	
Information Needed	**Provider**
Prescription Drug Benefits Administrator • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Formulary of Preferred Drugs • Precertification of Certain Drugs • Direct Member Reimbursement (for non-network retail pharmacy use) • Specialty Drug Program: Precertification and Ordering • PrudentRx Specialty Drug Program • Drug Claims and Claim Appeals including External Review	**CVS Caremark** **Retail Pharmacy and Customer Service Toll-free Phone:** Phone: (877) 456-0109 Website: www.caremark.com To order **Specialty Drugs** call: (800) 237-2767 **PrudentRx Program** Phone: (800) 578-4403 **Mail Order (Home Delivery) Service** FastStart Ordering: (800) 875-0867 M-F Toll-free Phone: (877) 456-0109 Website: www.caremark.com **Paper Claims** CVS Caremark Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136 Claim Appeal and External Review CVS Caremark: External Review Appeals Department MC109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax Number: (866) 689-3092 Physicians may submit urgent appeal requests by calling the physician-only toll-free phone: (866) 443-1183.
Telemedicine Three types of Healthcare available • Medical: see a doctor right away for a range of common illnesses, aches, and pains as well as prescribing medication ($49 for HDHP) • Counseling: certified psychologists or counselors available within minutes or by appointment ($95 doctorate level or $80 master level for HDHP) • Psychiatry: connect with board-certified psychiatrist face-to-face by video or voice ($175 initial visit or $90 15-minute follow for HDHP)	**BlueCare Anywhere** Toll-free Phone: (844) 606-1612 Website: www.BlueCareAnywhereAZ.com

QUICK REFERENCE CHART	
Information Needed	**Provider**
Employee Assistance Program (EAP) The EAP program is available to Employees and their families of Employers participating in NAPEBT: Up to **six (6) free counseling visits** are available for each event and public safety employees are eligible for up to an additional six (6). The EAP provides confidential information, support, and referral to help individuals cope with personal problems that impact their home and work life. EAP counselors can help with stress, marriage/family/work-related problems, substance abuse, financial and legal problems. Public Safety employees who have suffered from a traumatic event should contact their Employer's Department using the Quick Reference Chart for more information about additional services.	**EAP Program:** Jorgensen Brooks Group Toll-free Phone: (888) 520-5400 or Tucson (520) 575-8623 Website: www.jorgensonbrooks.com **EAP Traumatic Event Counseling for the City of Flagstaff and Coconino County:** Dr. Dallaqua 408 N. Kendrick Street, Suite #4, Flagstaff, AZ 86001 Phone: (928) 774-6364
Dental Plan (Insured) • Dental Network and Provider Directory • Dental Claims and Appeals	**Delta Dental of Arizona, Inc** Customer Service 15648 N. 35th Avenue Phoenix, AZ 85053-3863 Phone: (602) 938-3131 or (800) 352-6132 Website: www.deltadentalaz.com
Vision Plan (Insured) • Vision Network and Provider Directory • Vision Claims and Appeals	**Vision Service Plan (VSP)** 3333 Quality Drive Rancho Cordova, CA 95670 Phone: (916) 852-5000 or (800) 877-7195 Website: www.vsp.com
Wellness Incentive Program • Information on earning wellness program incentives • Sign up for wellness events • Technical Issues with Wellness Point Tracking System	**NAPEBT Wellness Administrative Specialist** Phone: (928) 679-7176 Website: https://coconino.az.gov/3189/NAPEBT-Document-Center

QUICK REFERENCE CHART	
Information Needed	**Provider**
Health & Wellness Clinic • Preventive, Primary and Acute Care • Health Coaching • Occupational Care • My Vera app for wellness incentive and scheduling	**VERA Whole Health** 1500 E. Cedar Avenue., Suite 80 Flagstaff, AZ 86004 Phone: (928) 774-3985 Website: flagstaff@verawholehealth.com or https://patients.verawholehealth.com/clinic/flagstaff/ My Vera App: Download from My Vera at verawholehealth.com
Flexible Spending Account (FSA) Administrator • Member Services	**Health Equity** Reimbursements: Fax (801) 999-7829 or Health Equity Attn: Reimbursement Account 15 W. Scenic Pointe Drive., Suite 400 Draper, UT 84020 Phone: (877) 472-8632 Website: www.myhealthequity.com
Health Savings Account (HSA) Administrator • Member Services	**Health Equity** Phone: (866) 346-5800
Life Insurance (Insured) • Life Insurance • Accidental Death and Dismemberment Insurance (AD&D)	**OCHS/Minnesota Life (Securian Financial Group, Inc)** Group Insurance 400 Robert Street North St Paul, MN 55101-2098 Customer Service: (800) 392-7295 Claims: (888) 658-0193 Website: www.lifebenefits.com
Disability Insurance (Insured) • Voluntary benefit employees may elect coverage • Short-term coverage available • Long-term coverage available for City personnel only	**Coconino County – AFLAC** Phone: (800) 433-3036 **Coconino Community College – Sun Life Financial** Phone: (800) 232-9642 **City of Flagstaff – Reliance Standard Life Insurance Company** **FUSD - Assurant** Phone: (800) 232-9642 **Mountain Line – AFLAC** Phone: (800) 433-3036 **CCASD – Principal Financial Group** Phone: (800) 843-1371

QUICK REFERENCE CHART	
Information Needed	**Provider**
Human Resources Department for Coconino County • Enrollment and Eligibility for Benefits • Medicare Part D Notice of Creditable Coverage • HIPAA Privacy and Security Officer and Notice of Privacy Practice • Any other Notices required by law	**Coconino County** 219 E. Cherry Avenue Flagstaff, AZ 86001 Phone: (928) 679-7100 Fax: (928) 773-1948 Website: www.coconino.az. gov
Human Resources Department for the City of Flagstaff • Enrollment and Eligibility for Benefits • Medicare Part D Notice of Creditable Coverage • HIPAA Privacy and Security Officer and Notice of Privacy Practice • Any other Notices required by law	**City of Flagstaff** 211 W. Aspen Avenue Flagstaff, AZ 86001 Phone: (928) 213-2090 Fax: (928) 213-2089 Website: www.flagstaff.az.gov/benefits
Human Resources Department for Coconino Community College • Enrollment and Eligibility for Benefits • Medicare Part D Notice of Creditable Coverage • HIPAA Privacy and Security Officer and Notice of Privacy Practice • Any other Notices required by law	**Coconino Community College (CCC)** 2800 S. Lone Tree Road Flagstaff, AZ 86005 Phone: (928) 226-4204 Fax: (928) 226-4114 Website: www.coconino.edu
Business Services Department for Flagstaff Unified School District #1 (FUSD) • Enrollment and Eligibility for Benefits • Medicare Part D Notice of Creditable Coverage • HIPAA Privacy and Security Officer and Notice of Privacy Practice • Any other Notices required by law	**Flagstaff Unified School District #1 (FUSD)** 3285 E. Sparrow Ave. Flagstaff, AZ 86004 Phone: (928) 527-6046 Fax: (928) 527-6065 Website: www.fusd1.org
Human Resources Department for Kachina Village Improvement District (KVID) • Enrollment and Eligibility for Benefits • Medicare Part D Notice of Creditable Coverage • HIPAA Privacy and Security Officer and Notice of Privacy Practice • Any other Notices required by law	**Kachina Village Improvement District (KVID)** 3150 Jadito Trail Flagstaff, AZ 86005 Phone: (928) 525-1775 Fax: (928) 525-2529 Email: smossman@kachinawater.com

QUICK REFERENCE CHART	
Information Needed	**Provider**
Human Resources Department for Mountain Line • Enrollment and Eligibility for Benefits • Medicare Part D Notice of Creditable Coverage • HIPAA Privacy and Security Officer and Notice of Privacy Practice • Any other Notices required by law	**Mountain Line** 3773 N. Kaspar Drive Flagstaff, AZ 86004 Phone: (928) 679-8926 Fax: (928) 779-6868 Website: www.Mountainline.az.gov
Human Resources Department for Coconino County Accommodation School District (CCASD) • Enrollment and Eligibility for Benefits • Medicare Part D Notice of Creditable Coverage • HIPAA Privacy and Security Officer and Notice of Privacy Practice • Any other Notices required by law	**Coconino County Accommodation School District** 2384 N. Steves Blvd. Flagstaff, AZ 86004 Phone: (928) 863-7132 Fax: (928) 526-5720 Website: www.ccasdaz.gov

AFFORDABLE CARE ACT EMPLOYEE ELIGIBILITY MEASUREMENT

The applicable large employers participating in NAPEBT reserve the right to use a **Monthly Measurement Method** and/or 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 month the employee attained in a prior period (called a measurement period).

For this Plan, **salaried employees** (except Coconino Community College District) are measured using the Monthly Measurement Method while **hourly employees** (and Coconino Community College District salaried employees) are measured using the Look Back Measurement Method. The specific duration of periods under the Look Back Measurement Method are addressed in policies/procedures in each employers' Human Resource department and can be changed on an annual basis as determined by the employer.

ACA Measurement Period: Each employer that participates in NAPEBT sets their own measurement period outlined in this chapter.

	Coconino County	Mountain Line	City of Flagstaff	Flagstaff Unified School District (FUSD)	Coconino Community College	Coconino County Accommodation School District	KVID
Initial Measurement period for new variable, seasonal and part-time employees	12-months	12-months	12-months	12-months	12-months	N/A as the District is not an applicable large employer	N/A as KVID is not an applicable large employer
Initial Measurement Period begins	First day of the month after date of hire	First day of the month after date of hire	First day of the month after date of hire	First day of the month after date of hire	First day of the month after date of hire		
Administration Period for new variable, seasonal and part-time employees	1-month	1-month	1-month	1-month	1-month		
Initial Stability Period for new variable, seasonal and part-time employees	12-months	12-months	12-months	12-months	12-months		

	Coconino County	Mountain Line	City of Flagstaff	Flagstaff Unified School District (FUSD)	Coconino Community College	Coconino County Accommodation School District	KVID
Standard Measurement Period for Ongoing Employees	12-months from May 1st through April 30th each year	12-months from May 1st through April 30th each year	12-months from May 1st through April 30th each year	12-months from May 1st through April 30th each year	12-months from May 1st through April 30th each year	N/A as the District is not an applicable large employer	N/A as KVID is not an applicable large employer
Standard Administrative Period	2-months from May 1st through June 30th each year	2-months from May 1st through June 30th each year	2-months from May 1st through June 30th each year	2-months from May 1st through June 30th each year	2-months from May 1st through June 30th each year		
Standard Stability Period for Ongoing Employees	12-months from July 1st through June 30th each year	12-months from July 1st through June 30th each year	12-months from July 1st through June 30th each year	12-months from July 1st through June 30th each year	12-months from July 1st through June 30th each year		

Break in Service/Leave of Absence:

For rehired employees or employees returning from a leave of absence, the employee will be credited with zero hours of service during the period of non-employment or unpaid leave of absence. (26 CFR §54.4980H-3(c)(4)(i-ii)).

If the period of absence with no hour of service is at least **13 consecutive weeks** (**at least 26 weeks for educational organizations**), then the employee may be treated as a new employee upon return to employment. When treated as a "new" employee, the employer can restart the initial measurement period OR apply a new waiting period before benefits become effective.

If the period of absence with no hour of service is less than 13 consecutive weeks (less than 26 consecutive weeks for educational organizations), but more than 4 consecutive weeks, then the employee MUST be considered a continuing employee upon return to employment. If the continuing employee had full-time status (for purposes of health care eligibility only) before the break & must be treated as a continuing employee upon return to work because the break was not long enough to establish a new employee status, the continuing employee will be offered coverage on the first day the employee is credited with an hour of service or, if later, on the first day of the month following the resumption of hours of service. Continuing employees being measured under the Look-back Method will be placed back into a measurement period.

If the period of absence with no hours of service lasted at least 4 weeks, and is between 4 and 13 weeks (or between 4 and 26 weeks for educational organizations) and the break is longer than the employee's period of employment before the break, the employee may be treated as a new employee in accordance with the Rule of Parity (26 CFR §54.4980H-3(c)(4)(v)).

ACTIVE EMPLOYEE ELIGIBILITY

WHO IS ELIGIBLE FOR COVERAGE AND START OF COVERAGE

Employee Eligibility: Each employer that participates in NAPEBT may have different eligibility rules that are outlined in this chapter.

	Coconino County/KVID	Mountain Line	City of Flagstaff	Flagstaff Unified School District (FUSD)	Coconino County Accommodation School District	Coconino Community College
Full-time and Part-time Regular Employee	Common law employees averaging 30 hours of service or more each week. Coverage will become effective as of the first day of the month following one calendar month of employment.	Common law employees averaging 20 hours of service or more each week. Coverage will become effective as of the first day of the month following 30 days of continuous employment.	Common law employees averaging 20 hours of service or more each week. Coverage will become effective as of the first day of the month following 30 days of continuous employment.	Common law employees averaging 30 hours of service or more per week (130 hours of service or more per month). Coverage will become effective the first of the month following the hire date if hired on or before the 16th of the month. Coverage will be effective the first of the month following one calendar month of employment if hired on or after the 17th of the month.	Working in a Benefits Eligible Position and Regularly working for classified Employees, and .75 FTE for administrative or certified Employees. Coverage will become effective as of the first day of the month following one calendar month of employment.	Common law employees averaging 30 hours of service or more each week. Coverage will become effective as of the first day of the month following one full calendar month of employment.

	Coconino County/KVID	Mountain Line	City of Flagstaff	Flagstaff Unified School District (FUSD)	Coconino County Accommodation School District	Coconino Community College
New Variable Hour, Seasonal and Part-time Employee	Averages 130 hours or more of service per month in 12-month initial measurement period commencing the first of the month following the date of hire or the first of the month when date of hire is the first of the month. Coverage becomes effective after a one-month administrative period and remains in force during employment for 12 months.	Averages 130 hours or more of service per month in 12-month initial measurement period. Coverage becomes effective after a one-month administrative period and remains in force during employment for 12 months.	Averages 130 hours or more of service per month in 12-month initial measurement period. Coverage becomes effective after a one-month administrative period and remains in force during employment for 12 months.	Averages 130 hours or more of service per month in 12-month initial measurement period. Coverage becomes effective after a one-month administrative period and remains in force during employment for 12 months.	Not applicable	Averages 130 hours or more of service per month in 12-month initial measurement period. Coverage becomes effective after a one-month administrative period and remains in force during employment for 12 months.
Other Classes of Eligible Individuals	Elected Officials, Medical Examiners, Dependents of public safety officers killed in the line of duty, and benefits eligible individuals pursuant to a legal agreement with the County.	Not applicable	Elected Officials, medically retired Participants, Dependents of public safety officers killed in the line of duty and benefits eligible individuals pursuant to a legal agreement with the City.	Not applicable	Not applicable	District Governing Board Members pursuant to Policy DGB 40-00.

Hours of Service is defined in the Definitions chapter.

ELIGIBILITY FOR LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

If an Employee is benefits-eligible, that Employee is automatically enrolled for basic group term life and AD&D. The details about the benefits under the Life and AD&D insurance are described in the life insurance certificate.

Additional (voluntary) life insurance coverage may be purchased for the Employee, or eligible Dependents or Domestic Partner and Children of a Domestic Partner. The Participant may be required to complete a form on Evidence of Insurability (proof of good health). Contact the Employer's Department using the Quick Reference Chart for more information. The name of the Life Insurance Company is listed on the Quick Reference Chart in the front of this document.

Evidence of Insurability: means, only with respect to life insurance coverage, evidence satisfactory to the Life Insurance Company of the good health of the prospective insured person and any other underwriting information the Life Insurance Company requires.

LIFE INSURANCE COVERAGE	ADDITIONAL INFORMATION
Basic Term Life and Accidental Death and Dismemberment (AD&D) *Employer-paid*	• Coverage varies by NAPEBT employer. • Coverage reduces based on age for active employees. • Provides an additional benefit of 100% of the basic AD&D principal sum up to $100,000 for public safety officers (police, fire, EMT, etc.) that suffer a loss while performing customary duties for their employer. • Contact the Employer's Department using the Quick Reference Chart for information on the amount of Life Insurance provided.
Voluntary Supplemental Employee Term Life *Employee-paid*	• Employees may elect in $10,000 increments up to $300,000 is guaranteed – no health questions or medical exams required, if elected within 31 days of initial eligibility. • At future annual Open Enrollment period, employees who are enrolled in Voluntary Term Life will have the opportunity to increase their existing life insurance coverage by $10,000 each year – no health questions or medical exams required *(up to the guaranteed issue limit of $*300,000*)*. • Employees may elect after initial enrollment period with evidence of insurability. • Employees may elect 7 times annual salary up to max of $1,000,000 with evidence of insurability. • No reductions in value related to age.
Voluntary Supplemental Dependent Term Life *Employee-paid*	***Spouse or Domestic Partner Coverage*** • The plan holder may elect for their Spouse or Domestic Partner in $5,000 increments up to $50,000 is guaranteed – no health questions or medical exams required, if elected within 31 days of initial eligibility. • Spouse or Domestic Partner may elect voluntary life even if the Employee does not elect coverage, up to 50% of the Employees Basic Life Insurance up to a maximum of $250,000 with evidence of insurability for amounts in excess of $50,000. • At future annual Open Enrollment period, a Spouse or Domestic Partner who are enrolled in Voluntary Term Life will have the opportunity to increase their existing life insurance coverage with evidence of insurability. • No reductions in value related to age. • Coverage terminates at age 70. ***Dependent Child(ren) Coverage*** • The plan holder may elect from $2,000 up to $20,000 in $1,000 increments for the employee's Dependent Child(ren), if elected within 31 days of initial eligibility. • All coverage is guaranteed each annual enrollment – no health questions or medical exams required. • A Dependent Child is eligible from live birth to age 26 regardless of student status, marital status, or financial status. Coverage may be extended for disabled children. • A Dependent Child may only be covered by one parent, if both parents are employees of NAPEBT.

RETIREE ELIGIBILITY

This chapter applies to all NAPEBT employees who may be eligible to receive retiree coverage under the group health plan. Please note employees hired by a NAPEBT employer on or after July 1, 2024 are not eligible to participate in the NAPEBT Retiree coverage under the group health plan. Exceptions could apply based on the Re-employment of Retiree information below.

Retiree Insurance Eligibility: Each employer that participates in NAPEBT may have different eligibility rules. Each NAPEBT Participant's employee eligibility rules are outlined in this chapter. However, it is important for every retiring employee to confirm whether there have been any changes to the eligibility rules of the employer from which the employee will be retiring. The retiree is eligible to receive retiree benefits from the NAPEBT Employer from which the employee retires, if the employee is filling a benefit eligible position at the time of retirement and meets the following eligibility rules.

	Coconino County/KVID	Mountain Line	City of Flagstaff	Flagstaff Unified School District (FUSD)	Coconino County Accommodation School District	Coconino Community College
Retiree Eligibility	Completed a minimum of 5 consecutive years of service with one or more NAPEBT employer(s) and are eligible to receive retirement benefits[1] from ASRS, PSPRS, CORP or EORP. Employees hired prior to November 18, 2015 who were eligible for long term disability from ASRS are eligible to receive retiree benefits.	Employees hired on or after July 1, 2015 who have completed a minimum of 5 consecutive years of service with one or more NAPEBT employer(s) and are eligible to receive retirement benefits[1] from ASRS. Employees hired prior to July 1, 2015 do not have a minimum years of service.	Employees hired on or after July 1, 2015 who have completed a minimum of 5 consecutive years of service with one or more NAPEBT employer(s) and are eligible to receive retirement benefits[1] from ASRS, PSPRS, or EORP. Employees hired prior to July 1, 2015 do not have a minimum years of service.	Employees hired on or after July 1, 2015 who have completed a minimum of 5 consecutive years of service with one or more NAPEBT employer(s) and are eligible to receive retirement benefits[1] from ASRS. Employees hired prior to July 1, 2015 do not have a minimum number years of service. Effective July 1, 2009, if eligible to retire from FUSD and meet the eligibility requirements from ASRS, coverage can be continued until age 65 by the retiree paying the premium costs less the ASRS subsidy.	Not applicable.	Employees who retire prior to January 1, 2014 must have 10 years of service in a benefit eligible position and meet one of the following two requirements 1) eligible to receive normal retirement benefits[1] from ASRS or 2) eligible to receive normal retirement benefits from the Optional Retirement Plan. Effective January 1, 2014, employees who have 5 consecutive years of service in a benefit eligible position one or more NAPEBT employer(s) and meet one of the following two requirements 1) eligible to receive retirement benefits[1] from ASRS or 2) eligible to receive normal retirement benefits from the Optional Retirement Plan.

	Coconino County/KVID	Mountain Line	City of Flagstaff	Flagstaff Unified School District (FUSD)	Coconino County Accommodation School District	Coconino Community College
Retirees Eligible for these Benefits:	If retired prior to July 1, 2011: eligible for Medical, Dental, Vision and Life until the earlier of Medicare entitlement or age 65; Dental and Vision (indefinitely) and Life Insurance eligibility continues up to age 70. If retired on or after July 1, 2011: eligible for Medical, Dental and Vision until the earlier of Medicare entitlement or age 65; Life Insurance eligibility continues up to age 70 with a reduction to half value at age 65 and zero at age 70.	Medical (until age 65), Dental and Vision (indefinitely) and Life Insurance (to age 70).	Medical and Dental Insurance until the earlier of Medicare entitlement or age 65.	Medical, Dental, Vision and Life until the earlier of Medicare entitlement or age 65, except for Administrators Life Insurance will remain in effect until age 70.	Not applicable.	Medical Insurance until the earlier of Medicare entitlement or age 65.

1: Questions about retirement eligibility, refer to Arizona State or Public Safety Personnel Retirement System Handbooks.

An employee who retires may be eligible to participate in one of the following: the State Retirement retiree insurance program, NAPEBT retiree coverage, or COBRA continuation coverage. The Employer's Department Benefits Administrator of the Employer will inform the retiring employee about the various benefits available to the retiring employee. Benefits Administrators will submit COBRA continuation coverage for all retirees and their covered dependents at the time of retirement even when the retiree elects NAPEBT's retiree coverage.

If retiree insurance coverage is elected, coverage begins on the first day of the month following the Retiree's retirement date. Employees who retire from a NAPEBT employer and are offered retiree coverage, but decline retiree coverage, may not enroll at a later date. The Employee will have an opportunity to enroll in retiree coverage when he or she retires the second time.

If the retiree is eligible for retirement under the State Retirement System, the Benefits Administrator will complete the health insurance authorization form including the retiree insurance elections along with the premium subsidy. The retiree is eligible to change plans and covered dependents at the time they elect coverage.

If the retiree is electing to change coverage, the Benefits Administrator will also request the necessary enrollment forms.

Retirees are able to change coverage each plan year during open enrollment, should the retiree need to make changes in the future. The retiree will receive the open enrollment notices in the same manner that active employees do each year. Retirees are not able to make changes mid-year unless there is a qualifying event and the paperwork is completed within 31 days from the date of the event or the retiree is terminating coverage.

A retiree remains eligible for the wellness incentive program. During the year in which an employee retires, that retiree will continue to be provided with the same incentive(s) he or she received as an active employee until the end of the plan year. A retiree shall enter wellness activities into the wellness portal (www.mywellsite.com/napebt) in order to receive a wellness incentive for the following plan years. Retirees will be provided with the same wellness incentive program notices as active employees.

Each month the NAPEBT employer from which the employee initially retired, will receive the retiree coverage subsidy from the Arizona State Retirement System. The NAPEBT employer will bill the retiree for the retiree's insurance on a monthly basis. The retiree is responsible for payment of insurance cost minus any wellness incentive and the State Retirement System subsidy, which will be reflected in the invoice provided to the retiree by the employer. In the case of late payments, the retiree has a 30-day grace period. If payment is not received within 30 days, coverage will be terminated retroactive to the last day of the month in which premiums were paid. FUSD retirees that are in arrears for more than 60 days will have coverage terminated. The NAPEBT employer will remit the subsidy in addition to the retiree's insurance payment to the NAPEBT Accounting Services Provider.

Termination of Retiree Coverage

The Retiree Insurance Coverage chart lists the retiree coverage offered by each NAPEBT employer and lists the eligibility criteria and length of eligibility for various benefits offered by each employer. In most cases once the Retiree turns age 65 and/or becomes entitled to Medicare, whichever is earlier, the retiree coverage ceases for the retiree and all covered dependents. For this purpose, coverage will cease at the end of the month prior to turning age 65 or becoming Medicare entitled. COBRA will not be offered to the retiree when coverage is terminated due to Medicare eligibility or reaching age 65 because it was offered at the initial time of retirement. If a retiree's dependent was covered at the date of the retiree's initial retirement, the dependent will be offered COBRA.

The retiree may terminate retiree coverage at the time that the retiree obtains other insurance for the retiree and/or covered dependents. The coverage will extend through the end of the month in which the coverage is terminated.

Re-Employment of Retiree

The retiree is responsible for notifying the new NAPEBT and former NAPEBT employer of the employee's current medical coverage upon re-employment and upon the end of their re-employment. The retiree must not have a break in coverage and has 31 days from the date their current coverage ends as an active NAPEBT employee to re-enroll in NAPEBT retiree coverage with their former NAPEBT employer. If the retiree has not retired under the current NAPEBT employer, the retiree is eligible to re-enroll in retiree coverage with their former employer where the Retiree retired and started drawing a retirement pension benefit. If the retiree has retired under the current NAPEBT employer, the retiree will continue retiree coverage with the current NAPEBT employer. If the Retiree has received a pension from multiple NAPEBT employers, the Retiree is eligible to re-enroll in retiree coverage with the NAPEBT employer where the employee most recently retired.

Retirees who return to active benefit eligible employment with the same NAPEBT employer will be enrolled in active employee coverage the first day of the month following the employee's re-hire date. The re-hired retiree will not be subject to the normal eligibility waiting period. If the retiree is re-hired to active benefit eligible employment with a different NAPEBT employer, the retiree will need to discontinue their participation in the retiree medical coverage; they cannot opt out of medical coverage with new NAPEBT employer. The employee will be eligible to re-enroll in NAPEBT retiree coverage upon their re-retirement or resignation as set forth in the paragraph above.

Retirees who return to variable hour, seasonal, or part-time employment with the same NAPEBT employer without a disqualifying break in service of 13 weeks (or 26 weeks for educational institutions) will return to the stability period that the employee was in upon retirement, and the employee will be re-enrolled in medical coverage, if the employee had been eligible prior to the break in service, effective the first day of the month following rehire. The retiree will not be subject to the normal eligibility waiting period, nor to an initial measurement period. However, the employee will be subject to the standard measurement period

to determine eligibility for health benefits for the next plan year. If the employee is determined not to be eligible for health benefits for the next plan year, the employee will be offered retiree coverage upon their loss of eligibility.

The employee may remain eligible for a retirement subsidy from ASRS or PSPRS subject to ASRS and PSPRS eligibility rules. The NAPEBT employer where the retiree is actively working will pay the difference in medical premium for employee only coverage (i.e. Total employee only premium minus the wellness incentive and retirement system subsidy). If the retiree has dependent coverage, this may or may not be subsidized by a dependent subsidy depending on the NAPEBT employer.

An Employee who is retiree eligible and moves to another NAPEBT employer on or after July 1, 2024 will retain eligibility for retiree coverage under the group health plan when the break in service is less than 31 days. For example, an Employee who is an active participate with the City of Flagstaff in June and becomes an Employee of Coconino County in July would retain retiree eligibility because the break in service is less than 31 days.

DEPENDENT ELIGIBILITY

When the employee or retiree elects coverage for themselves, they are also eligible to elect medical, dental, vision and life insurance coverage for their Eligible Dependents. Dependent coverage is effective on the day the employee or retiree becomes eligible for coverage, but only if they have enrolled the Eligible Dependent(s) using the Online Benefits Center, and if that coverage is in effect for the Participant on that day and they provide proof of Dependent status (when requested) and pay any required contribution for coverage of the Dependent(s).

A Dependent may not be enrolled for coverage unless the Employee (or Retiree) is also enrolled. Specific documentation to substantiate Dependent status may be required.

- **Eligible Dependents include a lawful Spouse (with state registered marriage license) and Dependent Child(ren), as those terms are defined in the Definitions chapter of this document**. Anyone who does not qualify as a Dependent Child or Spouse, (as those terms are defined by this Plan) has no right to any coverage for benefits or services under this Plan.
- Coverage for a Domestic Partner or Domestic Partner's Child (as those terms are defined by this Plan) may also become Eligible Dependents under this Plan. Note that coverage of a dependent that is not a tax-qualified dependent (such as a domestic partner) will result in imputed income to the employee or retiree.

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED

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

If a dependent does not yet have a social security number, you 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 complete the CMS model form (form is available from the Claims Administrator 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.

DOMESTIC PARTNER ELIGIBILITY

Domestic Partner coverage is only available for all participating NAPEBT Employers. Individuals who qualify as a Domestic Partner, as that term is defined in this Plan, may be eligible to enroll for coverage if the Employee/Retiree is also enrolled for coverage, upon completion of a signed and notarized Affidavit (signed declaration) of Qualified Domestic Partnership, proof of financial interdependence (for Coconino Community College, City of Flagstaff, Flagstaff Unified School District and Mountain Line), and completion of the applicable waiting period and proof of eligibility has been uploaded to the Online Benefits Center and completion of the Plan's enrollment procedures described in this chapter.

When a Domestic Partner is eligible to enroll, coverage is effective the first day of the month following completion of the Plan's enrollment procedures (or the first day of the new Plan Year if enrolled during the annual Open Enrollment Period).

- The coverage for the Domestic Partner will be the same as if covering a Spouse; however, such coverage for a Domestic Partner will generally result in imputed income for the Employee. Contributions for Domestic Partner coverage will be taken on a post-tax basis.
- The Child of a Domestic Partner may be covered if they meet the definition of a Domestic Partner Child (as defined in the Definitions chapter). The Domestic Partner and the Child of a Domestic Partner will generally not qualify as a tax-qualified Dependent of an Employee and as such, the Employee will be taxed on the value of the benefits provided to these individuals. This is called "imputed income."
- Temporary continuation of coverage under "COBRA-like" coverage may be available to Domestic Partners and the Child of a Domestic Partner as outlined in the COBRA chapter.
- Also note that if a Domestic Partner enrolls in a medical Plan option with a Health Savings Account, the Employee cannot seek reimbursement from the Health Savings Account to cover health care expenses of a non-tax-qualified Dependent (such as a Domestic Partner or Child of a Domestic Partner) without paying income taxes and a 20% penalty tax, unless the Domestic Partner or Child of a Domestic Partner qualifies as a tax-qualified Dependent of the Employee.
- A Domestic Partner and the Child of a Domestic Partner may enroll at the same times that are permitted for Employees and coverage becomes effective at the same times as with Employees.
- A Domestic Partner can be removed from coverage under the Plan at any time. Some NAPEBT employers may require a signed and notarized affidavit. The Participant should contact their Employer's Department using the Quick Reference Chart. Once coverage is dropped the Domestic Partner and Child of a Domestic Partner can only be re-enrolled at the next Open Enrollment Period.
- When an Employee transfers from one participating NAPEBT employer to another, the Employee will complete the Domestic Partner enrollment process with the new NAPEBT employer.

EXTENSION OF ELIGIBILITY FOR SURVIVING LAWFUL SPOUSE/SURVIVING DEPENDENTS OF A DECEASED LAW ENFORCEMENT OFFICER

The following provision **relates only to the following Employers whose employees may be law enforcement officers** that participate in NAPEBT: the City of Flagstaff, and Coconino County.

The surviving lawful Spouse and surviving Dependent(s) of a deceased law enforcement officer are entitled to continue health coverage under the Plan after the death of the law enforcement officer unless they no longer are eligible (see the section on "When Coverage Ends" for termination provisions). "Law enforcement officer" means a peace officer who is certified by the Arizona peace officer standards and training board, 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 a corrections officer or firefighter who works on behalf of the State of Arizona or a political subdivision of this State through a contract with a private company.

The following terms apply:

a. the law enforcement officer: (1) must have been killed in the line of duty; or (2) must have died from injuries suffered in the line of duty; and

b. the law enforcement officer must have been enrolled in the NAPEBT health coverage at the time of death; and

c. the surviving lawful Spouse and surviving Dependents must have been covered by NAPEBT's health coverage at the time of the officer's death; and

d. premiums for coverage must be paid by the surviving lawful Spouse and surviving Dependents at the same rate that applies to active Employees (if single) or active employees and their families (if had family coverage); and

e. upon termination of coverage, the surviving lawful Spouse and surviving Dependent(s) will have the opportunity to elect COBRA continuation of coverage.

The participating NAPEBT Employer is responsible for collecting and submitting the appropriate premium to NAPEBT in a timely manner. See also the section on when coverage ends later in this chapter.

PROOF OF DEPENDENT STATUS

Specific **documentation to substantiate Dependent status may be requested** by the Plan and may include a birth certificate, marriage certificate, proof of the dependent's age, and the dependent's social security number. See also the definition of Dependent in the Definitions chapter of this document. If requested, these are the types of documents needed for proof of Dependent status:

EVENT	PROOF OF DEPENDENT STATUS MEANS PROVIDING PROOF IN THE FORM OF:
Marriage	copy of the certified marriage certificate (plus driver's license or SSN to help demonstrate name change, if applicable).
Divorce	copy of the divorce decree.
Birth	copy of the certified birth certificate.
Adoption or Placement for Adoption	court order adoption papers signed by the judge.
Stepchild	marriage certificate and child's certified birth certificate.
Foster Child	copy of the foster child placement papers from a qualified state placement agency, or proof of judgment decree or court order of a court of competent jurisdiction, and any proof of any state provided health coverage.
Legal Guardianship	copy of your court-appointed legal guardianship documents and a copy of the certified birth certificate.
Qualified Medical Child Support Order (QMCSO)	Valid QMCSO document or National Medical Support Notice.
Disabled Dependent Child as defined in Dependent Definitions	Medical reports, acceptable under this benefit Plan, must substantiate the incapacity and must be submitted by the Participant within thirty-one (31) days of the date such disabled Dependent Child would lose eligibility. The Child's eligibility to continue this coverage is subject to periodic review. The Social Security Administration medical criteria is used to determine disabilities when evaluating the extent of the Participant's Dependent Child's disability. See the section of this chapter called "When Coverage Ends" for information on termination of benefits for disabled Dependent Children.

EVENT	PROOF OF DEPENDENT STATUS MEANS PROVIDING PROOF IN THE FORM OF:
Domestic Partner	Employer may require a signed and notarized qualified Domestic Partner affidavit and proof of financial interdependence.
Dissolution of Domestic Partnership	Employer may require a signed and notarized Dissolution of Domestic Partnership affidavit.

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 chapter.

Procedures to Enrollment:

Generally, an individual will receive instructions on how to enroll for group health coverage from the Employer's Department using the Online Benefits Center. Note that the Open Enrollment procedures can differ from this process and if so, the procedures on how to enroll at this time will be announced by the Plan at the beginning of the Open Enrollment Period. Once Enrollment is requested, the Participant will be provided with the steps to enroll that include all the following:

a. complete the enrollment process using the Online Benefits Center, and

b. provide proof of Dependent status (as requested), and

c. for a Domestic Partner, provide notarized qualified Domestic Partner Affidavit (including proof of financial interdependence when required), and

d. pay any required contributions for coverage, and

e. perform steps a through d above in a timely manner according to the timeframes noted under the Initial, Mid-Year Change of Status, or Open Enrollment provisions of this Plan.

Proper enrollment is required for coverage under this Plan. If enrollment has been requested within the required time limit but proper enrollment including paperwork has not been completed during the initial enrollment period, the Participant will be automatically enrolled in the default Plan(s) according to the provisions of automatic enrollment.

AUTOMATIC (DEFAULT) ENROLLMENT

NAPEBT Employers pay 100% of the premium for the High Deductible Health Plan (HDHP) for Employees. If an Employee fails to elect benefits during the Initial Enrollment period, the Employee will automatically be defaulted into (enrolled in) the High Deductible Health Plan for employee only with no employer contribution to the HSA or FSA. The employee must actively enroll in a Plan to receive the HSA or FSA employer contribution, except for CCC and CCASD. The Participant will also be enrolled in the Basic Dental Plan, Basic Vision Plan and Life and AD&D insurance at the single level of coverage. Employees may not waive the Basic Dental Plan, Basic Vision Plan, and Life and AD&D Plan provided by the NAPEBT employers, except CCC employees may waive the Basic Dental Plan. The Employee will not be allowed to make a change in coverage or add Dependents until the next Open Enrollment period unless there is a qualified mid-year change of status event.

Employees who are enrolled in the HDHP and who elect to participate in a Flexible Spending Account will be enrolled in the Limited Purpose Flexible Spending Account.

FAILURE TO PROVIDE PROOF OF DEPENDENT STATUS

When proof of Dependent status is requested, and the Participant fails to provide proof of Dependent status within 31 days of enrollment or a Mid-Year Change of Status, their Dependents will not be covered. Remember, the Participant may only drop or add Dependents from coverage at initial enrollment, Open Enrollment time or within 31 days of an applicable mid-year change of status. Given there may be a delay in receiving documentation necessary for a newborn baby, an employee expressing intent to enroll their newborn baby will satisfy this requirement until the documentation has been received.

DECLINING (OPT-OUT/WAIVE) COVERAGE

The only opportunity for Employees to decline (opt-out/waive) NAPEBT's group medical coverage is to provide proof of coverage under another Employer's (non-NAPEBT) Medical Plan or other public assistance (i.e., Medicare, Indian Health Services, Medicaid, TRICARE, etc.). Employees may not be enrolled as a spouse or dependent by another NAPBT employee, unless required by the ACA based on dependent status, or under eligibility requirements outlined for FUSD Two Employee Discount. The **Health Insurance Marketplace** does not qualify as group medical coverage. Employees may not decline the Basic Dental Plan, Basic Vision Plan, and Life and AD&D Plan provided by NAPEBT employers, except at CCC Employees may decline the Basic Dental Plan. For more information about the Health Insurance Marketplace, visit www.healthcare.gov.

WELLNESS INCENTIVE PROGRAM ELIGIBILITY

Employees covered under the Northern Arizona Public Employee Benefit Trust can earn discounts on their insurance by participating in the Wellness Incentive Program. The Wellness Incentive Program is optional. Any benefit eligible employee can participate in the Wellness Incentive Program. Non-Benefit eligible employees may participate in NAPEBT and employer sponsored wellness events but will not earn points or monetary discounts.

The details of this program are outlined on the wellness portal at www.napebt.org. Eligible employees must meet the requirements of the Wellness Incentive Program every plan year to earn the premium discount for the following plan year. Currently no proof is required; however, employees should retain proof of participation as a back-up.

INITIAL ENROLLMENT

The Participant must enroll prior to the effective date of coverage by completing the enrollment process through the Online Benefits Center, providing proof of Dependent status (as requested) and paying any required contributions for coverage. If the Participant wants Dependent coverage, they must enroll their Eligible Dependents at the same time. If enrollment is not completed prior to the effective date of coverage, the Participant will be defaulted according to the provisions of Automatic Enrollment.

Start of Coverage Following Initial Enrollment: A Participant's coverage begins on the date outlined in the Employee Eligibility section at the front of this chapter. Coverage of their enrolled Spouse, Dependent Child(ren), Domestic Partner or Domestic Partner's Child begins on the date the Participant's coverage begins.

Failure to Enroll Dependents During Initial Enrollment: If the Participant does not enroll their Eligible Dependents during the Initial Enrollment period, they will not be able to enroll them until the next Open Enrollment Period or within 31 days of an applicable Mid-Year Change of Status.

SPECIAL ENROLLMENT

There are three HIPAA Special enrollment opportunities to enroll in the Plan's benefits mid-year: a) upon gaining (acquiring) a new dependent, b) loss of other coverage, and c) on account of Medicaid or a State Children's Health Insurance Program (CHIP). These opportunities are explained below:

Acquire a New Dependent: If the Participant **acquires a Spouse by marriage or acquires any Dependent Child(ren) by birth, adoption or placement for adoption**, the Participant may request enrollment for the Participant (if not already enrolled) and their newly acquired Spouse and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption, or placement for adoption. A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

Loss of Coverage: Also, if the Participant did not request enrollment under this Plan for their Spouse, and/or any Dependent Child(ren) when coverage was first offered because they had health care coverage under another group health Plan, or COBRA Continuation Health Coverage, or certain types of individual health insurance, or Medicare, or other public program, **and** their Spouse and/or any Dependent Child(ren) **lose coverage under that other group health plan or**

health insurance policy, they may request enrollment for their Spouse, and/or any Dependent Child(ren) within 31 days after the termination of their coverage under that other group health plan or health insurance policy **if** that other coverage terminated because of:

- loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of Employee to pay premiums on a timely basis or termination of the other coverage for cause); or
- 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
- the health insurance was provided under COBRA Continuation Coverage, and the COBRA coverage was "Exhausted" (Exhausted is explained below); or
- 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
- the other plan ceasing to offer coverage to a group of similarly situated individuals; or
- the loss of Dependent status under the other plan's terms; or
- the termination of a benefit package option under the other plan, unless substitute coverage offered; or
- the loss of eligibility due to reaching the lifetime benefit maximum on all medical plan benefits under the other medical plan. (For Special Enrollment that arises from reaching a lifetime benefit maximum on all medical plan benefits, an individual will be allowed to request Special Enrollment in this Plan within 31 days after a claim is denied due to the operation of a lifetime limit on all medical plan benefits.)

See also the Enrollment Procedures section of this chapter for more information. Proof of loss of coverage may be required by this Plan.

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 of COBRA Continuation Coverage has expired.

Medicaid Or A State Children's Health Insurance Program (CHIP): The participant and their eligible dependents may also enroll in this plan if they (or their eligible dependents):

- have coverage through **Medicaid or a State Children's Health Insurance Program (CHIP)** and they (or their Dependents) **lose eligibility for that coverage**. However, they must request enrollment in this Plan within **60 days** after the Medicaid or CHIP coverage ends; or
- become **eligible for a premium assistance program through Medicaid or CHIP**. However, they must request enrollment in this Plan within **60 days** after they (or their Dependents) are determined to be eligible for such premium assistance.

Start of Coverage Following Special Enrollment:

- **Coverage of an individual enrolling because of loss of other coverage or because of marriage:** If an individual requests Special Enrollment **within 31 days** of the date of the event that created the Special Enrollment opportunity, generally coverage will become effective the first day of the month following date of the event that created the Special Enrollment (e.g., the marriage). Under IRS rules, any coverage changes associated with a mid-year change in status event must be prospective, except for a newborn who is effective on the date of birth and newly adopted child, or child placed for adoption who is effective on the date of adoption or placement for adoption. For this plan if coverage is effective retroactively from the mid-year change event it will be subject to post-tax contribution, see your Employer's Department using the Quick Reference Chart for more information.
- If the individual requests enrollment **within 60 days** of the date of the Special Enrollment related to **Medicaid or CHIP,** generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment event.
- **Coverage of a newborn or newly adopted Dependent Child or Dependent Child Placed for Adoption** is described under the "Coverage for Newborn" section discussed later in this chapter.
- 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.

<table>
<tr><th>Enrollment Effective on Date of Event</th><th>Enrollment Effective First Day of Month Following Date of Event</th></tr>
<tr><td>Birth, Adoption and Placed for Adoption</td><td rowspan="2">All other Special Enrollment Circumstances (i.e., Marriage, Loss of Coverage, Divorce, QMCSO, Medicare Eligibility)</td></tr>
<tr><td>Death</td></tr>
</table>

Failure to Enroll During Special Enrollment: If a Participant fails to request enrollment for their Eligible Dependents within 31 days (or as applicable 60 days) after the date on which they first become eligible for Special Enrollment, they will not be able to enroll them until the next Open Enrollment Period.

OPEN ENROLLMENT

Open Enrollment Period: Open Enrollment is the period of time during the spring or summer of each year to be designated by the Employer's Department during which eligible Participants may make the elections specified below. Enrollment instructions and/or forms may be obtained from the Employer's Department using the Quick Reference Chart for more information.

Elections Available During Open Enrollment: During the Open Enrollment Period Eligible Participants may elect to:

- **add or drop** Eligible Dependents to the medical, dental, or vision coverage;
- **change** medical, dental or vision Plan options for themselves and their Dependents;
- **enroll in the Health flexible spending account and/or Dependent care spending accounts**;
- elect contribution amount for Heath Savings Account (H.S.A.) when enrolled in a High Deductible Health Plan;
- add or increase voluntary life insurance (if enrolled during Initial Enrollment or anytime, with proof of insurability);
- add, enroll, or change other voluntary benefits;

- elect how the Participant wants to receive the personal wellness incentive through the Rewards Center on the My Vera App, except FUSD and CCC.

Contribution amounts to the HSA can be changed throughout the year.

Restrictions on Elections During Open Enrollment: No Dependent may be covered in a Plan unless the Participant is also covered, except for Voluntary Term Life Insurance. Contact the Employer's Department using the Quick Reference Chart for details.

All relevant parts of the enrollment process must be completed, and the information must be submitted before the end of the Open Enrollment Period using the Online Benefits Center, along with proof of Dependent and/or Domestic Partner status (as requested).

Start of or Changes to Coverage Following Open Enrollment:

- If the Participant's Spouse, Dependent Child(ren), Domestic Partner, or Domestic Partner's Children are **enrolled for the first time during an Open Enrollment Period**, that person's coverage will begin on the first day of the new Plan Year following the Open Enrollment.
- If the Participant or their Spouse, Dependent Children, Domestic Partner, or Domestic Partner's Children are **changing or discontinuing coverage during Open Enrollment**, such changes will become effective on the first day of the new Plan Year following Open Enrollment.
- If the Participant discontinues coverage for a Spouse and/or Dependent Child(ren) the Employer's Department will inquire if discontinuance is due to legal separation or divorce to administer COBRA appropriately.

Failure to Make a New Election During Open Enrollment: If the Participant has been enrolled for coverage and they fail to make a new election during the Open Enrollment Period, they will be considered to have made an election to retain the same medical, dental, vision and life insurance coverage they had during the preceding Plan Year.

Note, that **to participate in the Plan's Flexible Spending Account for the next Plan Year** the Participant **must enroll online using the Online Benefits Center,** even if they were enrolled in the Flex Plan the previous year. If they do not complete a new Flex Plan enrollment form, they will not be able to participate in the Flexible Spending Account for the entire Plan Year.

Caution: Open Enrollment procedures can differ from the process outlined above and if so, the procedure on how to enroll at Open Enrollment time will be announced by the Employer's Department at the beginning of the Open Enrollment Period.

Failure to Enroll During Open Enrollment: If the Participant fails to enroll their Eligible Dependents within the Open Enrollment Period, they will not be able to enroll them until the next Open Enrollment Period or within 31 days of a Special Enrollment or other Mid-Year Change of Status event.

COVERAGE FOR NEWBORN CHILDREN, NEWLY ADOPTED, OR PLACED FOR ADOPTION CHILDREN

Under this Plan, **a Child is automatically enrolled for Medical Plan coverage for the first thirty-one calendar (31) days after the date of birth, so long as the birth parent covered under this plan remains eligible for coverage during that period** and the newborn or child adopted or placed for adoption is otherwise an eligible dependent under this plan. Then, **coverage may only continue for the child after the first 31 days after birth, or from the date of birth, adoption, or placement for adoption as a dependent of a non-birth parent, if** the Participant enrolls using the Online Benefits Center **within** the first 31 days of the date of birth, adoption, or placement for adoption.

Failure to properly enroll a newborn or newly adopted child means the child **will not be covered under this Medical Plan** and may not be added until the next Open Enrollment or within 31 days of a new Special Enrollment or other Mid-Year Change of Status event.

If completed enrollment forms for dental, vision and life insurance benefits are not submitted using the Online Benefits Center within 31 days of the date of birth, adoption or placement for adoption, the Child will not be covered under these Plans and may not be added until the next Open Enrollment or within 31 days of a new Special Enrollment or other Mid-Year Change of Status event.

The Participant should discuss any applicable contributions for dependent coverage with their Employer's Department using the contact information in the Quick Reference Chart.

WHEN THE PARTICIPANT AND ANY OF THEIR DEPENDENTS BOTH WORK FOR NAPEBT (SPECIAL RULE FOR ENROLLMENT)

1. No individual may be **double covered** under this Plan as an Employee, Retiree and/or a Dependent (Spouse, Domestic Partner, or Child). There are some exceptions to this rule for Dental Plan coverage. Contact your Employer's Department using the Quick Reference Chart for more information.
2. No Child can be enrolled in this Plan as a Dependent of more than one Employee or one Retiree. There are some exceptions to this rule for Dental Plan coverage. Contact your Employer's Department using the Quick Reference Chart for more information.
3. **If both the Participant and their Spouse, or Domestic Partner, are benefits-eligible Employees of NAPEBT**:
    - Each Employee will enroll as an eligible Employee. Except, under FUSD, if either Employee wants to cover benefit eligible Children, the Spouses or Domestic Partners who are FUSD Employees must choose which one of them will elect the Employee coverage and then the other Employee will become the Dependent of the Employee who elects coverage under the Two Employee Discount.
    - Covered Employees that currently have a Spouse or Domestic Partner that are employed by a NAPEBT Employer may be eligible for dependent coverage when one or the other loses coverage through their current NAPEBT Employer. Enrollment must take place within 31 days of the loss of coverage.
4. **If, while your family coverage is in effect, any of your covered Dependent Children becomes an Employee of a NAPEBT Employer and becomes eligible for coverage as an Employee,** the Employee or Child must notify the Employer's Department using the Quick Reference Chart. The Child may be enrolled as either an Employee or as a Dependent but cannot be enrolled as both.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) (Special Rule for Enrollment)

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:

- Designates one parent to pay for a Child's health Plan coverage;
- 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;
- 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;
- States the period for which the QMCSO applies; and
- Identifies each health care Plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any benefit option that the Plan does not otherwise provide, except as required by a state's Medicaid-related Child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent Child of the Employee, the Employer's Department as identified in the Quick Reference Chart 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 Employer's Department as identified in the Quick Reference Chart 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).

Enrollment Related to a Court Order: If the Plan has determined that a Court Order is a valid QMCSO it will accept enrollment of the alternate recipient as of the date specified in the Court Order or, if not specified, the first day of the month after the Change of Status Event request is received by the Plan. Coverage will be subject to all terms and provisions of the Plan, including any and requirements for authorizations of services, as permitted by applicable laws.

If the Employee is already a Plan Participant, 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 Plan Participant. The Plan will accept a mid-year Change of Status Event of the alternate recipient specified by the QMCSO from either the Employee or the custodial parent. **Coverage of 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 Change of Status Event request is received by the Plan**. Coverage will be subject to all terms and provisions of the Plan, including any and requirements for authorization of services, as permitted by applicable law.

Contributions for Coverage: No coverage will be provided for any alternate recipient under a QMCSO unless the applicable Employee contributions for that alternate recipient's coverage are paid, and all the Plan's requirements for enrollment and coverage of that alternate recipient have been satisfied. Contributions required for coverage under a QMCSO are any contributions not covered by the Employer.

Termination of Coverage: Generally, coverage under the Plan terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the Plan for other Dependent Children. This includes termination of coverage for failure to pay any required contributions. When coverage terminates, alternate recipients may be eligible for COBRA continuation coverage.

PAYMENT FOR THE PARTICIPANT'S COVERAGE

Participants may be required to share in the cost of the medical, dental, vision or supplemental life insurance Plan(s). If the Participant elects medical, dental and vision coverage for themselves and/or their Dependents, the cost for their coverage will depend on which Plan options are chosen. The specific amount the Participant must pay for coverage is announced when the Participant enrolls the Dependent and annually during the Open Enrollment Period or contact their Employer's Department using the Quick Reference Chart for information. The Participant pays their contributions for healthcare coverage for tax-qualified Dependents such as a Spouse and Dependent Child, on a **before-tax** (pre-tax) basis. This means that their payments for these coverages come from their pay before federal and state taxes are withheld.

NOTE: If the Participant elects coverage for a non-tax qualified Dependent such as a Domestic Partner or a Child of a Domestic Partner, the contributions they make toward the cost of this coverage must be paid on an after-tax basis, in accordance with IRS regulations. In addition, the amount their Employer pays toward the cost of Domestic Partner coverage and coverage for the Children of Domestic Partners must be **imputed as income** to the Employee and therefore is taxable. If the Participant has questions about the tax implications of covering a Domestic Partner, they should contact their tax consultant.

If a Participant wants their benefit to be post-tax (after tax) that Participant should contact their Employer's Department using the Quick Reference Chart to see if such after-tax procedure is permitted.

CHANGING YOUR COVERAGE DURING THE YEAR (MID-YEAR CHANGE OF STATUS/ELECTION CHANGE)

Government regulations generally require that the Participant's Plan coverages remain in effect throughout the Plan Year (from July 1 through June 30), but they may be able to make some changes during the year (mid-year) if the Plan Administrator or its designee determines that the Participant has a permissible **change** in their status as permitted by the IRS and the Plan as outlined below:

QUALIFYING LIFE EVENT Mid-Year Election Changes Are Only Permitted on Account of:
1. **Change in Employee's legal marital status**, including gaining a Spouse through marriage, or losing a Spouse through divorce, legal separation (where permissible by law), annulment or death.
2. **Change in number of Employee's Dependents**, including gaining a Child through birth, adoption, or placement for adoption, or losing a Child such as through death.
3. **Change in the employment status or work schedule of the Employee, Spouse or Dependent Child affecting eligibility for benefits**, including the start or termination of employment, an increase or decrease in hours of employment (including a switch in part-time and full-time employment), a strike or lock-out, the start of or return from an unpaid leave of absence that is either required by law (such as FMLA and military leave), other leave permitted by the Participant's Employer, or a change of work-site.
4. **Change in Dependent status that satisfies or ceases to satisfy the Plan's eligibility requirements**, including changes due to attainment of age, or a change affecting a requirement described under the definition of Dependent in this document. Reminder to Administrators: Student status is no longer considered a mid-year change of status due to ACA.
5. **Change of residence or worksite that allows or impairs** the Employee, Spouse or Dependent Child's eligibility for benefits.
6. **Change required under the terms of a Qualified Medical Child Support Order (QMCSO),** including a change necessary to add the Child as a covered Dependent as specified in the order, or to cancel coverage for the Child if the order requires the Participant's former Spouse, to provide that coverage.
7. **Change consistent with your right to Special Enrollment** as allowed under HIPAA or any other Federal Regulations.
8. **Change consistent with entitlement to (or loss of eligibility for) Medicare or Medicaid** affecting the Employee, Spouse or Dependent Child (except for coverage solely under the program for distribution of pediatric vaccines), including prospective cancellation of NAPEBT coverage for the person entitled to Medicare/Medicaid following the date of entitlement, prospective reinstatement, or election of NAPEBT coverage following the loss of eligibility for Medicare/Medicaid.
9. **Change in the cost of the Participant's coverage:** a. **Automatic increase or decrease in the Participant's contributions for coverage** under any of their Employer's Health Care Plan options as a result of: ➢ a change in the cost of coverage for all Plan Participants, or ➢ as a result of a change in the number of their covered Dependents, or ➢ a permitted mid-year change of status to another of their Employer's Health Care Plan options if the increase or decrease in contributions is or would be required from all similarly situated Employees. The Plan may automatically increase or decrease contributions on a reasonable and consistent basis. b. **Significant increase or decrease in the Participant's contributions for coverage** under their Employer's Health Care Plan options or their Spouse's Employer's health care Plans or programs. In such a case the Participant may start coverage in the Plan option with the decreased cost; or, revoke coverage in the Plan option with an increased cost and either elect, on a prospective basis, coverage under another Plan option providing similar coverage, if one is available.

QUALIFYING LIFE EVENT Mid-Year Election Changes Are Only Permitted on Account of:
10. **Significant curtailment of Your (or Your Spouse's) coverage:** a. **Significant curtailment**. If the coverage under the Plan is significantly curtailed or ceases during a Plan Year, the Participant may revoke their elections under the Plan (*if they make a contribution for their benefits*). In that case, the Participant may make a new election on a prospective basis for coverage under another benefit package providing similar coverage. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to affected Participants under the Plan. b. **Addition or elimination of a benefit package option providing similar coverage.** If during a Plan Year, the Plan adds or eliminates benefit package options the Participant may elect from the available options prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.
11. **Addition or significant improvement of any Plan option** under the Employer's Health Care Programs or the Employer Sponsored Health Care Program of the Participant's Spouse. In such a case the Participant may revoke coverage in the current Plan and elect, on a prospective basis, coverage under a new or improved Plan option.
12. **Change in coverage under another Employer's Plan or program** that permits Participants to make an election change that would be permitted by these mid-year changes, or that permits Participants to make an election for a period of coverage that is different from the Plan Year of this Plan (e.g., spouse's employer coverage has different open enrollment/plan year). In such a case the Participant may elect, on a prospective basis, the same change in coverage under this Plan that was available under the other Plan.
13. **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 mid-year 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.

These rules apply to making changes to the Participant's benefit coverage(s) during the year (mid-year):

1. Government regulations require that any change the Participant makes to their 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 a birth event to drop the Spouse from coverage at this time;)* **and**
2. The Participant must notify their Human Resource Department in writing within 31 days of the change in status, otherwise, the request will be denied, and they will have to wait until the next Open Enrollment Period to make their changes in coverage (You have 60 days from the loss of eligibility for Medicaid or CHIP to request to enroll in this Plan as discussed under Special Enrollment); **and**
3. If the Participant has a permissible change in status, government regulations require that they are only allowed to make changes to their 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 (Proof of the change of status event will be required); **and**
4. Under IRS rules, any coverage changes associated with a mid-year change in status event **must be prospective**, except for a newborn who is effective on the date of birth and newly adopted child, or child placed for adoption who is effective on the date of adoption or placement for adoption. For this Plan if coverage is effective retroactively from the mid-year change event it will be subject to post-tax contribution, see your Human Resource Department for more information.

NOTE: THIS CHART BELOW IS ONLY VALID FOR CERTAIN NAPEBT EMPLOYERS THAT PAY 100% FOR EMPLOYEE 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. This chart should NOT be referenced for Health FSA or Dependent Care Account Plan (DCAP).

NOTE: This chart is only valid while the Plan pays 100% for Employee coverage.

If you experience the following Event...	You may make the following change(s)* within 31 days (where applicable 60 days) of the Event…	YOU MAY NOT make these types of changes...
	Family Events	
Marriage	• Enroll yourself, if applicable • Enroll your new Spouse and other eligible Dependents • Change health Plans, when options are available	• Drop health coverage
Divorce	• Remove your Spouse from your health coverage • Enroll your Children if they were previously enrolled in your Spouse's plan.	• Change health Plans • Drop health coverage for yourself or any other covered Dependent(s)
Gain a Child due to birth or adoption	• Enroll the eligible Child and any other eligible Dependents • Change health Plans when options are available	• Drop health coverage for yourself or any other Dependent(s)
Child requires coverage due to a QMCSO	• Add Child named on QMCSO to your health coverage (enroll yourself, 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
Loss of a Child's eligibility (*e.g.,* Child reaches the maximum age for coverage)	• Remove the Child from your health coverage • Child will be offered COBRA.	• Change health Plans • Drop health coverage for yourself or any other Dependent(s)
Death of a Dependent (Spouse or Child)	• Remove the Dependent from your health coverage • Change health Plans when options are available	• Drop health coverage for yourself or any other Dependent(s)
Covered person has become entitled to (or lost entitlement to) Medicaid 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 yourself or any other Dependent(s)
	Employment Status Events	
Spouse becomes eligible for health benefits in another group health Plan	• Remove your Spouse from your health coverage, with proof of other plan coverage • Remove your Children from your health coverage, with proof of other Plan coverage	• Change health Plans • Add any eligible Dependents to your health coverage
Spouse loses employment or otherwise becomes ineligible for health benefits in another plan	• Enroll your Spouse and, if applicable, eligible Children in your health Plan • Change health Plans when options are available	• Drop health coverage for yourself or any other covered Dependents
You lose employment or otherwise become ineligible for health benefits	• Enroll in your Spouse's plan, if available • Elect temporary COBRA coverage for the qualified beneficiaries (you and your covered Dependents)	
Proof of a status change may be required to make a corresponding change in coverage/enrollment. **If you have any questions, contact your Employer's Department using the Quick Reference Chart.**		

NOTE: THIS CHART BELOW IS ONLY VALID FOR NAPEBT EMPLOYERS WHOSE EMPLOYEES CONTRIBUTE TO THEIR OWN 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 change. This chart should NOT be referenced for Health FSA or Dependent Care Account Plan (DCAP).

NOTE: This chart is valid when the Employee contributes to their own coverage.

If you experience the following Event...	You may make the following change(s)* within 31 days (where applicable 60 days) of the Event…	YOU MAY NOT make these types of changes...
	Family Events	
Marriage	• Enroll yourself, if applicable • Enroll your new Spouse and other eligible Dependents • Drop health coverage (to enroll in your Spouse's plan) • Change health Plans when options are available	• Drop health coverage and not enroll in Spouse's non-NAPEBT Plan; if you do, you won't receive coverage.
Divorce	• Remove your Spouse from your health coverage • Enroll yourself (and your Children) if you or they were previously enrolled in your Spouse's plan	• Change health Plans • Drop health coverage for yourself or any other Dependent(s)
Gain a Child due to birth or adoption	• Enroll yourself, if applicable • Enroll the eligible Child and any other eligible Dependents • Change health Plans when options are available	• Drop health coverage for yourself or any other Dependent(s)
Child requires coverage due to a QMCSO	• Add Child named on QMCSO to your health coverage (enroll yourself, 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
Loss of a Child's eligibility (*e.g.,* Child reaches the maximum age for coverage)	• Remove the Child from your health coverage • Child will be offered COBRA.	• Change health Plans • Drop health coverage for yourself or any other Dependent(s)
Death of a Dependent (Spouse or Child)	• Remove the Dependent from your health coverage • Change health Plans when options are available	• Drop health coverage for yourself or any other Covered Individuals
Covered person has become entitled to (or lost entitlement to) Medicaid 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 yourself or any other Dependent(s)
	Employment Status Events	
Spouse becomes eligible for health benefits in another group health plan	• Remove your Spouse from your health coverage, with proof of other plan coverage • Remove your Children from your health coverage, with proof of other plan coverage • Drop coverage for yourself only with proof that Spouse added you to the Spouse's new group health plan	• Change health Plans • Add any eligible Dependents to your health coverage
Spouse loses employment or otherwise becomes ineligible for health benefits in another plan	• Enroll your Spouse and, if applicable, eligible Children in your health Plan • Enroll yourself in a health Plan if previously not enrolled because you were covered under your Spouse's plan • Change health Plans when options are available	• Drop health coverage for yourself or any other covered Dependents

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 change. This chart should NOT be referenced for Health FSA or Dependent Care Account Plan (DCAP). ***NOTE: This chart is valid when the Employee contributes to their own coverage.***		
If you experience the following Event...	**You may make the following change(s)* within 31 days (where applicable 60 days) of the Event…**	**YOU MAY NOT make these types of changes...**
You lose employment or otherwise become ineligible for health benefits	• Enroll in your Spouse's plan, if available • Elect temporary COBRA coverage for the Qualified Beneficiaries (you and your covered Dependents)	
Proof of a status change may be required to make a corresponding change in coverage/enrollment. If you have any questions, contact your Employer's Department using the Quick Reference Chart.		

RETURN TO WORK AND BENEFIT CONTINUATION ISSUES

If the Participant ceases to be a benefits-eligible Employee or Retiree and then within thirty 31 days returns to work in a benefits-eligible position for the same employer, they will be required to take the same benefit election for the remaining portion of the Plan Year as they had before they terminated. Participation will be effective the first of the month following return to work.

If the Participant ceases to be a benefits-eligible Employee or Retiree and returns to work in a benefit–eligible position for the same employer more than 31 days following the termination date, the employer will determine if and when the Participant will become eligible for benefits in accordance with IRS regulations under the Affordable Care Act (ACA).

SWITCHING TO A DIFFERENT EMPLOYER THAT PARTICIPATES IN NAPEBT

If the benefits-eligible Participant changes jobs from one Employer covered under the NAPEBT Plans to another Employer covered under the NAPEBT Plans within 31 days, the waiting period for medical coverage will be waived. Participation will be effective the first of the month following such election or date of hire. When the employee enrolls using the Online Benefits Center, the employee shall indicate they are transferring from another NAPEBT employer. Please remember that the Participant may have a gap in coverage depending on the date coverage ends under one NAPEBT employer and start of employment with another NAPEBT employer. For example,

- if the Participant terminates employment on June 2nd they are covered under their Employer's plan until June 30th, and if they begin employment with the new Employer on June 28th and coverage begins July 1st, the Participant will not have a gap in coverage.
- if the Participant terminates employment on June 26th they are covered under their Employer's plan until June 30th, and if they begin employment as a benefits-eligible employee with the new Employer on July 15th and coverage begins August 1st they will have a gap in coverage (the month of July). In this example, the Participant may want to elect COBRA coverage from their former Employer during the month of July until their new coverage begins in August with the new employer. If the employee is ready and willing to work for the new Employer and there is a business reason why the Employee cannot start work (i.e., orientation, pay period, etc.), then the Employee's coverage will begin the first day of the month without a gap in service.

If the Participant changes from one NAPEBT Employer to another NAPEBT Employer within 31 days and remains covered under the NAPEBT Plan they may continue the same level of voluntary life insurance they had with their prior Employer and the evidence of insurability requirements will be waived. After 31 days the Participant will be required to satisfy the life insurance company's evidence of insurability requirements as any other new Employee under the plan.

WHEN COVERAGE ENDS (TERMINATION OF COVERAGE)

WHEN COVERAGE ENDS	WHOSE COVERAGE ENDS				
	EMPLOYEE	RETIREE	DEPENDENT (SPOUSE AND CHILD)	DOMESTIC PARTNER	CHILD OF A DOMESTIC PARTNER
On the last day of the month in which the Employee's employment ends	✓		✓	✓	✓
On the last day of the month in which the Retiree's coverage ends		✓	✓	✓	✓
On the last day of the month in which the Employee or Spouse enter the Armed Forces (the military) on full-time active duty (except the County – please see the **LEAVE OF ABSENCE – BENEFIT CONTINUATION** section below.)	✓		✓	✓	✓
On the last day of the month in which you are no longer eligible to participate in the Plan	✓	✓	✓	✓	✓
On the last day of the month in which you cease to make any contributions required for your coverage	✓	✓	✓	✓	✓
The date the Plan is discontinued	✓	✓	✓	✓	✓
The date of the Employee's or Retiree's death (Dependents have coverage through the end of the month in which the Employee dies; however see the special provision for extension of coverage for a Surviving Lawful Spouse and Surviving Dependent child of a deceased law enforcement officer, in this Eligibility chapter)	✓	✓	✓	✓	✓
The month prior to the month in which the Retiree or disabled Employee becomes entitled (eligible and enrolled) to Medicare Part A or B. (Exceptions apply to County employees who retired prior to July 1, 2011.)		✓	✓	✓	✓
The last day of the month prior to the day the Retiree becomes 65 years of age (*except for the County*, where if retired prior to July 1, 2011: then eligible for Medical until the earlier of Medicare entitlement or age 65; eligible for Dental and Vision (indefinitely) and Life Insurance eligible to age 70. If retired on or after July 1, 2011: then eligible for Medical until the earlier of Medicare entitlement or age 65; eligible for Dental and Vision to age 65 and Life Insurance eligible to age 70.		✓			
The last day of the month in which there is the expiration of the period of coverage stated in the QMCSO.			✓		✓

WHEN COVERAGE ENDS	WHOSE COVERAGE ENDS				
	EMPLOYEE	RETIREE	DEPENDENT (SPOUSE AND CHILD)	DOMESTIC PARTNER	CHILD OF A DOMESTIC PARTNER
For a Surviving Lawful Spouse and Surviving Dependents of a deceased law enforcement officer, 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: the surviving Dependents no longer meet the definition of Spouse or Dependent Child(ren) as provided in the Definitions chapter of this document); or • the date the surviving Spouse remarries; or • the end of the month in which the surviving Spouse becomes Medicare eligible; or • the date the surviving Spouse or surviving dependent child dies; 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.			✓		

OPTIONS WHEN COVERAGE UNDER THIS PLAN ENDS

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

In the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a **spouse's plan**), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

WHEN THE PLAN CAN END THE PARTICIPANT'S COVERAGE FOR CAUSE

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when premiums and contributions are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan, as discussed below:

A. The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause 30 days after it gives you written notice of its finding that you or your covered Dependent:

   1. **engages 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 (for example, keeping an ineligible dependent enrolled under the Plan, such as an ex-spouse, ex-Domestic Partner, over-age, or ineligible dependent child, etc. is considered fraud); 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 your coverage is terminated for any of the above reasons, it may be terminated retroactively to the date that you or your covered Dependent performed or permitted the acts described above.

B. The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause **30 days after it gives you written notice** of its finding that you or your covered Dependent(s) engaged in **conduct that was abusive, obstructive, or otherwise detrimental to a Physician or Health Care Practitioner**. If your coverage is terminated for this reason, it will be terminated on a going forward basis.

C. The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause **15 days after it gives you written notice** of its finding that you have failed to pay your premium payment. In this instance, your coverage may be terminated retroactively to the date of the delinquent premium payment. In addition, your coverage may be suspended during the 15-day notice period. FUSD will provide up to 60 days for payment prior to terminating coverage.

INFORMATION A PARTICIPANT OR THEIR DEPENDENTS MUST FURNISH TO THE PLAN

The Participant or their covered Dependents must provide information they have that may affect eligibility for coverage or claims under the Plan. Contact your Employer's Department at the address/phone number listed on the Quick Reference Chart.

Failure to give this Plan a timely notice (as noted below) will cause the Participant's Spouse, and/or Dependent Child(ren) to **lose their right to obtain COBRA Continuation Coverage,** and cause their Domestic Partner or Domestic Partner's Child to lose the option to obtain COBRA-like continuation coverage or will cause the coverage of a Dependent Child or Domestic Partner's Child to end when it otherwise might continue because the Child may meet the Plan's requirements for a disabled Dependent Child.

The Participant **must notify the Plan within 60 days** after the date a:

- Spouse ceases to meet the Plan's definition of Spouse (such as in a divorce);
- Dependent Child ceases to meet the Plan's definition of Dependent (such as the Dependent Child reaches the Plan's limiting age or the Dependent Child ceases to meet the Plan's requirements for a disabled Dependent Child. See the definition of Dependent Child in the Definition chapter);
- Domestic Partner ceases to meet the Plan's definition of Domestic Partner; or
- Domestic Partner's Child ceases to meet the Plan's definition of Domestic Partner Child.

Note that for certain changes, like divorce or a child reaching the limiting age, if you do not notify the Plan within 60 days of that change, the opportunity to elect COBRA will not apply.

Type of Information Needed by the Plan	Date Information is to be Submitted to the Plan
• Change of name or address or the existence of other health care coverage for any covered person.	As soon as possible but not later than 60 days after the change or addition of other coverage.
• Marriage, divorce, legal separation, addition of a new Dependent, death of any covered person.	As soon as possible but not later than 60 days after the change or addition of other coverage.
• Covered Dependent (Spouse or Child) becomes disabled or is no longer disabled.	Within 31 days of the date the person becomes disabled or is no longer disabled.
• Covered Child ceases to be a Dependent as defined by this Plan (*e.g.,* over the limiting age of the Plan, etc.)	As soon as possible but not later than 60 days after the change or addition of other coverage.

Type of Information Needed by the Plan	Date Information is to be Submitted to the Plan
• Employee receives a determination of disability from the Social Security Administration (SSA) or is no longer disabled according to SSA. • Medicare enrollment or disenrollment.	See the COBRA chapter for timeframe.

LEAVE OF ABSENCE BENEFIT CONTINUATION

In general, to be eligible for FMLA, an employee must have worked for their employer for at least 12 months, met the 1,250 hours of service requirement in the 12 months prior to the leave, and worked at a location where the employer employed at least 50 employees within 75 miles. If the employee is eligible for FMLA 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, to provide care of a Spouse, child or parent who is seriously ill, or for the employee's own serious illness. While you are officially on such a family or medical leave, you can keep coverage for yourself and your Dependents in effect during that family or medical leave period by continuing to pay your contributions during that period.

Each applicable large employer of NAPEBT reserves the right to determine benefits eligibility and payment of benefits during a leave in accordance with Health Reform and the employer's specific measurement methodology, which may impact the information outlined in the following chart. See your Employer's Department using the Quick Reference Chart for more information.

LEAVE OF ABSENCE – BENEFIT CONTINUATION GUIDELINES							
Type of Leave		**Coconino County/KVID**	**Coconino County Accommodation School District**	**City of Flagstaff**	**Flagstaff Unified School District (FUSD)**	**Mountain Line**	**Coconino Community College**
FMLA	**Payment**	Employer continues to pay contribution for benefits until 480 hours (1,040 hours in some cases) of FMLA are exhausted. Employee is responsible for their portion of benefit costs. If Employee remains on payroll during leave, deductions are made through payroll. If accruals are exhausted, Employee may submit payment while on leave or set up payroll deduction upon return to work.	Employer continues to pay contribution for benefits until 480 hours (1,040 hours in some cases) of FMLA are exhausted. Employee is responsible for their portion of benefit costs. If Employee remains on payroll during leave, deductions are made through payroll. If accruals are exhausted, Employee may submit payment while on leave or set up payroll deduction upon return to work.	Employer continues to pay contributions for benefits until 12 weeks, 480/672 hours (1,040/1,456 hours in some cases) of FMLA are exhausted. Employee is responsible for their portion of benefit costs. If employee remains on payroll during leave, deductions are made. If accruals are exhausted, employee may submit payment while on leave or set up payroll deductions upon return to work.	Employer continues to pay contribution for benefits until 12 weeks (26 weeks in some cases) of FMLA are exhausted. If Employee remains on payroll during leave, deductions will be made through payroll. If leave accruals are exhausted, Employee may submit payment while on leave. Employee may be responsible for all benefits costs paid during FMLA if they do not return to work after their allotted 12 weeks (26 weeks in some cases).	Health Insurance Benefit: Qualified Employees will be entitled to continue group health, dental, vision and term life/accidental death & dismemberment insurance benefits for up to 12 weeks (26 weeks in some cases), with no cost for Employee-only coverage. As it is Mountain Line's policy to run FMLA concurrently with paid leave, Dependent coverage and optional insurance is generally covered through regular payroll deductions. However, if paid leave is exhausted, the Employee is responsible for any premiums for Dependent coverage or optional insurance which is normally paid through deductions. To keep Dependent and optional insurance coverage in force during unpaid family and medical leave, the Employee on leave must arrange to make direct monthly payments to, and in accordance with a schedule determined by, the Employer's Department referenced in the Quick Reference Chart. Should an Employee exhaust their 12 weeks (26 weeks in some cases) of leave, they have the option of requesting a leave of absence. If the leave of absence is approved, insurance coverage would terminate at the end of that month, and the Employee would be offered COBRA continuation coverage.	The College shall maintain the employee's full coverage for health, basic life, vision, and dental insurance at the level and under the conditions coverage would have been provided if the employee had been employed continuously for the duration of such leave. Normal employee contributions to health, vision, and dental benefits will be deducted from any payments made to the employee while on leave. The employee is responsible for their portion of benefit costs and may submit payment while on leave.

LEAVE OF ABSENCE – BENEFIT CONTINUATION GUIDELINES							
Type of Leave		**Coconino County/KVID**	**Coconino County Accommodation School District**	**City of Flagstaff**	**Flagstaff Unified School District (FUSD)**	**Mountain Line**	**Coconino Community College**
FMLA	**Dependent Coverage**	Employer continues to pay contribution until 480 hours (1,040 hours in some cases) of FMLA are exhausted. Employee is responsible for their portion of benefit costs. If Employee remains on payroll during leave, deductions are made through payroll. If accruals are exhausted, Employee may submit payment while on leave or set up payment options upon return to work.	Employer continues to pay contribution until 480 hours (1,040 hours in some cases) of FMLA are exhausted. Employee is responsible for their portion of benefit costs. If Employee remains on payroll during leave, deductions are made through payroll. If accruals are exhausted, Employee may submit payment while on leave or set up payment options upon return to work.	Coverage is continued until 12 weeks, 480/672 hours (1,040/1,456 hours in some cases) of FMLA are exhausted. Employee is responsible for their portion of benefit costs. If employee remains on payroll during leave, deductions are made. If accruals are exhausted, employee may submit payment while on leave or set up payroll deductions upon return to work.	Employer does not pay for dependent coverage for Employees on FMLA. Employee may continue to pay contribution for dependent benefits until 12 weeks (26 weeks in some cases) of FMLA are exhausted.	Contact the Employer's Department using the Quick Reference Chart for information.	Employee will continue to pay contribution for dependent benefits until 12 weeks (26 weeks in some cases) of FMLA are exhausted.

LEAVE OF ABSENCE – BENEFIT CONTINUATION GUIDELINES							
Type of Leave		**Coconino County/KVID**	**Coconino County Accommodation School District**	**City of Flagstaff**	**Flagstaff Unified School District (FUSD)**	**Mountain Line**	**Coconino Community College**
	Termination	End of the month in which 480 hours (1,040 hours in some cases) of FMLA are exhausted unless extended Leave of Absence is approved. See Personal Leave of Absence (Paid) or Personal Leave of Absence (Unpaid)	End of the month in which 480 hours (1,040 hours in some cases) of FMLA are exhausted unless extended Leave of Absence is approved. See Personal Leave of Absence (Paid) or Personal Leave of Absence (Unpaid)	End of month in which 12 weeks, 480/672 hours (1,040/1,456 hours in some cases) are exhausted unless applicable Paid Leave of Absence or Unpaid Leave of Absence is requested and approved.	End of month in which 12 weeks (26 weeks in some cases) of FMLA are exhausted, with the option for COBRA. If the Employee does not return to work after 12 weeks (26 weeks in some cases) of FMLA, they have to request a leave of absence. Insurance would terminate at the end of that month, with the option for COBRA.	Contact the Employer's Department using the Quick Reference Chart for information.	Coverage ends with the exhaustion of FMLA and then the employee can elect COBRA.

LEAVE OF ABSENCE – BENEFIT CONTINUATION GUIDELINES							
Type of Leave		**Coconino County/KVID**	**Coconino County Accommodation School District**	**City of Flagstaff**	**Flagstaff Unified School District (FUSD)**	**Mountain Line**	**Coconino Community College**
Military	**Payment**	Employer continues to pay contribution for benefits up to 90 days. Employee is responsible for their portion of benefit costs. If Employee remains on payroll during leave, deductions are made through payroll. If accruals are exhausted, Employee may submit payment to Coconino County while on leave. Coverage terminates at the end of the month in which 90 days of military leave is exhausted. Coverage may be continued through COBRA up to a maximum of 18 months. Employee is responsible for the entire cost of coverage plus 2% administrative fee. Coverage will be effective the first of the month after the employee returns to work.	Contact the Employer's Department using the Quick Reference Chart for information.	Employer continues to pay contributions for benefits until the end of the month in which employee starts military leave. Employee is responsible for their portion of benefit costs. If the employee chooses to use accrued time during military leave, benefits may continue, otherwise, benefits cease at the end of the month.	Employer continues to pay contributions for benefits until the end of the month in which Employee starts military leave.	Health Insurance Benefits: Employees on paid military leave as described above will be entitled to continue group health and dental insurance benefits as an active Employee. Employees on unpaid military leave will continue to receive group health and dental insurance benefits as an active Employee up to a maximum period of ninety days. To keep medical and dental insurance coverage in force during unpaid military leave which exceeds 90 days up to a maximum of 18 months, the Employee on leave must arrange to make direct monthly payments to, and in accordance with a schedule determined by, the Employer's Department listed in the Quick Reference Chart.	College-sponsored health insurance coverage may be continued for up to 18 months of unpaid leave, even if the Employee is participating in military health benefits coverage. The Employer's health Plan must be the primary pay when such dual coverage exists. If the military leave is for less than 31 days, the Employee will pay the same share for coverage as any active Employee. If more than 30 days, the Employee must pay the entire cost of coverage plus a 2% administrative fee. This extended coverage may be terminated if the Employee does not make timely payments or does not return to work.

LEAVE OF ABSENCE – BENEFIT CONTINUATION GUIDELINES							
Type of Leave		**Coconino County/KVID**	**Coconino County Accommodation School District**	**City of Flagstaff**	**Flagstaff Unified School District (FUSD)**	**Mountain Line**	**Coconino Community College**
	Dependent Coverage	Employer continues to pay contribution for benefits up to 90 days. Employee is responsible for their portion of benefit costs.	Contact the Employer's Department using the Quick Reference Chart for information.	Coverage continues until the end of the month in which employee starts military leave. Employee is responsible for their portion of benefit costs. If employee chooses to use accrued time during military leave, benefits may continue, otherwise, benefits cease at the end of the month.	Employer does not pay for dependent coverage for Employees on military leave. Employee may continue to pay contribution for dependent benefits until accrued leave is exhausted.	Contact the Employer's Department using the Quick Reference Chart for information.	
	Termination	End of the month in which 90 days of military leave is exhausted.	Contact the Employer's Department using the Quick Reference Chart for information.	End of the month in which employee starts military leave or exhausts accrued time.	End of the month in which employee starts military leave or exhausts accrued time, with the option for COBRA.	Contact the Employer's Department using the Quick Reference Chart for information.	
Personal Leave of Absence (Paid)	**Payment**	Employer continues to pay contribution for benefits during an approved leave of absence for employees who remain on payroll. Employee is responsible for their portion of benefit costs; deductions are made through payroll.	Employer continues to pay contribution for benefits during an approved leave of absence for employees who remain on payroll. Employee is responsible for their portion of benefit costs; deductions are made through payroll.	Employer continues to pay contributions for coverage. Employee is responsible for their portion of benefit costs.	Not Applicable	Contact the Employer's Department using the Quick Reference Chart for information.	Not Applicable

LEAVE OF ABSENCE – BENEFIT CONTINUATION GUIDELINES							
Type of Leave		**Coconino County/KVID**	**Coconino County Accommodation School District**	**City of Flagstaff**	**Flagstaff Unified School District (FUSD)**	**Mountain Line**	**Coconino Community College**
	Dependent Coverage	Employer continues to pay contribution for benefits up to 6 months of paid leave of absence. Employee is responsible for their portion of benefit costs.	Employer continues to pay contribution for benefits up to 6 months of paid leave of absence. Employee is responsible for their portion of benefit costs.	Coverage continues. Employee is responsible for their portion of benefit costs.	Not Applicable	Contact the Employer's Department using the Quick Reference Chart for information.	Not Applicable
	Termination	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Contact the Employer's Department using the Quick Reference Chart for information.	Not Applicable
Personal Leave of Absence (Unpaid)	**Payment**	Employer continues to pay contribution for benefits through the end of the month in which the employee goes off payroll. Employee is responsible for their portion of benefit costs. Coverage is terminated the end of the month in which the employee goes off payroll. Employee is eligible to continue coverage though COBRA; Employee is responsible for the entire cost of coverage plus 2% administrative fee.	Employer continues to pay contribution for benefits through the end of the month in which the employee goes off payroll. Employee is responsible for their portion of benefit costs. Coverage is terminated the end of the month in which the employee goes off payroll. Employee is eligible to continue coverage though COBRA; Employee is responsible for the entire cost of coverage plus 2% administrative fee.	Coverage will cease at the end of the month in which unpaid status begins.	Employer does not pay contributions for employees on any leave of absence. If an Employee requests a leave of absence for an entire school year, insurance would end June 30 of the current school year, and when the Employee comes back, insurance would start again July 1 of the new school year. For a partial year request, coverage resumes the first of the month following return to work.	Contact the Employer's Department using the Quick Reference Chart for information.	An Employee on an extended personal leave without pay may continue in the group insurance Plans through applicable COBRA provisions. An Employee does not accrue PTO nor do full-time faculty accrue sick leave when in an absence without pay status.

LEAVE OF ABSENCE – BENEFIT CONTINUATION GUIDELINES							
Type of Leave		**Coconino County/KVID**	**Coconino County Accommodation School District**	**City of Flagstaff**	**Flagstaff Unified School District (FUSD)**	**Mountain Line**	**Coconino Community College**
	Dependent Coverage	Contact the Employer's Department using the Quick Reference Chart for information.	Contact the Employer's Department using the Quick Reference Chart for information.	Coverage will cease at the end of the month in which unpaid status begins for the employee.	Employer does not pay for dependent coverage for Employees on any leave of absence.	Contact the Employer's Department using the Quick Reference Chart for information.	
	Termination	Contact the Employer's Department using the Quick Reference Chart for information.	Contact the Employer's Department using the Quick Reference Chart for information.	Coverage will cease at the end of the month in which unpaid status begins for the employee.	Coverage is terminated at the end of the month last worked before the leave of absence begins, with the option for COBRA.	Contact the Employer's Department using the Quick Reference Chart for information.	
Industrial Leave (Workers Comp)	**Payment**	Employer continues to pay contribution for benefits up to 6 months. Employee is responsible for their portion of benefit costs. If Employee remains on payroll during leave, deductions are made through payroll. If accruals are exhausted or Employee chooses to go off payroll, Employee may submit payment to Coconino County while on leave.	Employer continues to pay contribution for benefits up to 6 months. Employee is responsible for their portion of benefit costs. If Employee remains on payroll during leave, deductions are made through payroll. If accruals are exhausted or Employee chooses to go off payroll, Employee may submit payment to Coconino County while on leave.	Employer continues to pay contributions for coverage while the employee is on paid industrial leave.	Employer continues to pay contribution for benefits until FMLA or accrued leave is exhausted.	Contact the Employer's Department using the Quick Reference Chart for information.	Contact the Employer's Department using the Quick Reference Chart for information.

LEAVE OF ABSENCE – BENEFIT CONTINUATION GUIDELINES							
Type of Leave		**Coconino County/KVID**	**Coconino County Accommodation School District**	**City of Flagstaff**	**Flagstaff Unified School District (FUSD)**	**Mountain Line**	**Coconino Community College**
	Dependent Coverage	Contact the Employer's Department using the Quick Reference Chart for information.	Contact the Employer's Department using the Quick Reference Chart for information.	Employee is responsible for their portion of benefit costs while on paid industrial leave.	Employer does not pay for dependent coverage for Employees on industrial leave. Employee may continue to pay contribution for dependent benefits until accrued leave is exhausted.	Contact the Employer's Department using the Quick Reference Chart for information.	
	Termination	Contact the Employer's Department using the Quick Reference Chart for information.	Contact the Employer's Department using the Quick Reference Chart for information.	Coverage will cease at the end of the month in which unpaid status begins for the employee.	Coverage is terminated at the end of the month in which accrued leave or FMLA leave is exhausted, with the option for COBRA.	Contact the Employer's Department using the Quick Reference Chart for information.	
Maternity / Paternity Leave	**Payment**	Refer to FMLA or Personal Leave of Absence (Paid or Unpaid).	Refer to FMLA or Personal Leave of Absence (Paid or Unpaid).	N/A with exception of FMLA, Paid Leave of Absence.	Employer continues to pay contribution for benefits until 12 weeks (26 weeks in some cases) of FMLA or accrued leave are exhausted.	Contact the Employer's Department using the Quick Reference Chart for information.	Not Applicable with exception of FMLA, or Unpaid Leave of Absence
	Dependent Coverage	Contact the Employer's Department using the Quick Reference Chart for information.	Contact the Employer's Department using the Quick Reference Chart for information.		Employer does not pay for dependent coverage for Employees on any leave of absence other than FMLA.	Contact the Employer's Department using the Quick Reference Chart for information.	Not Applicable with exception of FMLA, or Unpaid Leave of Absence

LEAVE OF ABSENCE – BENEFIT CONTINUATION GUIDELINES							
Type of Leave		**Coconino County/KVID**	**Coconino County Accommodation School District**	**City of Flagstaff**	**Flagstaff Unified School District (FUSD)**	**Mountain Line**	**Coconino Community College**
	Termination	Contact the Employer's Department using the Quick Reference Chart for information.	Contact the Employer's Department using the Quick Reference Chart for information.		Coverage is terminated at the end of the month in which accrued leave or FMLA leave is exhausted, with the option for COBRA.	Contact the Employer's Department using the Quick Reference Chart for information.	Not Applicable with exception of FMLA, or Unpaid Leave of Absence
Faculty Sabbatical leave	**Payment**	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Faculty members on sabbatical leave retain the rights and benefits of all full-time regular faculty, except that no sick leave accrues.
	Dependent Coverage	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	
	Termination	Contact the Employer's Department using the Quick Reference Chart for information.	Contact the Employer's Department using the Quick Reference Chart for information.	Not Applicable	Not Applicable	Not Applicable	

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

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA? USERRA Continuation Coverage is a temporary continuation of coverage when it otherwise would end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An employee's coverage under this Plan will terminate when the employee enters active duty in the uniformed services.

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months.
- If the employee goes into active military service for **up to 31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.

Duty to Notify the Plan: The Plan will offer the employee USERRA continuation coverage only after the Plan Administrator has been notified by the employee in writing that they have been called to active duty in the uniformed services. The employee must notify the Plan Administrator (contact information is on the

Quick Reference Chart in the front of this document) as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage:

- Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately.
- Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected, (both cannot be elected by the same person). Contact your Employer's Department using the Quick Reference Chart to obtain a copy of the USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Paying for USERRA Coverage:

- If the employee goes into active military service for up to **31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.
- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA chapter for more details.

In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this Plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces:

When the employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The employee must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated. Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to your Employer's Department using the Quick Reference Chart.

OUTPATIENT PRESCRIPTION DRUG BENEFITS: RETAIL AND MAIL ORDER DRUGS

This section describes the outpatient prescription drug benefits that are part of the benefits of any of the medical plan options offered under NAPEBT. The outpatient prescription drug benefits are self-funded by NAPEBT and administered by an independent Prescription Drug Benefits Administrator whose name and contact information is listed on the Quick Reference Chart in the front of this document. The Prescription Drug Benefits Administrator extends discounts on drugs purchased at network pharmacy locations to individuals enrolled in the Medical Plans and the administrator also processes prescription drug claims and appeals. Only individuals who are covered under one of the medical plan options offered by NAPEBT are eligible to receive outpatient prescription drug benefits. For the location of network retail and mail order pharmacies, contact the Prescription Drug Benefits Administrator.

PRESCRIPTION DRUG PLAN DESIGN

If you are enrolled in the **Base Plan or Buy Up Plan** these are your Outpatient Prescription Drug Benefits:

Base Plan or Buy Up Plan				
	In-Network Retail Pharmacy (up to a 30-day supply) You pay the following	**In-Network Retail-90 Pharmacy (up to a 90-day supply)** You pay the following	**Mail Order Service (up to a 90-day supply)** You pay the following:	**Specialty Drug Program (up to a 30-day supply)** You pay the following:
Generic:	$8.00 copay	$20.00 copay	$16.00 copay	Drugs on the PrudentRx Program Drug List if you are enrolled in the PrudentRX Program: No Charge All others: 30% coinsurance*
Formulary	$35.00 copay	$87.50 copay	$70.00 copay	
Non-Formulary	$55.00 copay	$137.50 copay	$110.00 copay	

Under the Base Plan and the Buy Up Plan, outpatient prescription drugs do not accumulate toward the Plan's Deductibles but copays (other than those for drugs on the PrudentRx Program Drug List) do accumulate to meet a separate annual **Outpatient Drug Out-of-Pocket Limit of $2,350 per person; $4,700 per family** (in-network and out-of-network combined).

Certain drugs are payable without cost-sharing when obtained in from an in-network pharmacy, such as female contraceptives, certain drugs to reduce the risk of breast cancer, and certain over-the-counter drugs. See also the section on Coverage of Certain Over-the-Counter Drugs.

Drugs filled at an Out-of-Network Pharmacy: You pay 40% of the Allowed Charge (with a $5.00 minimum) up to your annual medical plan out-of-pocket maximum limit.

*In accordance with IRS Notice 2019-45, the Plan will provide 100% coverage, no deductible for certain medical services and drugs that are classified as preventive care **for individuals with chronic conditions**. For more information see the section on Coverage of Preventive Care for Chronic Conditions.*

*More information about the PrudentRX program in the PrudentRX Program for Certain Specialty Drugs section below.

If you are enrolled in the **High Deductible Health Plan (HDHP)** these are your Outpatient Prescription Drug Benefits:

<table>
<tr><th colspan="5">High Deductible Health Plan (HDHP)</th></tr>
<tr><th></th><th>In-Network Retail Pharmacy
(up to a 30-day supply)
You pay the following</th><th>In-Network Retail-90 Pharmacy
(up to a 90-day supply)
You pay the following</th><th>Mail Order Service
(up to a 90-day supply)
You pay the following:</th><th>Specialty Drug Program
(up to a 30-day supply)
You pay the following:</th></tr>
<tr><td>Generic</td><td colspan="4" rowspan="3">After your annual medical plan deductible is met, you pay
In-Network Pharmacy: You pay 20% of the cost of the drug (with a $8.00 minimum) up to your annual medical plan out-of-pocket maximum limit.
Out-of-Network Pharmacy: You pay 40% of the Allowed Charge (with a $5.00 minimum) up to your annual medical plan out-of-pocket maximum limit.
Under the HDHP, both outpatient prescription drugs and medical plan benefits accumulate to meet your annual deductible and annual Out-of-Pocket Limit of $5,000 per person; $10,000 per family.
Certain drugs are payable without cost-sharing when obtained from an in-network pharmacy, such as female contraceptives, certain drugs to reduce the risk of breast cancer, and certain over-the-counter drugs.
In accordance with IRS Notice 2019-45, the Plan will provide 100% coverage, no deductible for certain medical services and drugs that are classified as preventive care for individuals with chronic conditions. For more information see the section on Coverage of Preventive Care for Chronic Conditions.
See also the section on Coverage of Certain Over-the-Counter Drugs.</td></tr>
<tr><td>Formulary</td></tr>
<tr><td>Non-Formulary</td></tr>
</table>

COVERAGE OF CERTAIN PREVENTIVE CARE DRUGS MANDATED BY THE AFFORDABLE CARE ACT (ACA)

The following chart outlines the current preventive care and prescription drugs that are payable by the NAPEBT non-grandfathered medical plan options, in accordance with the Affordable Care Act (Health Reform) and the US Preventive Service Task Force (USPSTF) A and B recommendations. To be covered, at no cost, drugs must be purchased at a participating network retail or mail order pharmacy and be presented to the pharmacist along with a prescription for the drug. (Note that while OTC drugs require a prescription, insulin is payable by the Plan without a prescription).

Where the information in this document conflicts with newly released Health Reform regulations affecting the coverage of prescription drugs, this Plan will comply with the new requirements on the date required.

Drug Name	Who Is Covered for this Drug?	Cost-Sharing?	Payment Parameters for ACA-mandated Drugs in addition to a prescription from your Physician or Health Care Practitioner:
FDA-approved contraceptives for females, such as birth control pills, spermicidal products, and sponges.	All females	None, if payment parameters are met	Up to a 30-day supply at retail or 90-day supply at mail order of FDA-approved contraceptives per purchase are payable under the plan's Prescription Drug Program for females younger than 60 years of age. Generic FDA approved contraceptives are at no cost to the plan participant. Brand contraceptives are payable only if a generic alternative is medically inappropriate.
Aspirin	• For pregnant women who are at high risk for preeclampsia (a pregnancy complication). • Low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	None, if payment parameters are met	• For non-pregnant adults, since dosage not established by USPSTF, plan covers up to one bottle of 100 tablets every 3 months. • For pregnant women at high risk for preeclampsia: plan covers daily low dose aspirin (81mg) as preventive medication after 12 weeks gestation. • The use of aspirin is recommended when the potential benefit outweighs the potential harm due to an increase in gastrointestinal hemorrhage
Folic acid supplements	All females planning or capable of pregnancy should take a daily folic acid supplement containing 0.4 - 0.8mg of folic acid.	None, if payment parameters are met	Excludes women >55 years of age, and products containing > 0.8mg or < 0.4mg of folic acid. Plan covers generic folic acid up to one tablet per day.
Tobacco cessation products (FDA-approved)	Individuals who use tobacco products.	None, if payment parameters are met	FDA-approved tobacco cessation drugs (including both prescription and over-the-counter medications) are payable under the Plan's Prescription Drug Program, up to two 90-day courses of treatment per year, which applies to all FDA-approved products. No precertification requirement.
Fluoride supplements	For children starting at age 6 months up to 6 years when recommended by provider because primary water source is deficient in fluoride.	None, if payment parameters are met	Plan covers generic versions of systemic dietary fluoride supplements (tablets, drops or lozenges) available only by prescription for children to age 6 years. Excludes products for individuals age 6 and older, topical fluoride products like toothpaste or mouthwash and excludes brand name fluoride supplements.
Preparation "prep" Products for a Colon Cancer Screening Test	For individuals receiving a preventive colon cancer screening test	None, if payment parameters are met	Plan covers the over-the-counter or prescription strength products prescribed by a physician as preparation for a payable preventive colon cancer screening test, such as a colonoscopy for individuals age 45-75 years.

Drug Name	Who Is Covered for this Drug?	Cost-Sharing?	Payment Parameters for ACA-mandated Drugs in addition to a prescription from your Physician or Health Care Practitioner:
Breast cancer preventive medication	Women who are at increased risk for breast cancer and at low risk for adverse medication effects.	None, if payment parameters are met	Plan covers generic breast cancer preventive drugs such as tamoxifen, raloxifene, or aromatase inhibitors.
Statin preventive medication	Adults ages 40-75 years with: no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.	None, if payment parameters are met	For adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke), the Plan covers a low- to moderate-dose statin (generic only) for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening (a lab test) in adults ages 40 to 75 years. Brand statins are payable only if a generic alternative is medically inappropriate, as determined by the Physician or Health Care Practitioner.
Pre-exposure prophylaxis (PrEP)	Persons at increased risk of HIV acquisition	None, if payment parameters are met	Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy.
Prediabetic preventive intervention	Adults ages 35-70 with no claim for an anti-diabetic agent in their history (other than metformin 850 mg) in the past 180 days	None, if payment parameters are met	• Member age is 35-70 • Claims is for generic form of metformin 850 mg* • Member has not claim for an anti-diabetic agent in their history (other than metformin 850 mg) in the past 180 days *While generic metformin is not specifically listed in the USPSTF, the Plan will cover this drug as described above.

The prescription drug benefits administrator outlines the coverage in summary plan documents. The Participant may obtain summary plan documents form the Employer's Department using the Quick Reference Chart. Coverage is provided for prenatal vitamins; FDA-approved contraceptives for all females (such as birth control pills/patch, diaphragms); insulin, diabetic supplies (including lancets, test strips, supplies for blood glucose testing meter/devices, alcohol swabs); tobacco cessation FDA-approved drugs, and self-administered injectables (such as EpiPen and Glucagon). Note that a blood glucose testing meter/device is payable under the medical plan, not this prescription drug benefit.

For insulin dependent diabetics in the Base Plan or Buy Up Plan there is no copay for covered diabetes supplies (such as covered blood glucose monitor test strips and lancets) when these supplies are filled on the same day as the covered insulin is filled, at either a retail pharmacy or through the mail order service.

Also, there is no copay on covered diabetic insulin syringes filled through a retail pharmacy or mail order service. This benefit does not apply to participants enrolled in the NAPEBT High Deductible Health Plan.

RETAIL, MAIL ORDER AND SPECIALTY DRUG COVERAGE

Coverage is provided for those pharmaceuticals (drugs and medicines) approved by the US Food and Drug Administration (FDA) as requiring a prescription and are FDA approved for the condition, dose, route, duration, and frequency, if prescribed by a Physician or other Health Care Practitioner authorized by law to prescribe them.

- **Retail Drugs**: To obtain your discounted supply of medicine, for the copay/coinsurance noted in the charts above, present your ID card to any In-Network retail pharmacy. Contact the Prescription Drug Benefits Administrator (whose name is listed on the Quick Reference Chart) for the location of In-Network retail pharmacies. You can purchase a **30-day or 90-day supply** of medication at the retail pharmacy. For the HDHP, the deductible must be met before the Plan can pay benefits.
- **Mail Order (Home Delivery) Drug Service:** The mail order service is the easiest and least expensive way to obtain many medications plus the medications are mailed directly to your home. You may use the mail order service (see the Quick Reference Chart) to receive up to a **90-day supply** of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure or diabetes unless considered a specialty drug. Note that not all medicines are available via mail order. Check with the Prescription Drug Benefits Administrator for further information. To use the mail order service:
  a) Have your doctor write the prescription for a 90-day supply, with the appropriate refills.
  b) Mail your prescription, copay, and the mail order form to the Mail Order Services of the Prescription Drug Benefits Administrator whose address is listed on the Quick Reference Chart. Mail order forms may be obtained from the Prescription Drug Benefits Administrator. Allow up to 10 days to receive your order.
- **Specialty Drugs**: Specialty drugs are available on an outpatient basis by contacting the Prescription Drug Benefits Administrator. Specialty drugs are generally considered high-cost injectable, infused, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique health concerns and include items such as injectables for multiple sclerosis, rheumatoid arthritis, or hepatitis. These drugs may need precertification, often require special handling, are date sensitive and injectables are generally available only in a 30-day quantity.
- **Dispense As Written 1**: Prescription drug benefits will be dispensed as written (DAW) with outreach to the physician for non-generic orders when a generic is available.
- **Dispense As Written 2**: Employees who choose a non-generic drug when a generic is available will pay the difference in price in addition to the co-pay.

PRUDENTRX PROGRAM FOR CERTAIN SPECIALTY DRUGS

The PrudentRx Copay Program assists members by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% co-insurance. However, enrolled members who get copay card for their specialty medication (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Copay Program will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible members will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program. You must call 1-800-578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications – in that case, you must speak to someone at PrudentRx at 1-800-578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx, or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's out-of-pocket maximum. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

PREVENTIVE CARE NO COST DRUGS WHEN OBTAINED AT A NETWORK PHARMACY

- **FDA-approved contraceptives for females:** 100%, no cost-sharing from in-network providers for generic contraceptives submitted with a prescription. No charge for brand prescription contraceptives only if a generic contraceptive is unavailable, or generic is medically inappropriate as determined by the attending provider.
- **Tobacco/smoking cessation benefit**: Coverage is extended for over the counter or prescription FDA-approved tobacco cessation products (such as nicotine gum or patches), or programs intended to assist an individual to stop smoking or using tobacco products. The drugs are payable through the Prescription Drug Program at no cost. Present a written prescription from a Physician for FDA-approved tobacco cessation products to the retail pharmacist. This benefit is not available through the Plan's mail order program.
- Certain Drugs to Reduce the Risk of Breast Cancer: no charge at a network Retail or Mail Order location for **generic tamoxifen,** raloxifene, or aromatase inhibitors prescribed for women who are at increased risk of breast cancer and low risk for adverse medication effects.
- Certain **CDC recommended vaccinations,** including vaccines for COVID-19, are payable at 100%, no cost sharing when obtained at a network retail pharmacy. Immunization-certified pharmacists may administer certain CDC-recommended immunizations and vaccines (e.g., for flu and pneumonia). Contact the Prescription Drug Benefits Administrator for more information.
- In accordance with the Affordable Care Act (ACA, certain **preventive care drugs** are payable at no charge when prescribed and filled at a network pharmacy. For details, see the OTC chart on page 48 of this document.
- **Preexposure prophylaxis (PrEP)** is payable at 100% no cost sharing in accordance with USPSTF recommendations for those who present a higher risk of acquiring human immunodeficiency virus (HIV).

COVERAGE OF PREVENTIVE CARE FOR CHRONIC CONDITIONS.

The wellness/preventive services payable by this Plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC).

Additionally, in accordance with IRS Notice 2019-45, the Plan will provide 100% coverage, no deductible for certain medical items and services that are classified as preventive care for individuals with chronic conditions. Under this guidance, specified services and items that are used for certain **chronic conditions** are considered preventive care for High Deductible Health Plan (HDHP) and Health Savings Account (HSA) eligibility purposes when prescribed for individuals diagnosed with the associated condition to prevent exacerbation of the condition or the development of a secondary condition. For a full list of covered services, see the chart below or go to www.irs.gov for more information. The services and items, along with the conditions for which they must be prescribed to qualify as preventive care, are as follows:

Preventive Care for Specified Conditions	For Individuals Diagnosed With
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

DIRECT MEMBER REIMBURSEMENT FOR USE OF AN OUT-OF-NETWORK RETAIL PHARMACY

If you fill a prescription at an Out-of-Network pharmacy location, you will need to pay for the drug at the time of purchase and later, send your drug receipt to the Prescription Drug Benefits Administrator using the Direct Member Reimbursement (DMR) process as listed on the Quick Reference Chart. DMR forms may be obtained from the Prescription Drug Benefits Administrator.

For eligible prescriptions, under Base Plan and Buy-Up Plan, you will be reimbursed according to the amount that would have been allowed had you used an In-Network retail pharmacy minus the appropriate copay/coinsurance (and for the HDHP, the deductible must have been met in order to be reimbursed. Then claims are reimbursed by the Plan at 60% coinsurance (you pay 40% coinsurance) with a minimum $5.00 charge for out-of-network claims).

MANAGEMENT OF THE PRESCRIPTION DRUG BENEFIT

Contact the Prescription Drug Benefits Administrator (whose phone number is listed on the Quick Reference Chart in the front of this document) for the following:

- The list of drugs on the **Preferred Drug formulary.**
- Information on **drugs needing preapproval** by the clinical staff of the Prescription Drug Benefits Administrator (such as compounded drugs, sleeping pills, certain pain medication, specialty drugs).
- Information on which **drugs have a limit to the quantity** payable by this Plan (such as antimigraine drugs).
- Information on the drugs that are part of the **step therapy program** where you first try a proven, cost-effective medication before moving to a more costly drug treatment option.

Drugs not yet approved by the FDA are not covered. New FDA-approved drugs will be covered by the Plan unless a Plan amendment states otherwise or the class of drug is excluded.

Drug Exception Process: The Plan has an exception process managed by the Prescription Drug Benefits Administrator (whose contact information is listed on the Quick Reference Chart in the front of this document). The exception process allows a member's physician to contact the Prescription Drug Benefits Administrator to request that a non-covered drug be payable under the Plan. The physician is to fax the request for a drug exception and the clinical reasons why the drug is needed, including why a formulary (Preferred drug) cannot be used in its place, to the clinical team of the Prescription Drug Benefits Administrator who will review and respond to the physician with their determination.

EXCLUSIONS UNDER THE OUTPATIENT PRESCRIPTION DRUG BENEFIT

The following classes of drugs are not covered under this Outpatient Prescription Drug Benefit:

1. Over the counter (OTC) medications, except insulin and products listed under the section titled "Coverage of Certain Preventive Care Drugs" that the Plan must cover in compliance with the Affordable Care Act.
2. Cosmetic drugs such as to promote hair growth or to promote hair removal, anti-wrinkle cream.
3. Non-prescription contraceptives for males such as condoms.
4. Erectile dysfunction drug treatment.
5. Fertility products or agents.
6. Weight management drugs.
7. Pharmaceuticals requiring a prescription that have not been approved by the US Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route, duration, and frequency for which they are prescribed (i.e., are used "off-label"); or are Experimental and/or Investigational or not medically necessary, as these terms are defined in the Definitions chapter of this document.
8. Self-help devices such as a scale for weight or body fat measurement, pill crusher, pill splitter, magnifying glass/device, home personal use blood pressure measuring device.
9. Certain Topical Analgesics (pain patches) containing ingredients (alone or in combination) in strengths typically used over the counter for the temporary relief of minor aches and muscle pains. Such ingredients include, but are not limited to, menthol, capsaicin, or methyl salicylate.
10. This Plan has adopted the Prescription Drug Program's current formulary, including its preferred drug list, as the Plan's covered formulary of covered drugs. Based on the Prescription Drug Program's formulary (which is updated from time to time), certain drugs are not covered by the Plan, or are covered only when they are pre-approved by the Prescription Drug Program. Contact the Prescription Drug Program for information about the formulary or the Drug Exception Process.

INFORMATION ABOUT MEDICARE PART D PRESCRIPTION DRUG PLANS FOR PEOPLE WITH MEDICARE

If the Participant and/or their Dependent(s) are entitled to Medicare Part A or enrolled in Medicare Part B, they are also eligible for Medicare Part D Prescription Drug benefits. **It has been determined that the prescription drug coverage under <u>all of the NAPEBT medical plan options is "creditable</u>.** "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan Participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Because this Plan's prescription drug coverage is as good as Medicare, the Participant does not need to enroll in a Medicare Prescription Drug Plan in order to avoid a late penalty under Medicare. The Participant may, in the future, enroll in a Medicare Prescription Drug Plan during Medicare's annual enrollment period (October 15th through December 7th of each year).

The Participant can keep their current medical and prescription drug coverage with this Plan and does not have to enroll in Medicare Part D. If, however, the Participant keeps this Plan coverage and also enrolls in a Medicare Part D prescription drug plan they will have dual prescription drug coverage and this Plan will coordinate its drug payments with Medicare. See the section on Coordination of Benefits in this chapter for more details on how the Plan coordinates with Medicare.

If the Participant enrolls in a Medicare prescription drug plan, they will need to pay the Medicare Part D premium out of their own pocket.

Note that the Participant may not drop just the prescription drug coverage under this Plan. That is because prescription drug coverage is part of the entire medical plan. Generally, the Participant may only drop medical plan coverage at this Plan's next Open Enrollment Period.

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from October 15th through December 7th); or
- for beneficiaries leaving Employer group health coverage, they may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

> **IMPORTANT NOTE**: If you are enrolled in the High Deductible Health (HDHP) Plan with the Health Savings Account (HSA) **you and your employer may not continue to make contributions to your HSA** once you are enrolled in Medicare including being enrolled in a Medicare Part D drug plan. If you want to continue to make contributions to your HSA account, you will not want to enroll in a Medicare Part D plan.

For more information about creditable coverage or Medicare Part D coverage see the NAPEBT Notice of Creditable Coverage (a copy is available from the Employer's Department using the Quick Reference Chart). See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

CLAIM AND APPEAL PROCEDURES FOR OUTPATIENT PRESCRIPTION DRUGS, ELIGIBILITY

TIME LIMIT FOR INITIAL FILING OF OUTPATIENT PRESCRIPTION DRUG CLAIMS

All post-service outpatient prescription drug claims must be submitted to the Prescription Drug Benefits Administrator within **ONE YEAR** from the date of service. No Plan benefits will be paid for any claim not submitted within this period.

If your prescription drug request or drug claim is not approved, or your claim for benefits is denied based on a finding you are not eligible, you may appeal that denial by following the steps in this Claim Appeal section. NAPEBT has delegated final claims and appeal authority for the outpatient prescription drug benefits of this Plan to the independent Prescription Drug Benefits Administrator. This section discusses the claim appeal process for the following types of claims: Pre-authorization Claim Review Services, Pre-Service Appeals Review Services, and Post-Service Appeals Review Services. Eligibility claims are considered Post-Service Claims.

Definitions Pertinent to Claims and Appeals

- **Adverse Benefit Determination** – A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Plan benefit. An adverse benefit determination includes a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a Plan benefit based on the application of a utilization review or on a determination of an individual's eligibility to participate in the Plan. An adverse benefit determination also includes a failure to cover a Plan benefit because use of the benefit is determined to be experimental, investigative, or not medically necessary or appropriate.
- **Appropriate Administrator** – The administrator responsible for adjudicating the claim. For prescription drug claims, this is the Prescription Drug Benefit Administrator. For eligibility claims, this is the Plan Administrator.
- **Claim** – A request for a Plan benefit that is made in accordance with the Plan's established procedures for filing benefit claims.
- **Independent Review Organization (IRO)** – An entity that conducts independent external reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to the requirements of the ACA.
- **Medically Necessary (Medical Necessity)** – Medications, health care services or products are considered Medically Necessary if:
  - Use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
  - Use of the medication, service, or product is based on recognized standards for the health care specialty involved;
  - Use of the medication, service, or product represents the most appropriate level of care for the individual, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed; and
  - Use of medication, service or product is not solely for the convenience of the individual, individual's family, or provider.
- **Post-Service Claim** – A Claim for a Plan benefit that is not a Pre-Service Claim.
- **Pre-Authorization** – A pre-service review of an individual's initial request for a particular medication. The Prescription Drug Benefits Administrator will apply a set of pre-defined criteria to determine whether there is need for the requested medication.

- **Pre-Service Claim** – A Claim for a medication, service, or product that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining the requested medical care or service. Pre-Service Claims include individual requests for pre-authorization.
- **Urgent Care Claim** – A Claim for a medication, service, or product where a delay in processing the Claim: (i) could seriously jeopardize the life or health of the individual, and/or could result in the individual's failure to regain maximum function, or (ii) in the opinion of a physician with knowledge of the individual's condition, would subject the individual to severe pain that cannot be adequately managed without the requested medication, service, or product.

The Claims and Appeals Process

Pre-Authorization Review: The Prescription Drug Benefits Administrator will implement the prescription drug cost containment programs by comparing individual requests for certain medicines and/or other prescription benefits against pre-defined preferred drug lists or formularies **befo**re those prescriptions are filled. If the Prescription Drug Benefits Administrator determines that the individual's request for pre-authorization cannot be approved, that determination will constitute an Adverse Benefit Determination.

Appeals of Adverse Benefit Determinations of Pre-Service and Urgent Care Claims

If an Adverse Benefit Determination is rendered on the individual's prescription drug claim or eligibility claim, the individual may file an appeal of that determination. The individual's appeal of the Adverse Benefit Determination must be made in writing and submitted to the Appropriate Administrator (address listed on the Quick Reference Chart) within 180 days after the individual receives notice of the Adverse Benefit Determination.

If the Adverse Benefit Determination is rendered with respect to an **Urgent Care Claim**, the individual and/or the individual's attending physician may submit an appeal by calling the Prescription Drug Benefits Administrator (phone number listed on the Quick Reference Chart).

The individual's appeal should include the following information:

- Name of the person the appeal is being filed for;
- The Prescription Drug Benefits Administrator Identification Number (if applicable);
- Date of birth;
- Written statement of the issue(s) being appealed;
- Drug name(s) or benefit being requested; and
- Written comments, documents, records, or other information relating to the Claim.

The individual's appeal and supporting documentation should be mailed or faxed to the Prescription Drug Benefits Administrator, (address listed on the Quick Reference Chart.

The Prescription Drug Benefits Administrator's Review

The Prescription Drug Benefits Administrator will provide the first-level review of appeals of Pre-Service Claims. If the individual appeals the Prescription Drug Benefits Administrator's decision, the individual can request an additional second-level Medical Necessity review. That review will be conducted by an Independent Review Organization ("IRO").

Timing of Review

- **Pre-Authorization Review** – The Prescription Drug Benefits Administrator will make a decision on a Pre-Authorization request for a Plan benefit within 15 days after it receives the request. If the request relates to an Urgent Care Claim, the Prescription Drug Benefits Administrator will make a decision on the Claim within 24 hours.
- **Pre-Service Claim Appeal** – The Prescription Drug Benefits Administrator will make a decision on a first-level appeal of an Adverse Benefit Determination rendered on a Pre-Service Claim within 15 days after it receives the individual's appeal. If the Prescription Drug Benefits Administrator renders an Adverse Benefit Determination on the first-level appeal of the Pre-Service Claim, the individual may appeal that decision by providing the information described above. A decision on the individual's second-level appeal of the Adverse Benefit Determination will be made (by the IRO) within 15 days after the new appeal is received. If the individual is appealing an Adverse Benefit Determination of an Urgent Care Claim, a decision on such appeal will be made not more than 72 hours after the request for appeal(s) is received (for both the first-and second-level appeals, combined).
- **Post-Service Claim Appeal** – The Prescription Drug Benefits Administrator will make a decision on an appeal of an Adverse Benefit Determination rendered on a Post-Service Claim within 60 days after it receives the appeal.

Scope of Review:

During its pre-authorization review, first-level review of the appeal of a Pre-Service Claim, or review of a Post-Service Claim, the Prescription Drug Benefits Administrator will:

- Take into account all comments, documents, records, and other information submitted by the individual relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination on the Claim;
- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents;
- Follow reasonable procedures to ensure that the applicable Plan provisions are applied to the individual in a manner consistent with how such provisions have been applied to other similarly situated individuals; and
- Provide a review that does not afford deference to the initial Adverse Benefit Determination and is conducted by an individual other than the individual who made the initial Adverse Benefit Determination (or a subordinate of such individual).

If an individual appeals the Prescription Drug Benefits Administrator's denial of a Pre-Service Claim, and requests an additional second-level Medical Necessity review by an IRO, the IRO shall:

- Consult with an appropriate health care professionals who was not consulted in connection with the initial Adverse Benefit Determination (nor a subordinate of such individual);
- Identify the health care professional, if any, whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination; and
- Provide for an expedited review process for Urgent Care Claims.

Notice of Adverse Benefit Determination

Following the review of an individual's Claim, the Prescription Drug Benefits Administrator will notify the individual of any Adverse Benefit Determination in writing. (Decisions on Urgent Care Claims will also be communicated by telephone or fax.) This notice will include:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to pertinent Plan provision on which the Adverse Benefit Determination was based;
- A statement that the individual is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either a copy of the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion will be provided free of charge upon written request; and
- If the Adverse Benefit Determination is based on a Medical Necessity, either the IRO's explanation of the scientific or clinical judgment for the IRO's determination, applying the terms of the Plan to the individual's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

Authority as Claims Fiduciary

The Prescription Drug Benefits Administrator has been designated by the NAPEBT Board of Trustees as the claims fiduciary with respect to all types of claim appeal review of prescription drug benefit claims arising under the Plan. The Prescription Drug Benefits Administrator shall have on behalf of the Plan, sole and complete discretionary authority to determine these Claims conclusively for all parties. The Prescription Drug Benefits Administrator is not responsible for the conduct of any second-level Voluntary Medical Necessity review performed by an IRO.

External Review

The Patient Protection and Affordable Care Act ("ACA") imposes new external review requirements on group health plans including these outpatient prescription drug benefits. Under the ACA, an individual who receives a "Final Internal Adverse Determination" (as defined below) of a "Claim" may be permitted to further appeal that denial using the **voluntary external review process only if the claim was denied as not Medically Necessary, as Experimental/Investigational, a claim subject to the No Surprises Act, or if the denial qualifies as a rescission of coverage**. The external review process provides individuals with another option for protesting the denial of their claim.

NAPEBT pays for the cost of an external review. For prescription drug claims, the Prescription Drug Benefits Administrator contracts with at least three Independent Review Organizations (IRO) and when an external review is requested, will rotate the case among the IROs. The final decision will be made by the IRO and determination will be reported back to the Prescription Drug Benefits Administrator. For eligibility claims, the Plan contracts with at least three Independent Review Organizations (IRO) and when an external review is requested, will rotate the case among the IROs. The final decision will be made by the IRO and determination will be reported back to the Plan Administrator.

Definitions Pertinent To The External Review Process Provided By The Prescription Drug Benefits Administrator

- **Adverse Benefit Determination** – A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Plan benefit. Such denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) may apply to both clinical and non-clinical determinations.
- **Claim** – A request for a Plan benefit that is made in accordance with the Plan's established procedures for filing benefit claims.

- **Final Internal Adverse Benefit Determination** – An Adverse Benefit Determination that has been upheld by the Plan at the completion of the internal appeals process, or an Adverse Benefit Determination with respect to which the internal appeals process has been exhausted under the "deemed exhaustion" rules of the ACA.
- **Independent Review Organization (IRO)** – An entity that conducts independent external reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to the requirements of the ACA.

Standard/Non-Expedited Federal External Review Process

Request for Review: An individual whose Claim for prescription drug benefits is denied, who experiences a rescission of coverage, or experiences a claim denial subject to the No Surprises Act, may request, in writing, an External Review of his or her Claim within 4 months after receiving notice of the Final Internal Adverse Benefit Determination. The individual's request should include their name, contact information including mailing address and daytime phone number, individual ID number, and a copy of the coverage denial. The individual's request for External Review and supporting documentation may be mailed or faxed to the Prescription Drug Benefits Administrator at their address listed on the Quick Reference Chart in the front of this document.

Preliminary Review: Within 5 days of receiving a Plan individual's request for External Review, the Prescription Drug Benefits Administrator will conduct a "preliminary review" to ensure that the request qualifies for External Review. In this preliminary review, the Prescription Drug Benefits Administrator will determine whether:

- The individual is or was covered under the Plan at the time the benefit at issue was requested, or in the case of a retrospective review, was covered at the time the benefit was provided;
- The Adverse Benefit Determination or Final Internal Adverse Benefit Determination does not relate to the individual's failure to meet the Plan's requirements for eligibility (for example, worker classification or similar determinations), as such determinations are not eligible for Federal External Review;
- The individual has exhausted the Plan's internal appeal process (unless the individual's Claim is "deemed exhausted" under the ACA); and
- The individual has provided all the information and forms necessary to process the External Review.

Within one day after completing this preliminary review, the Prescription Drug Benefits Administrator will notify the individual, in writing, that: (i) the individual's request for External Review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for External Review is complete, but not eligible for review.

Referral to IRO: If the individual's request for External Review is complete and the individual's Claim is eligible for External Review, the Prescription Drug Benefits Administrator will assign the request to one of the IROs with which the Prescription Drug Benefits Administrator has contracted. The IRO will notify the individual of its acceptance of the assignment. The individual will then have 10 days to provide the IRO with any additional information the individual wants the IRO to consider. The IRO will conduct its external review without giving any consideration to any earlier determinations made on behalf of the Plan.

The IRO may consider information beyond the records for the individual's denied Claim, such as:

- The individual's medical records;
- The attending health care professional's recommendations;
- Reports from appropriate health care professionals and other documents submitted by the Plan, the individual, or the individual's treating physician;
- The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the plan (unless those terms are inconsistent with applicable law);
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national, or professional medicine societies, boards, and associations;

- Any applicable clinical review criteria developed and used on behalf of the Plan (unless the criteria are inconsistent with the terms of the Plan or applicable law); and
- The opinion of the IRO's clinical reviewer(s) after considering all information and documents applicable to the individual's request for External Review, to the extent such information or documents are available and the IRO's clinical reviewer(s) considers it appropriate.

Timing of IRO's Determination

The IRO will provide the individual and the Prescription Drug Benefits Administrator (on behalf of the Plan) with written notice of its final External Review decision within 45 days after the IRO receives the request for External Review. The IRO's notice will contain:

- A general description of the reason for the request for External Review, including information sufficient to identify the Claim (including the date or dates of service, the health care provider, the claim amount (if available), the diagnosis code and its meaning, the treatment code and its meaning, and the reasons for the previous denials);
- The date the IRO received the External Review assignment from the Prescription Drug Benefits Administrator, and the date of the IRO's decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, the IRO considered in making its determination;
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to the either the Plan or to the individual;
- A statement that the individual may still be eligible to seek judicial review of any adverse External Review determination; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen available to assist the individual.

Reversal of the Plan's Prior Decision

If the Prescription Drug Benefits Administrator, acting on the Plan's behalf, receives notice from the IRO that it has reversed the prior determination of the individual's Claim, the Prescription Drug Benefits Administrator will immediately provide coverage or payment for the Claim.

Expedited Federal External Review Process

An individual may request an **expedited** External Review:

- If the individual receives an Adverse Benefit Determination related to a Claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual, and/or could result in the individual's failure to regain maximum function, and the individual has filed a request for an expedited internal appeal; or
- If the individual receives a Final Internal Adverse Benefit Determination related to a Claim that involves: (i) a medical condition for which the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the individual, and/or could result in the individual's failure to regain maximum function; or (ii) an admission, availability of care, continued stay, or a prescription drug benefit for which the individual has received emergency services, but has not been discharged from a facility; or
- If the individual receives an Adverse Benefit Determination related to a Claim that involves a service or supply subject to the No Surprises Act's protections.

Request for Review

If the individual's situation meets the definition of urgent under the law, the external review of the Claim will be conducted as expeditiously as possible. In that case, the individual or the individual's physician may request an expedited external review by calling the Customer Care toll-free at the number on their benefit ID card or contacting their benefits office. The request should include the individual name, contact information including mailing address and daytime phone number, individual ID number, and a description of the coverage denial. Alternatively, a request for expedited External Review may be faxed; individual contact information and coverage denial description and supporting documentation may be faxed to the attention the Prescription Drug Benefits Administrator External Review Appeals Department at fax number 1-866-689-3092. **All requests for expedited review must be clearly identified as "urgent" at submission**.

Preliminary Review

Immediately on receipt of an individual's request for expedited External Review, the Prescription Drug Benefits Administrator will determine whether the request meets the reviewability requirements described above for standard External Review. Immediately upon completing this review, the Prescription Drug Benefits Administrator will notify the individual that: (i) the individual's request for External Review is complete and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for External Review is complete, but not eligible for review.

Referral to IRO

Upon determining that an individual's request is eligible for expedited External Review, the Prescription Drug Benefits Administrator will assign an IRO to review the individual's Claim. The Prescription Drug Benefits Administrator will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Adverse Benefit Determination to the assigned IRO electronically, by telephone, by fax, or by any other available expeditious method. The assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, must consider the information and documents described above. In reaching a decision on an expedited request for External Review, the IRO will review the individual's Claim de novo and will not be bound by the decisions or conclusions reached on behalf of the Plan during the internal claims and appeals process.

Timing of the IRO's Determination

The IRO must provide the individual and the Prescription Drug Benefits Administrator, on behalf of the Plan, with notice of its determination as expeditiously as the individual's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the individual's request for External Review. If this notice is not provided in writing, within 48 hours after providing the notice, the IRO will provide the individual and the Prescription Drug Benefits Administrator, on behalf of the Plan, with written confirmation of its decision.

Authority for Review

The Prescription Drug Benefits Administrator will be responsible only for conducting the preliminary review of an individual's request for External Review, ensuring that the individual is timely notified of the decision as to eligibility for External Review, and for assigning the request for External Review to an IRO. The actual External Review of an individual's appeal will be conducted by the assigned independent review organization (IRO). The Prescription Drug Benefits Administrator is not responsible for the conduct of the External Review performed by an IRO.

FACILITY OF PAYMENT

If the Plan Administrator or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the Health Care Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support.

Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, claim administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

ELIMINATION OF CONFLICT OF INTEREST

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons employment status (such as decisions related to hiring, compensation, promotion, termination, or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

DEEMED EXHAUSTION OF THE PLAN'S INTERNAL CLAIMS AND APPEALS PROCEDURES

If the Plan fails to strictly adhere to its internal claims and appeals requirements, the Plan participant is deemed to have exhausted the Plan's internal claims and appeals process and can initiate a request for a voluntary external review (when external review is applicable) or can proceed with legal action.

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You or any other claimant may not start a lawsuit to obtain Plan benefits, including proceedings before administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal review procedures described in this document) **for every issue deemed relevant by the claimant**, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. No lawsuit may be started more than three years after the end of the year in which services were provided.

COBRA: TEMPORARY CONTINUATION OF HEALTH CARE COVERAGE

This section describes the temporary continuation of group insurance coverage offered under NAPEBT. The name, address, and telephone number of the COBRA Administrator responsible for the administration of COBRA, and to whom you can direct questions about COBRA, is shown in the Quick Reference Chart.

ENTITLEMENT TO COBRA CONTINUATION COVERAGE

In compliance with a federal law commonly called COBRA, this Plan, NAPEBT offers its eligible Employees, eligible Retirees and their covered Dependents (called "Qualified Beneficiaries") the opportunity to elect a temporary continuation of the group health coverage including medical, dental, vision, employee assistance program (EAP) coverages, and in certain circumstances, the health care flexible spending account (the "Plan"), when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

"COBRA-like" Coverage May be Possible for a Domestic Partner or a Child of a Domestic Partner

Domestic Partners and Children of Domestic Partners are not considered Qualified Beneficiaries (unless they are the tax-qualified Dependent of the Employee/Retiree). Domestic Partners and Children of Domestic Partners who are not Qualified Beneficiaries have no right to elect COBRA; however, under this Plan, they may be offered the ability to elect "COBRA-like" temporary continuation of benefits when coverage ends (as described in this chapter). Contact your Employer's Department using the Quick Reference Chart to find out more information about "COBRA-like" continuation coverage and under what circumstances and for how long.

"COBRA-like" benefits may be offered to a Domestic Partner who loses coverage or to a Child of a Domestic Partner who loses coverage if the Employee terminates employment , the Employee has a reduction in work hours causing that Employee to lose health coverage, the death of the Employee, the Employee and Domestic Partner terminate their Domestic Partnership or when the Child of the Domestic Partner loses coverage on account of not meeting the Plan's definition of a Child of a Domestic Partner.

This Plan provides no greater COBRA rights than what is required by law and nothing in this chapter is intended to expand a person's COBRA rights.

WHO IS ENTITLED TO COBRA CONTINUATION COVERAGE, WHEN AND FOR HOW LONG

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event, that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. A parent or legal guardian may elect COBRA for a minor Child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered Participants and their Dependent(s) including Special Enrollment.

1. "**Qualified Beneficiary**": Under the law, a Qualified Beneficiary is any Employee, or the Spouse or Dependent Child of an Employee or Retiree who was covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage.

A Child who becomes a Dependent Child by birth, adoption, or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

- A Child of the covered Employee or Retiree who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the Employee's or Retiree's period of employment, is entitled to the same rights under COBRA as an eligible Dependent Child.
- A person who becomes the new Spouse of an existing COBRA Participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA Participant but is not a "Qualified Beneficiary." This means that if the existing COBRA Participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse, is not entitled to elect COBRA.

2. **"Qualifying Event"**: Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered Participant or Dependent(s) LOSES health care coverage under this Plan**.

   If a **Participant or Dependent(s)** has a qualifying event but does not lose their health care coverage under this Plan, (e.g., Employee continues working even though entitled to Medicare) then COBRA is not yet offered.

Reminder to Administrators: COBRA continuation coverage should be offered to employees at the time of retirement or long-term disability. When entering COBRA information into the COBRA Administrator's website ensure you are selecting rates that include any ASRS or PSPRS subsidy.

SPECIAL ENROLLMENT RIGHTS

The Participant and/or Dependents have special enrollment rights under federal law that allow special enrollment under another group health plan for which they are otherwise eligible (such as a plan sponsored by their Spouse's Employer) within 30 days (or as applicable 60 days) after their group health coverage ends because of the qualifying events listed in this chapter. The special enrollment right is also available if COBRA is continued for the maximum time available.

COBRA QUESTIONS OR TO GIVE NOTICE OF CHANGES IN YOUR CIRCUMSTANCES

If you have any questions about your COBRA rights, please contact your Employer's Department whose address is listed on the Quick Reference Chart.

Also, remember that to avoid loss of any of the Participant's rights to obtain or continue COBRA Continuation Coverage, the Participant <u>must</u> notify their Employer's Department using the Quick Reference Chart:

1. preferably within 31 days (but no later than 60 days) of a change in marital status (e.g., marry, divorce); or have a new Dependent child; or
2. within 60 days of the date the Participant or a covered Spouse or Dependent Child has been determined to be **totally and permanently disabled** by the Social Security Administration; or
3. within 60 days if a covered Child **ceases to be a "Dependent Child"** as that term is defined by the Plan; or
4. promptly if an individual has **changed their address, becomes entitled to Medicare, or is no longer disabled**.

BRIEF OUTLINE ON HOW CERTAIN LAWS INTERACT WITH COBRA

FMLA and COBRA: Taking a leave under the Family & Medical Leave Act (FMLA) is not a COBRA qualifying event. A qualifying event can occur **after** the FMLA period expires, **if** the Employee does not return to work and thus loses coverage under their group insurance Plan. Then, the COBRA period is measured from the date of the qualifying event—in most cases, the last day of the FMLA leave. Note that if the Employee notifies the Employer that they are not returning to employment prior to the expiration of the maximum FMLA 12-week period, a loss of coverage could occur earlier.

Leave of Absence (LOA) and COBRA: If an Employee loses coverage under their group insurance Plan, the COBRA period is measured from the date of the qualifying event. In most cases, this will be the last day of the month in which the unpaid leave began.

MEDICARE ENTITLEMENT

A person becomes entitled to Medicare on the first day of the month in which they attain age 65, but only if they submit the required application for Social Security retirement benefits within the time period prescribed by law. Generally, a person becomes entitled to Medicare on the first day of the 30th month after the date on which they were determined by the Social Security Administration to be totally and permanently disabled so as to be entitled to Social Security disability income benefits.

MAXIMUM PERIOD OF COBRA CONTINUATION COVERAGE

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, **measured from the date of the loss of Plan coverage (generally the end of the month in which the Qualifying Event occurred)**. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (described in another section of this chapter on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this chapter.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries[1] *See also the provision in this chapter on extension of COBRA due to disability.*		
	Employee	**Spouse**	**Dependent Child(ren)**
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in hours worked (making Employee ineligible for the same coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months
Retiree becomes Medicare eligible.	N/A	18 months	18 months
Retiree coverage is terminated, or coverage is substantially reduced within one year before or after the Employer files for bankruptcy reorganization under Chapter 11 of the federal Bankruptcy Act.	Retiree: for Life	Varies[2]	Varies[2]
Disability if disabled during the first 60 days of COBRA coverage.	29 months	29 months	29 months

1: *When a covered Employee's qualifying event (e.g. termination of employment or reduction in hours) occurs within the 18-month period after the Employee becomes entitled to Medicare (entitlement means the Employee is eligible for and enrolled in Medicare), the Employee's covered Spouse and Dependent Children who are qualified beneficiaries (but not the Employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.*

2: *Employer's bankruptcy under Title 11 of the US Code may trigger COBRA coverage for certain Retirees and their related qualified beneficiaries such as COBRA coverage for the life of the Retiree. The Retiree's Spouse and Dependent Children are entitled to COBRA for the life of the Retiree and if they survive the Retiree, for 36 months after the Retiree's death. If the Retiree is not living when the qualifying event occurs, but the Retiree's surviving Spouse is alive and covered by the group health plan, then that surviving Spouse is entitled to coverage for life.*

PROCEDURE FOR NOTIFYING THE PLAN OF A QUALIFYING EVENT

In order to have the chance to elect COBRA Continuation Coverage after loss of coverage due to a divorce, legal separation, or a Child ceasing to be a "Dependent Child" under the Plan, **you must inform the Plan <u>in writing</u> of that event no later than <u>60 days after that event occurs</u>.**

That written notice should be sent to the Participants Employer's Department whose address is listed on the Quick Reference Chart. The written notice can be sent via first class mail, or be hand-delivered, and is to include name, the qualifying event, the date of the event, and appropriate documentation in support of the qualifying event, such as divorce documents.

NOTE: If such a notice is <u>not</u> received by the Employer's Department listed in the Quick Reference Chart within the 60-day period, the Qualified Beneficiary will <u>not</u> be entitled to choose COBRA Continuation Coverage.

The Employer's Department whose contact information is listed in the Quick Reference Chart should be notified by an Official of the Employer of an Employee's death, termination of employment, reduction in hours, or entitlement to Medicare. However, **the Participant should also promptly notify the** Employer's Department using the Quick Reference Chart **in writing** if any such event occurs in order to avoid confusion over the status of their group health coverage in the event there is a delay or oversight in providing that notification.

NOTICES RELATED TO COBRA CONTINUATION COVERAGE

When:

a. **The Participant's Employer notifies the Plan** that their group health coverage has ended because their employment terminated, their hours are reduced so that they are no longer entitled to group insurance coverage under the Plan, they died, have become entitled to Medicare, or

b. **The Participant notifies their** Employer's Department using the Quick Reference Chart that a Dependent Child lost Dependent status, they divorced or have become legally separated,

then their Employer's Department listed in the Quick Reference Chart will contact the COBRA Administrator. The COBRA Administrator provides the Participant and/or their covered Dependents the information and forms needed to elect COBRA Continuation Coverage. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage. Under the law, the Participant and/or their covered Dependents will then have only 60 days from the date of receipt of that notice, to elect COBRA Continuation Coverage.

NOTE: If the Participant and/or any of their covered Dependents do not choose COBRA coverage within 60 days after receiving notice, the Participant and/or their Dependents will have no group coverage from this Plan after the date coverage ends.

THE COBRA CONTINUATION COVERAGE THAT WILL BE PROVIDED

If the Participant elects COBRA Continuation Coverage, they will be entitled to the same group insurance coverage that they had when the event occurred that caused their group health coverage under the Plan to end, but they must pay for it. See the section on Paying for COBRA Continuation Coverage that appears later in this chapter for information about how much COBRA Continuation Coverage will cost the Participant and about grace periods for payment of those amounts. If there is a change in the group insurance coverage provided by the Plan to similarly situated active Employees and their families, that same change will apply to the Participant's COBRA Continuation Coverage.

When COBRA continuation coverage in the health care flexible spending account (Health FSA) is available, it will be offered on the same terms outlined above for group insurance coverage, but since the person who elects COBRA will no longer be employed by their Employer, it will not be possible to make contributions to the health care flexible spending account on a before-tax basis.

PAYING FOR COBRA CONTINUATION COVERAGE (THE COST OF COBRA)

By law, any person who elects COBRA Continuation Coverage will have to pay the full cost of the COBRA Continuation Coverage. The Employer is permitted to charge the full cost of coverage for similarly situated active Employees and families (including both the Employer's and Employee's share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. If the cost of group health coverage changes, the cost of the COBRA Continuation Coverage may be subject change.

If a COBRA participant is eligible for an Arizona State Retirement Subsidy due to retirement or long-term disability, the Employer's Department as referenced in the Quick Reference Chart will input the amount of the subsidy into the subsidy section of the COBRA Administrator's online system. The COBRA participant fee will be automatically reduced by the subsidy amount.

The employer will remit the total amount of the subsidy for the COBRA participant to Accounting Services Provider with the monthly billing, unless special arrangements are made with COBRA Administrator to collect and remit the subsidy.

GRACE PERIODS

The initial payment for the COBRA Continuation Coverage is due to the COBRA Administrator 45 days after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After the initial COBRA payment, subsequent payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

FOR MONTHLY PAYMENTS, WHAT IF THE FULL COBRA PREMIUM PAYMENT IS NOT MADE WHEN DUE?

If the COBRA Administrator receives a COBRA premium payment that is not for the full amount due, the COBRA Administrator will determine if the COBRA premium payment is short by an amount that is significant or not. A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall exceeds the lesser of $50 or 10% of the required COBRA premium payment.

If there is a significant shortfall, then COBRA continuation coverage will end.

If there is not a significant shortfall, the COBRA Administrator will notify the Qualified Beneficiary of the deficiency amount and allow a reasonable period of 30 days to pay the shortfall. If the shortfall is paid in the 30-day time period, then COBRA continuation coverage will continue for the month in which the shortfall occurred. If the shortfall is not paid in the 30-day time period, then COBRA continuation coverage will end as of the end of the month in which the last full COBRA premium payment was made.

CONFIRMATION OF COVERAGE BEFORE ELECTION OR PAYMENT OF THE COST OF COBRA CONTINUATION COVERAGE

If a Health Care Provider requests confirmation of coverage and the Participant, their Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** the Participant, their Spouse or Dependent Child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

ADDITION OF NEWLY ACQUIRED DEPENDENTS

If, while the Participant (the Employee or Retiree) is enrolled for COBRA Continuation Coverage, they marry, have a newborn Child, adopt a Child, or have a Child placed with you for adoption, the Participant may enroll that Spouse or Dependent Child for coverage for the balance of the period of COBRA Continuation Coverage if they do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse or Dependent Child may cause an increase in the cost of COBRA Continuation Coverage. Contact the COBRA Administrator to add a Dependent.

LOSS OF OTHER GROUP HEALTH COVERAGE

If, while the Participant (the Employee or Retiree) is enrolled for COBRA Continuation Coverage their Spouse or Dependent Child loses coverage under another group health plan, they may enroll the Spouse or Dependent Child for coverage for the balance of the period of COBRA Continuation Coverage. The Spouse or Dependent Child must have been eligible but declined the pre-COBRA health care plan due to coverage under another group health plan or other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of Employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or Participant to pay premiums on a timely basis or termination of coverage for cause. The Participant must enroll their Spouse or Dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount the Participant must pay for COBRA Continuation Coverage. Contact the COBRA Administrator to add a Dependent.

QUESTIONS REGARDINGCOBRA COVERAGE ELIGIBILITY

In the event the Plan is notified of a qualifying event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by their Employer's Department listed in the Quick Reference Chart, an explanation indicating why COBRA coverage is not available. Any questions regarding COBRA Eligibility should be referred to the COBRA Administrator as listed in the Quick Reference Chart for more information.

EXTENDED COBRA CONTINUATION COVERAGE WHEN A SECOND QUALIFYING EVENT OCCURS DURING AN 18-MONTH COBRA CONTINUATION PERIOD

The initial 18-month COBRA Continuation Coverage for the Spouse or Dependent Child may be extended to 36 months if one of the following events occurs: a) the death of the Participant b) the Participant becomes divorced or legally separated c) the Participant becomes entitled to Medicare d) or if a covered Child ceases to be a Dependent Child under the Plan. The 36 months is measured from the date of COBRA eligibility.

Medicare entitlement is not a qualifying event under this Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for Spouses and Dependents who are qualified beneficiaries.

Notifying the Plan: To extend COBRA when a second qualifying event occurs, the Participant must notify the COBRA Administrator in writing within 60 days of a second qualifying event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include the Participant's name, the second qualifying event, the date of the second qualifying event, and appropriate documentation in support of the second qualifying event, such as divorce documents.

This extended period of COBRA Continuation Coverage is not available to anyone who became the Participant's Spouse, or was enrolled as a dependent during open enrollment, after the termination of employment or reduction in hours. This extended period of COBRA Continuation Coverage is available to any Child(ren) born to, adopted by or Placed for Adoption with the Participant (the covered Employee) during the 18-month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months (except for Retirees who become entitled to COBRA because of a Chapter 11 bankruptcy reorganization proceeding on the part of the Employee's Employer.)

EXTENDED COBRA COVERAGE IN CERTAIN CASES OF DISABILITY DURING AN 18-MONTH COBRA CONTINUATION PERIOD

If, prior to the Qualifying event, or during the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that the Participant or a covered Spouse or Dependent Child become totally and permanently disabled so as to be entitled to Social Security Disability Income benefits (SSDI), the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

1. This extension is available only if:
    - the Social Security Administration determines that the individual's disability began no later than 60 days after the termination of employment or reduction in hours; **and**
    - **Notifying the COBRA Administrator**: The Participant or another family member must follow this procedure (to notify the Plan) by sending a written notification to the COBRA Administrator of the determination from the Social Security Administration within 60 days after that determination was received by the Participant or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the COBRA Administrator before the end of the 18-month COBRA Continuation period.
2. Although a plan is permitted by federal law to increase the cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage to be 50% higher than the cost for coverage during the first 18-month period, this Plan currently does not increase the COBRA premium rate, subject to change.
3. The COBRA Administrator must also be notified within 30 days of the determination by the Social Security Administration that the Participant is no longer disabled.

EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

1. The date the amount due for COBRA coverage is **not paid in full and on time**;
2. The date the Employer or NAPEBT no longer provides group insurance coverage to any of its Employees;
3. The date the qualified beneficiary becomes entitled to Medicare after electing COBRA;
4. During an extension of the maximum COBRA coverage period to 29 months due to the disability of the qualified beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled; or

5. The date the Plan has determined that the qualified beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA Participants under the plan).

NOTICE OF EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

The Plan will notify a qualified beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the qualifying event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the qualified beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the COBRA Administrator determines that COBRA coverage will terminate early.

ENTITLEMENT TO CONVERT DENTAL OR VISION PLAN COVERAGE TO AN INDIVIDUAL HEALTH PLAN AFTER COBRA ENDS

At the end of the 18-month or 36-month period of COBRA Continuation Coverage, the Participant may be allowed to enroll in an individual conversion dental or vision Plan provided by the insurance company, if that right is offered by the insurance company at the time their COBRA Continuation Coverage period runs out.

Conversion rights are not available for the self-funded medical Plan and no conversion rights are available for the health care flexible spending account.

You will be advised if conversion rights are available when the Participant's COBRA Continuation Coverage ends.

ENTITLEMENT TO CONVERT BASIC AND VOLUNTARY LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE TO INDIVIDUAL COVERAGE

The participant will receive conversion and portability information relating to the basic and voluntary life insurance and accidental death and dismemberment with the COBRA notification.

DUAL SPOUSE COVERAGE

As an eligibility requirement under NAPEBT policies, each benefits-eligible employee must sign up for medical plan coverage, unless they waive coverage according to NAPEBT's policy outlined in the Eligibility chapter of this NAPEBT Administrative Manual. In some cases, NAPEBT will have two (2) employees who are married to each other. Below is how deductible and out-of-pocket credits will apply from the single contract to the spouse's family contract.

Eligibility

- Two NAPEBT Employees married to each other, or Employee has enrolled a Domestic Partner.
- Dependents other than the two married Employees must be covered on the plan(s).
- Employee applications must indicate their Spouse or Domestic Partner works for NAPEBT.
- Employee applications must indicate their Spouse or Domestic Partner's identification number.
- One Employee must elect single coverage. Their Spouse or Domestic Partner must elect family coverage.
- Single contract deductible and out-of-pocket amounts met will be credited toward the family deductible and out-of-pocket amounts of the Spouse or Domestic Partner's plan (exceptions apply – * see note below)

PPO (Buy-up plan) single contract to PPO (Base plan) family contract

The portion of the deductible met up to the single contract deductible under the Buy-Up plan can be credited toward the family deductible under the Base plan. The portion of the out-of-pocket met up to the single contract out-of-pocket under the Buy-Up plan can be credited toward the family out-of-pocket under the Base plan.

PPO (Base plan) single contract to PPO (Buy-up plan) family contract

The portion of the deductible met up to the single contract deductible under the Buy-Up plan can be credited toward the family deductible under the Buy-Up plan. The portion of the out-of-pocket met up to the single contract out-of-pocket under the Buy-Up plan can be credited toward the family out-of-pocket under the Buy-Up plan.

PPO (High Deductible Health Plan) single contract to PPO (Buy-up plan) family contract

The portion of the deductible met under the HDHP up to the single contract deductible amount under the Buy-Up plan can be credited toward the family deductible under the Buy-Up plan. The portion of the out-of-pocket met under the HDHP up to the single contract out-of-pocket under the Buy-Up plan can be credited toward the family out-of-pocket under the Buy-Up plan.

PPO (High Deductible Health Plan) single contract to PPO (Base plan) family contract

The portion of the deductible met under the HDHP up to the single contract deductible amount under the Base plan can be credited toward the family deductible under the Base plan. The portion of the out-of-pocket met under the HDHP up to the single contract out-of-pocket under the Base plan can be credited toward the family out-of-pocket under the Base plan.

ENROLLMENT

The Employer's Department listed in the Quick Reference Chart will notify BCBSAZ when a Dual Spouse is identified. The Employer's Department listed in the Quick Reference Chart will provide the Employee's name, the Employee's Spouse or Domestic Partner's name, the Employee's Spouse or Domestic Partner's date of birth, and which NAPEBT Employers the Employee and the Employee's Spouse or Domestic Partner work, and what plan the Employee and Employee's Spouse or Domestic Partner are enrolled.

Dual Spouse information will be solicited from Employees upon hire and during each annual open enrollment period. This will ensure any changes that occurred during the year have been captured.

*Please note: Single contract deductibles and out-of-pocket amounts cannot be credited to the PPO (High Deductible Health Plan) family deductible and out-of-pocket. If crediting did occur, the plan would fail to meet the requirements necessary to be an HSA qualified High Deductible Health Plan.

COORDINATION OF BENEFITS (COB)

Please see the appropriate Medical Plan, Dental Plan or Vision Plan Booklet for more information on coordination of benefits.

HOW DUPLICATE COVERAGE OCCURS

This chapter describes the circumstances when you or your covered Dependents may be entitled to health care benefits under the group insurance offered by NAPEBT and may also be entitled to recover all or part of your health care expenses from some other source. In this chapter the term "You" references all covered Plan Participants. In many of those cases, either this Plan or the other source (the primary plan or program) pays benefits or provides services first, and the other (the secondary plan or program) pays some or all the difference between the total cost of those services and payment by the primary plan or program. In other cases, only one plan pays benefits. This can occur if you or a covered Dependent is also covered by:

- Another group health care plan (including but not limited to a plan which provides the Participant or Dependent(s) with COBRA Continuation Coverage);
- Medicare;
- Other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs or any coverage provided by a federal, state, or local government or agency;
- Workers' compensation;
- Coverage resulting from a judgment at law or settlement;
- Any responsible third party, its insurer, or any other source on behalf of that party;
- Any first party insurance (e.g., medical, personal injury, no-fault, underinsured motorist, or uninsured motorist coverage);
- Any policy from any insurance company or guarantor of a third party; or
- Any other source (e.g., crime victim restitution, medical, disability, school insurance).

The Plan's benefit coverage is excess to other responsible parties' coverage sources such as coverage from a judgment, settlement, or any responsible party.

This Plan operates under rules that prevent it from paying benefits which, together with the benefits from another source you possess (as described above), would allow you to recover more than 100% of expenses you incur. In many instances, you may recover less than 100% of those expenses from the duplicate sources of coverage or recovery.

COVERAGE UNDER MORE THAN ONE GROUP HEALTH PLAN

When and How Coordination of Benefits (COB) Applies

1. For the purposes of this Coordination of Benefits chapter, the word "plan" refers to any group medical, group dental, or group vision policy, contract, or plan, whether insured or self-insured, that provides benefits payable on account of medical, dental or vision services incurred by the Covered Individual or that provides health care services to the Covered Individual. A "group plan" provides its benefits or services to Employees, Retirees or members of a group who are eligible for and have elected coverage (including but not limited to a plan that provides the Covered Individual with COBRA Continuation Coverage).
2. Many families have family members covered by more than one medical, dental or vision plan. If this is the case with your family, **you must inform the medical, dental or vision provider and insurers about <u>all</u> your coverage.**
3. Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the health care expenses incurred.** Sometimes, the combined benefits that are paid will be less than the total expenses.

WHICH PLAN PAYS FIRST: ORDER OF BENEFIT DETERMINATION RULES

The Overriding Rules

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

This Plan does not coordinate benefits with an individual plan. This means that when a plan participant is covered by an individual (non-group) plan/policy including a policy through the Health Insurance Marketplace, this plan will not pay benefits toward claims that are covered by that individual plan/policy.

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

Rule 1: Non-Dependent or Dependent

A. The plan that covers a person other than a Dependent, for example, as an Employee, Retiree, member, or subscriber is the primary plan that pays first; and the plan that covers the same person as a Dependent is the secondary plan that pays second.

B. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person as other than a Dependent (that is, the plan covering the person as a retired Employee); then the order of benefits is reversed, so that the plan covering the person as a Dependent pays first; and the plan covering the person other than as a Dependent (that is, as a retired Employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

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

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

C. The word "Birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

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

   If the specific terms of a court decree state that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the plan that covers the parent whose Birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose Birthday falls later in the calendar year pays second.

E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the Child's health care services or expenses, the order of benefit determination among the plans of the parents and their Spouses/Domestic Partners (if any) is:
   1. The plan of the custodial parent pays first; and
   2. The plan of the Spouse/Domestic Partner of the custodial parent pays second; and
   3. The plan of the non-custodial parent pays third; and
   4. The plan of the Spouse/Domestic Partner of the non-custodial parent pays last.

F. For a dependent child who has coverage under either or both parents' plans and also has his/her own coverage as a dependent under a Spouse's plan, the order of benefits shall be determined, as described in Rule 5 (the longer/shorter length of coverage) and if the length of coverage is the same, then the birthday rule (Rule 2) applies between the dependent child's parent's coverage and the dependent spouse's coverage. For example, if a married dependent child on this Plan is also covered as a dependent on the group plan of their Spouse, this Plan looks to Rule 5 first and if the two plans have the same length of coverage, then the Plan looks to whose birthday is earlier in the year: the employee-parent covering the dependent child or the employee-spouse covering the dependent child.

Rule 3: Active/Laid-Off or Retired Employee

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

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

C. If a person is covered as a laid-off or retired Employee under one plan and as a Dependent of an active Employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an Employee, Retiree, member, or subscriber (or as that person's Dependent) pays first, and the plan providing continuation coverage to that same person pays second.

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

C. If a person is covered other than as a Dependent (that is, as an Employee, former Employee, Retiree, member, or subscriber) under a right of continuation coverage under federal or state law under one plan and as a Dependent of an active Employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

C. The start of a new plan does not include a change:
   1. in the amount or scope of a plan's benefits;
   2. in the entity that pays, provides, or administers the plan; or
   3. from one type of plan to another (such as from a single Employer plan to a multiple Employer plan).

D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Rule 6: When No Rule Determines the Primary Plan

If none of the previous rules determines which plan pays first, each plan will pay an equal share of the expenses incurred by the covered individual.

ADMINISTRATION OF COB

1. To administer COB, the Plan reserves the right to:
   - exchange information with other plans involved in paying claims;
   - require that you or your Health Care Provider furnish any necessary information;
   - reimburse any plan that made payments this Plan should have made; or
   - recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent.
2. If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.
3. To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.
4. This Plan follows the customary coordination of benefits rule that the medical program coordinates with only other medical plans or programs, and not with any dental plan or program and the dental program coordinates only with other dental plans or programs and not with any other medical plan or program. Therefore, when this Plan is secondary, it will pay secondary medical benefits only when the coordinating primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits. The Plan also coordinates vision claims only with other vision plans.
5. If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO, ACO, or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service will be the Allowed Charge as determined by this Plan.
6. If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained Out-of-Network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.
7. If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan may be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

COORDINATION OF BENEFITS WITH MEDICARE

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

B. Medicare Beneficiaries May Retain or Cancel Coverage Under This Plan: If an eligible individual under this Plan becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, that individual may either retain or cancel coverage under this Plan. If the eligible individual under this Plan is covered by both this Plan and by Medicare, as long as the eligible Employee remains actively employed, that Employee's medical expense coverage will continue to provide the same benefits and contributions for that coverage will remain the same. In that case, this Plan pays first, and Medicare pays second.

If an eligible individual under this Plan is covered by Medicare and an Employee cancels coverage under this Plan, coverage of their Spouse and/or Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage if there has been a COBRA Qualifying Event. See the COBRA chapter for further information about COBRA Continuation Coverage. If any of the eligible Employee's Dependents are covered by Medicare and the Employee **cancels** that Dependent's coverage under this Plan (for instance the dependent is dropped from coverage at open enrollment time), that Dependent will **not** be entitled to COBRA Continuation Coverage, since being dropped at open enrollment is not a COBRA Qualifying Event.

The choice of retaining or canceling coverage under this Plan of a Medicare Beneficiary is the responsibility of the Employee. Neither this Plan nor the Employee's Employer will provide any consideration, incentive, or benefits to encourage cancellation of coverage under this Plan.

C. Coverage Under Medicare and This Plan When Totally Disabled: If an eligible Employee under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, the eligible Employee will no longer be considered to remain actively employed. As a result, once the Employee becomes entitled to Medicare because of that disability, Medicare pays first, and this Plan pays second. Generally, if an eligible Dependent under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, this Plan pays first for that Dependent and Medicare pays second. This Medicare secondary payer rule applies to Employers with 100 or more Employees.

D. Coverage Under Medicare and This Plan for End-Stage Renal Disease: If, while actively employed, an eligible individual under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first, and Medicare pays second for 30 months starting the **earlier** of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first, and this Plan pays second.

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

Summary of the Coordination of Benefits between Medicare and the Group Health Plan			
If you:	**Situation**	**Pays First**	**Pays Second**
Are covered by both Medicare and Medicaid	Entitled to Medicare and Medicaid	Medicare	Medicaid, but only after other coverage such as a group health plan has paid
Are age 65 and older and covered by a group health plan because you are working or are covered by a group health plan of a working Spouse of any age	The employer has less than 20 employees	Medicare	Group health plan
	The employer has 20 or more employees	Group health plan	Medicare
Have an employer group health plan after you retire and are age 65 or older	Entitled to Medicare	Medicare	Group health plan (*e.g.* a retiree plan coverage)
Are disabled and covered by a large group health plan from your work or from a family member who is working	The employer has less than 100 employees	Medicare	Group health plan
	You are entitled to Medicare or the Employer has 100 or more employees	Group health plan	Medicare
Have End-Stage Renal Disease (ESRD is permanent kidney failure requiring dialysis or a kidney transplant) and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group health plan	Medicare
	After 30 months of eligibility or entitlement to Medicare	Medicare	Group health plan
Are covered under worker's compensation because of a job-related injury or illness	Entitled to Medicare	Workers' compensation for worker's compensation-related claims	Usually does not apply however Medicare may make a conditional payment.
Have black lung disease and are covered under the Federal Black Lung Benefits Program	Entitled to Medicare and the Federal Black Lung Benefits Program	Federal Black Lung Benefits Program for black lung-related claims	Medicare
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or Liability insurance, for the accident-related claims	Medicare
Are a veteran and have Veterans' benefits	Entitled to Medicare and Veterans' benefits	Medicare pays for Medicare-covered services. Veterans' Affairs pays for VA-authorized services. Generally, Medicare and VA cannot pay for the same service.	Usually does not apply

Summary of the Coordination of Benefits between Medicare and the Group Health Plan			
If you:	**Situation**	**Pays First**	**Pays Second**
Are covered under TRICARE	Entitled to Medicare and TRICARE	Medicare pays for Medicare-covered services. TRICARE pays for services from a military hospital or any other federal provider.	TRICARE may pay second
Are age 65 or over OR, are disabled and covered by both Medicare and COBRA	Entitled to Medicare	Medicare	COBRA
Have End-Stage Renal Disease (ESRD) and COBRA	First 30 months of eligibility or entitlement to Medicare	COBRA	Medicare
	After 30 months	Medicare	COBRA
See also : http://www.medicare.gov/Publications/Pubs/pdf/02179.pdf or 1-800-Medicare for more information			

HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY TO MEDICARE

1. **When Covered by this Plan and also by Medicare Parts A and B:** When an eligible individual under this Plan is also covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays the same benefits provided for active Employees less any amounts paid by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the billed charges of the Health Care Provider.

2. **When Covered by this Plan and also by a Medicare Advantage Program (formerly called Medicare + Choice or Part C) without prescription drug benefits:** If an individual is covered by both this Plan and a Medicare Advantage program, and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services In-Network when the Medicare Advantage program requires it, this Plan will reimburse all applicable copayments and will pay the same benefits provided for active Employees less any amounts paid by the Medicare Advantage program.

   Also, if an eligible individual does not comply with the rules of their Medicare Advantage program, including without limitation, approved referral, precertification/preauthorization, case management or utilization of in-network provider requirements, this Plan will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the individual receives.

3. **When Covered by this Plan and Eligible for but Not Covered by Medicare:** When the Covered Individual is covered by this Plan and is also eligible for, but is not enrolled in Medicare Parts A, B and/or D, this Plan pays the same benefits provided for active Employees.

4. **When Covered by this Plan and the Individual also Enters Into a Medicare Private Contract:** Under the law a Medicare Beneficiary is entitled to enter into a Medicare private contract with certain Health Care Practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare Beneficiary enters into such a contract this Plan will pay benefits for health care services and/or supplies the Medicare Beneficiary receives pursuant to it, but those benefits will be subject to all of the Plan's terms and provisions, including those relating to exclusions, Medical Necessity, allowed charges, and Utilization Management, and the Plan will pay the coinsurance and other cost-sharing that applies to an active Employee for the Eligible Medical Expenses after the Deductible is satisfied, and the Medicare Beneficiary is responsible for the rest.

5. **When Covered by this Plan and the Individual also has signed an Advance Beneficiary Notice (ABN):** Under the law a health care provider who believes that Medicare may not pay for a particular proposed service is to issue an Advance Beneficiary Notice (ABN) to a Medicare beneficiary (meaning an individual who is determined by the Social Security Administration to be eligible for and has actually enrolled in Medicare benefits). If the Plan receives a claim coded to explain that the Medicare beneficiary has signed an ABN, this Plan will pay benefits for health care services and/or supplies the Medicare Beneficiary receives pursuant to it, but those benefits will be subject to all of the Plan's terms and provisions, including those relating to exclusions, Medical Necessity, allowed charges, and Utilization Management, and the Plan will pay the coinsurance and other cost-sharing that applies to an active Employee for the Eligible Medical Expenses after the Deductible is satisfied, and the Medicare Beneficiary is responsible for the rest.

When Covered by this Plan and also by a Medicare Part D Prescription Drug Plan: If you have dual coverage under both this Plan and Medicare Part D, the following explains how this Plan and Medicare will coordinate that dual coverage:

a. For Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage is primary, and the group health plan pays secondary. Note that dual coverage may affect your out-of-pocket maximum limit under your Medicare prescription drug plan.

b. For Medicare eligible Active Employees and non-Medicare eligible Retirees and their Medicare eligible Dependents, the group health plan pays primary and Medicare Part D coverage is secondary.

For more information on Medicare Part D refer to www.medicare.gov or contact your Employer's Department using the Quick Reference Chart.

COORDINATION WITH OTHER GOVERNMENT PROGRAMS

A. **Medicaid**: If an individual is covered by both this Plan and Medicaid, this Plan pays first, and Medicaid pays second.

B. **TRICARE**: If a Covered Dependent is covered by both this Plan and the TRICARE Program that provides health care services to Dependents of active armed services personnel, this Plan pays first, and TRICARE pays second. For an Employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary, and this plan is secondary for active members of the armed services only. If an eligible individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, benefits are not payable by the Plan.

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

D. **Motor Vehicle Coverage Required by Law**: If an eligible individual under this Plan is covered for benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist, or personal injury protection rider to a motor vehicle liability policy this Plan pays.

E. **Other Coverage Provided by State or Federal Law**: If an eligible individual under this Plan is covered by both this Plan and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

WORKERS' COMPENSATION: This Plan **does not provide** benefits if the expenses are covered by workers' compensation or occupational disease law. If the individual's Employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease

law. However, before such payment will be made, the individual may be required to execute a reimbursement agreement acceptable to the Plan Administrator or its designee.

CLAIM FILING AND APPEALS: Refer to the Medical Plan, Dental Plan or Vision Plan documents for information on how to file a claim and how to appeal a claim. This document includes information on the appeals process for eligibility claims and outpatient prescription drugs only.

GENERAL PROVISIONS AND BENEFIT PROGRAM NOTICES

PLAN AMENDMENTS OR TERMINATION OF PLAN

NAPEBT reserves the right to amend or terminate this Plan, or any part of it, at any time without advance notice to Participants.

- Amendments to the self-funded health Plans may be made in writing by the NAPEBT Board of Trustees and become effective on the written approval of the Board of Trustees), or on such other date as may be specified in the document amending the Plan.
- The self-funded health Plan or any coverage under it may be terminated by the NAPEBT Board of Trustees, and new coverages may be added by the Board of Trustees. Upon termination, discontinuance, or revocation of participation in the Plan all elections and reductions in compensation related to the Plan will terminate.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or Administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF NAPEBT RIGHTS

NAPEBT makes no representation that employment with a participating Employer represents lifetime security or a guarantee of continued employment. Further, the Employee's eligibility or rights to benefits under this Plan should not be interpreted as a guarantee of employment. An individual's employment may be terminated because of:

- unsatisfactory job performance;
- unsatisfactory attendance;
- violation of Employer's rules and policies; or
- because an individual's services become excess to an Employer's staffing needs.

An individual's employment may also be terminated whenever the Employer, in its sole judgment, deems that to be in its best interest.

NAPEBT, as Plan Sponsor, intends that the terms of this Plan described in this document, including those relating to coverage and benefits, are legally enforceable, and that each Plan is maintained for the exclusive benefit of Participants, as defined by law.

Any written or oral statement other than a written statement signed by the Board of Trustees of NAPEBT that is contrary to the provisions of this subchapter **is invalid**, and no prospective, active, or former Employee or Retiree should rely on any such statement.

NO LIABILITY FOR PRACTICE OF MEDICINE

The Plan, Plan Administrator or any of their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care, or lack thereof, or any health care services provided or delivered to the Participant and their Dependents by any Health Care Provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

NON-ASSIGNMENT

Coverage and your rights to receive any benefits under this Plan may not be assigned either before or after receiving health care services without the express written permission of the Plan Sponsor. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person or entity without the express written permission of the Plan Sponsor; however, a Plan Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, prescription drug, dental and/or vision care services rendered, or to be rendered. A direction to pay a Health Care Provider is not an assignment of any right under this Plan, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty and is not an assignment of any legal or equitable right to institute any court proceeding. Any attempted assignment is void (invalid) and not recognized by the Plan, if performed without the Plan's express written permission (consent).

WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA)

The NAPEBT self-funded Medical Plans comply with the Women's Health and Cancer Rights Act (WHCRA) that indicates that for any Covered Individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage is provided 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 physical complications for all stages of mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles, copayments, and coinsurance applicable to other medical and surgical benefits provided under the various medical plans offered by NAPEBT. For more information on WHCRA benefits, contact the medical plan claims administrator or your Employer's Department using the Quick Reference Chart.

NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT (NEWBORNS' ACT)

The Medical Plans comply with the **Newborns' and Mothers' Health Protection Act** that prohibits restricting benefits for any hospital length of stay in connection with Childbirth for the mother or newborn Child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a Health Care Practitioner to obtain authorization from the Plan or its Utilization Management Company for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending Health Care Practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 14, 2003 a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA),** as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans maintain the privacy of personally identifiable health information (called **Protected Health Information or PHI**).

- The term **"Protected Health Information" (PHI)** includes all information related to past, present, or future health condition(s) that individually identifies the Participant or their Dependents or could reasonably be used to identify them and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- **PHI does not include** health information contained in employment records held by a participating Employer of NAPEBT in its role as an Employer, including but not limited to health information on disability, work-related illness/injury, sick leave and Family and Medical leave (FMLA).

A complete description of rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed during enrollment in the Plan and is also available from the Employer's Department at the address listed in the Quick Reference Chart or www.napebt.org. Information about HIPAA in this document is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor (NAPEBT Board of Trustees), will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without the Participant or their Dependent's written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or Employee benefit Plan of the Plan Sponsor**.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

A. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without the Participant or their Dependent's authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

- **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.
- **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:
  a. Determination of eligibility, coverage, cost sharing amounts (e.g., cost of a benefit, plan maximums, and copayments as determined for an individual's claim), and establishing Employee contributions for coverage;
  b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, billing, collection activities and related health care data processing, and claims auditing; and/or
  c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.
- **Health Care Operations** includes, but is not limited to:
  a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development, or improvement of methods of payment or coverage policies and quality assessment, patient safety activities;
  b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;
  c. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
  d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs; and/or

e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, plan sponsors, or other customers.

B. **When an Authorization Form is Needed:** Generally the Plan will require that the Participant or their Dependent sign a valid authorization form (available from the Employer's Department at the address listed in the Quick Reference Chart) in order for the Plan to use or disclose their PHI **other than** when they request their own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when the opportunity to agree or disagree before the Plan uses and discloses PHI.

C. **The Plan will disclose PHI to the Plan Sponsor only** upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law.
2. Ensure that any agents to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.
3. Not use or disclose the information for employment-related actions and decisions.
4. Not use or disclose the information in connection with any other benefit or Employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices).
5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for which it becomes aware.
6. Make PHI available to the individual in accordance with the access requirements of HIPAA.
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA.
8. Make available the information required to provide an accounting of PHI disclosures.
9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA.
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.
11. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

D. **In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained** in accordance with HIPAA, only the following Employees or classes of Employees may be given access to use and disclose PHI:

1. The Plan Administrator;
2. Group Health Plan staff in the Employer's Department listed in the Quick Reference Chart of each NAPEBT participating Employer; and/or
3. Business Associates under contract to the Plan including but not limited to the medical Claims Administrator, prescription benefit manager, preferred provider organization network, utilization management company, Health Savings Account Administrator, Flexible Benefits Administrator and COBRA Administrator.

E. The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. **Issues of noncompliance** (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer whose address and phone number are listed on the Quick Reference Chart in the front of this document.

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

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan,
2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

G. **Hybrid Entity**: For purposes of complying with the HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions. The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the self-funded medical plan options, including outpatient prescription drugs, COBRA administration and Health Flexible Spending Account (FSA) administration.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

The NAPEBT self-funded (non-grandfathered) medical plan options do not require the selection or designation of a primary care provider (PCP). Individuals have the ability to visit any network or non-network health care provider; however, payment by the Plan may be less for the use of a non-network provider.

An individual also does not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For information on medical plan benefits, refer to the benefit booklets provided by Blue Cross Blue Shield of Arizona or contact your Employer's Department using the Quick Reference Chart.

NONDISCRIMINATION IN HEALTH CARE

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. In this context, discrimination means treating a provider differently based solely on the type of the provider's license or certification. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

HEADINGS, FONT, AND STYLE DO NOT MODIFY PLAN PROVISIONS

The headings of chapters and subchapters and text appearing in **bold,** or CAPITAL LETTERS and font and size of sections, paragraphs and subparagraphs are included for the sole purpose of generally identifying the subject matter of the substantive text for the convenience of the reader. The headings are **not** part of the substantive text of any provision, and they **should not be construed to modify the text of any substantive provision in any way**.

IMPORTANT INFORMATION ABOUT THE WELLNESS PROGRAM

All employees participating in a NAPEBT-sponsored health plan have the opportunity to qualify for wellness program incentives at least once a year. Our NAPEBT Wellness Program is **voluntary** and is designed to **promote health or prevent disease**.

The Wellness Program also offers **incentives** for participation. Only employees enrolled in one of the NAPEBT medical plan options at have the opportunity to qualify for Wellness Program incentives. Incentives can be achieved at least **once a year**. The time commitment required to achieve incentives in our Wellness Program is reasonable. More information about our Wellness Program incentives is available at My Vera App and www.napebt.org.

The wellness program incentives have been reviewed and in accordance with law, do not exceed 30% of the total cost of employee-only coverage under the plan (including employee & employer contributions).

Reasonable Alternative Standard: If you think you might be unable to meet a standard for a certain reward under our Wellness Program, you might qualify for an opportunity to earn the same reward by a different means. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under the Wellness program, or if it is medically inadvisable for you to attempt to achieve the standards of the Wellness Program, then a reasonable alternative standard will be made available upon request. Contact your Employer's Department using the Quick Reference Chart for information on the wellness program and the need for reasonable alternatives.

Protections from Disclosure of Medical Information

Our group health plan is required by law to maintain the privacy and security of your personally identifiable health information.

Information collected from Wellness Program participants will only be received by your employer in aggregate form. Although the Wellness Program and NAPEBT may use aggregate information it collects to design a program based on identified health risks in the workplace, our group health plan will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Wellness Program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Wellness Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Wellness Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in

the Wellness Program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the Wellness Program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) health coaches and NAPEBT staff charged with administering the Wellness Program in order to provide you with services under the program.

In addition, all medical information obtained through the Wellness Program will be maintained separate from your personnel records and no information you provide as part of the Wellness Program will be used in making any employment decision. Appropriate precautions will be taken by the group health plan to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the Wellness Program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the Wellness Program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your Employer's Department using the Quick Reference Chart.

NO SURPRISES ACT

The No Surprises Act was signed into law in December 2020. This Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department and from air ambulances. In addition, the law protects patients who receive emergency services from a Non-PPO provider at an in-network facility. Effective July 1, 2022, beneficiaries receiving these services will only be responsible for paying their in-network cost sharing and cannot be balance billed by the provider or facility for emergency services. Please see your Medical and/or Chiropractic Plan Benefit information prepared by the entities noted in the Quick Reference Chart for additional information about these changes and your protections under the No Surprises Act.

In addition, an Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by a non-PPO provider at a PPO facility, and/or Air Ambulances services, as covered under the federal No Surprises Act, is eligible for External Review. Please see the Plan's External Review procedures for further information.

Continuity of Coverage

If you are a Continuing Care Patient, and the contract with your Network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

1. You will be notified in a timely manner of the contract termination and of your and of your right to elect continued transitional care from the provider or facility; and
2. You will be allowed up to ninety (90) days of continued coverage at Network cost sharing to allow for a transition of care to a Network provider.

Incorrect PPO Provider Information

A list of PPO providers is available to you without charge by visiting the website or by calling the phone number on your ID card, or the contact information listed in the Quick Reference Chart at the front of this document. If you obtain and rely upon incorrect information about whether a provider is a PPO provider from the Plan or its administrators, the Plan will apply PPO cost-sharing to your claim, even if the provider was Non-PPO.

DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding the Plan. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Actively At Work: You are considered to be Actively At Work when you are performing all of the regular duties of your employment in the customary manner either at one of the participating Employers of NAPEBT's regular places of business or at some location to which that participating Employer of NAPEBT's business requires you to travel. You are also considered to be Actively At Work on each day of a regular paid vacation, holiday, or on a non-working day on which you are Totally Disabled, but only if you were performing all of the regular duties of your occupation in the customary manner on the regular workday immediately preceding that day. **Note that this Actively At Work provision is not applicable to Employees not at work due to a health factor.**

Child(ren): See the definition of Dependent Child(ren).

Claims Administrator: The independent person or company(ies) retained by the Plan to administer the claim processing and payment responsibilities and other administration or accounting services as specified by the Plan.

COBRA: Means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. and refers to temporary continuation of health care coverage. See the COBRA chapter of this document for more information.

Covered Individual: Any Employee and or Retiree and that person's eligible Spouse, Dependent Child, Domestic Partner, or Domestic Partner's Child (as these terms are defined in the Plan) who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan.

Dependent(s): Any of the following individuals: Spouse, Dependent Child(ren), Domestic Partner, or Children of a Domestic Partner who have completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan, as those terms are defined in this document.

Dependent Child/Children for <u>Medical Plan Benefits</u>: (see also the definition of Domestic Partner Child)

A. For the purposes of the Medical Plan, a Dependent Child is any of the Employee's or Retiree's children listed below who are under the age of 26 (whether married or unmarried):
   - **natural child;** or
   - **stepchild** (proof of relationship and age may be required); or
   - **legally adopted child**, or child Placed for Adoption with the Employee or Retiree; (proof of adoption or placement for adoption may be requested); or
   - child for whom the Employee or Retiree has **legal guardianship** sustained by a court order (proof of guardianship may be requested); or
   - **foster child** who meets the following criteria: a child the Participant is raising as their own, or a child who lives in their home, or a child who is chiefly Dependent on them for support, or a child for whom they have taken parental responsibility and control. A foster child is not eligible if a child is temporarily living in the Participant's home or is a child placed with the Participant in their home by a social service agency which retains control of the child or a child whose natural parent is in a position to exercise or share parental responsibility and control (proof of foster child status may be requested); or
   - a **child named in a Qualified Medical Child Support Order** (QMCSO) is also an eligible Dependent under this Plan. See the Eligibility chapter for details on QMCSOs.

B. **Disabled Adult Child:** An unmarried Dependent Child (as defined above) age 26 or older may continue coverage under the medical plan if the child is otherwise eligible for the benefit Plan and meets **<u>all</u>** of the following criteria: is **permanently and totally disabled** with a disability that existed prior to the

attainment of the Plan's age limit and is chiefly Dependent upon the Employee or Retiree for maintenance and support (meaning the child is claimed as a dependent on the participant's tax return for each plan year for which coverage is provided). The Plan may require initial and periodic proof of disability.

C. See also the Proof of Dependent Status provisions in the Eligibility chapter.

D. **It is the Participant'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.**

E. With the exception of a Dependent Child(ren) who is permanently and totally disabled, coverage will terminate for the Child at the **end of month** in which that Child reaches his or her 26th birthday or no longer meets the eligibility requirements of the Plan. See also the termination provisions for Dependent Children listed in the Eligibility chapter of this document.

F. The following individuals are **not eligible** under the Plan: a spouse of a Dependent Child (e.g., employee/retiree's son-in-law or daughter-in-law).

Dependent Child(ren) for the Insured Dental Plan, Vision Plan and Life Insurance Benefits: (see also the definition of Domestic Partner Child(ren))

A. For the purposes of insured dental, vision and life insurance plans, a Dependent Child(ren) is any of the Employee's or Retiree's unmarried Children who have the same principal place of abode as the Employee or Retiree, including a:

- **natural child**, or
- **stepchild** (proof of relationship and age may be required); or
- **legally adopted Child**, or Child Placed for Adoption with the Employee or Retiree; (proof of adoption or placement for adoption may be requested); or
- Child for whom the Employee or Retiree has **legal guardianship** sustained by a court order (proof of guardianship may be requested); or
- **foster Child** who meets the following criteria: a Child the Participant is raising as their own, or a Child who lives in their home, or a Child who is chiefly Dependent on them for support, or a Child for whom they have taken parental responsibility and control. A foster Child is not eligible if a Child is temporarily living in the Participant's home or is a Child placed with them in their home by a social service agency which retains control of the Child or a Child whose natural parent is in a position to exercise or share parental responsibility and control (proof of foster Child status may be requested); or
- A Child named in a Qualified Medical Child Support Order (QMCSO) is also an eligible Dependent under this Plan. See the Eligibility chapter for details on QMCSOs provided:

1. the Dependent Child(ren) depends on the Employee or Retiree for **more than one-half of their support** and **is not a "qualifying Child" of any other person**. The term "qualifying Child" is defined in the Internal Revenue Code (IRC) in Section 152 (c). Note that a Child will not be treated as the qualifying Child of another person if that other person is not required by federal law to file an income tax return and that person either does not file an income tax return or files one solely to obtain a refund of withheld income taxes.

   If the Employee or Retiree is the legal guardian of a Child who is not a "relative," as listed in IRC Section 152(d)(2)(A) through (G), the Child must, for the entire year, have the same principal place of abode as the Employee or Retiree and be a member of the Employee's or Retiree's household. Proof of the same principal place of abode may be requested by the Plan; **AND**

2. **For All NAPEBT Employers for the Insured Dental, Vision, and Life Insurance:** The Child meets one of the following criteria:

   a. The Child has not reached his or her 26th birthday; **OR**

   b. The Child has reached his or her 26th birthday and is disabled. A **disabled Dependent Child** may continue coverage under this benefit Plan if the Child is otherwise eligible for the benefit Plan and meets **all** of the following criteria: (1) has been covered under this benefit Plan up to the day he/she is no longer eligible for coverage based on the age limits specified in this benefit Plan; and (2) is continuously incapable of self-sustaining employment

because of mental retardation or mental or physical disability; and (3) is chiefly Dependent upon the Employee or Retiree for maintenance and support (meaning the child is claimed as a dependent on the participant's tax return for each plan year for which coverage is provided).

B. See also the Proof of Dependent Status provisions in the Eligibility chapter.

C. **It is the Participant's obligation to inform the Plan promptly if any of the requirements set out in this definition of a Dependent Child(ren) are NOT met with respect to any Child for whom coverage is sought or is being provided.**

D. **For All NAPEBT Employers**:

E. Coverage of a Dependent Child(ren) ends at the **end of month** in which that Child:
   1. reaches his or her 26th birthday; or
   2. no longer meets the eligibility requirements of the Plan.

   See also the provisions in the Eligibility chapter on "When Coverage Ends."

F. The following individuals are **not eligible** under the Plan: a spouse of a Dependent Child (e.g. employee/retiree's son-in-law or daughter-in-law).

Domestic Partner: For the purposes of this Plan, a Domestic Partnership exists only if all of the following criteria are satisfied at all times:

1. For the City of Flagstaff and Mountain Line: A Domestic Partner is defined as a person of the same or opposite gender who:
   a. Is not a benefit eligible Employee/Retiree with another NAPEBT Employer;
   b. Has signed jointly with the subscriber, (an active Employee/Retiree) a notarized affidavit of such Domestic Partner relationship;
   c. Shares the Employee's/Retiree's permanent residence;
   d. Has resided with the Employee/Retiree continuously and is expected to continue to reside with the Employee/Retiree indefinitely;
   e. Has not signed a declaration or Affidavit of Qualified Domestic Partnership with any other person within the last twelve (12) months;
   f. Is financially interdependent with the Employee/Retiree in at least two (2) of the following ways:
      - Holding one or more credit or bank accounts jointly;
      - Owning or leasing your permanent residence as joint tenants;
      - Naming your partner as a beneficiary of your life insurance or your will and being named by your partner as a beneficiary or their life insurance or will; or
      - Each agreeing in writing to assume financial responsibility for the welfare of the other (i.e., durable power of attorney).
   g. Is no less than 18 years of age and is not a blood relative;
   h. Is not legally married to or legally separated from another person; and
   i. Both persons are capable of consenting to the Domestic Partnership.

   To terminate a Domestic Partner's coverage the Employee/Retiree must complete a "Termination Statement of Domestic Partnership" form within 31 days of the event. Once a domestic partnership is terminated another Affidavit of Domestic Partnership cannot be filed until twelve (12) months after a Termination Statement of Domestic Partnership has been filed with the Human Resource Department.

2. For Flagstaff Unified School District, Coconino County, Kachina Village Improvement District, Coconino Community College, and Coconino County Accommodation School District: A Domestic Partner is defined as a person of the same or opposite gender who:
   a. Shares a permanent residence with the Employee/Retiree and has resided with the Employee/Retiree continuously for at least 12 consecutive months before filing an application for benefits and is expected to continue to reside with the Employee/Retiree indefinitely as evidenced by completion of the County's affidavit of domestic partnership; AND

b. Has not signed a declaration or affidavit of domestic partnership with any other person and has not had another Domestic Partner within the 12 months prior to filing an application for benefits; AND
c. Does not have any other Domestic Partner or Spouse of the same or opposite sex; AND
d. Is not currently married to anyone or legally separated from anyone else; AND
e. Is not a blood relative any closer than would prohibit marriage between us in Arizona; AND
f. Was mentally competent to consent to contract when the domestic partnership began; AND
g. Is not acting under fraud or duress in accepting benefits; AND
h. Is at least 18 years of age; AND
i. Is financially interdependent in at least three of the following ways (supporting documents are required to be submitted):
   - Having a joint mortgage, joint property tax identification, or joint tenancy on a residential lease;
   - Holding one or more credit or bank accounts jointly, such as a checking account in both names;
   - Assuming joint liabilities (such as a utility bill);
   - Having joint ownership of significant property, such as real estate, a vehicle, or a boat;
   - Naming the partner as beneficiary on the Employee's/Retiree's life insurance, under the Employee's/Retiree's will, or Employee's/Retiree's retirement annuities and being named by the partner as beneficiary of the partner's life insurance, under the partner's will, or the partner's retirement annuities; or
   - Each agreeing in writing to assume financial responsibility for the welfare of the other, such as durable power of attorney.

To terminate a Domestic Partner's coverage the Employee/Retiree must complete a "Notice of Termination of Domestic Partnership" form within 31 days of the event. Once a domestic partnership is terminated another Affidavit of Domestic Partnership cannot be filed until twelve (12) months after a Notice of Termination of Domestic Partnership has been filed with the Human Resource Department.

Domestic Partner's Child(ren) for Medical Plan Benefits: If a Domestic Partner is enrolled in the Plan, the Participant may also apply for coverage for the Domestic Partner's Child(ren) who meet the requirements set out below:

A. For the purposes of the medical Plan, a Domestic Partner's Child(ren) is any of the Domestic Partner's Children under the age of 26 (whether married or unmarried, including a:
   - **natural child**, or
   - **stepchild**, (proof of relationship and age may be required); or
   - **legally adopted child** or child Placed for Adoption with the Domestic Partner (proof of adoption or placement for adoption may be requested); or
   - child for whom the Domestic Partner has **legal guardianship** under a court order (proof of guardianship may be requested); or
   - **foster child** who meets the following criteria: a Child the Domestic Partner is raising as their own, or a Child who lives in the Domestic Partner home, or a Child who is chiefly Dependent on the Domestic Partner for support, or a Child for whom the Domestic Partner has taken parental responsibility and control. A foster child is not eligible if a child is temporarily living in the Domestic Partner's home or is a child placed with the Domestic Partner in their home by a social service agency which retains control of the child or a child whose natural parent is in a position to exercise or share parental responsibility and control (proof of foster child status may be requested); or
   - a **child named in a Qualified Medical Child Support Order** (QMCSO) is also an eligible Dependent under this Plan. See the Eligibility chapter for details on QMCSOs.

B. **Disabled Adult Child**: An unmarried Dependent Child (as defined above) age 26 or older may continue under the medical plan if the child is otherwise eligible for the benefit Plan and meets **all** of the following criteria: is **permanently and totally disabled** with a disability that existed prior to the attainment

of the Plan's age limit and is chiefly Dependent upon the Employee or Retiree for maintenance and support (meaning the child is claimed as a dependent on the participant's tax return for each plan year for which coverage is provided). The Plan may require initial and periodic proof of disability.

C. See also the Proof of Dependent Status provisions in the Eligibility chapter.

D. **It is the Participant's obligation to inform the Plan promptly if any of the requirements set out in this definition of a Domestic Partner or Domestic Partner's Child are NOT met with respect to any person for whom coverage is sought or is being provided**.

E. Coverage of a Domestic Partner ends in accordance with the termination provisions outlined in the section titled "When Coverage Ends" in the Eligibility chapter in this document.

F. With the exception of a Dependent child who is permanently and totally disabled, coverage will terminate for the child of a Domestic Partner at the **end of the month** in which that child reaches his or her 26th birthday or no longer meets the eligibility requirements of the Plan. See also the termination provisions for Dependent Children listed in the Eligibility chapter of this document. Note that if the Domestic Partner loses benefits under the Plan the Children of a Domestic Partner also lose coverage.

G. The following individuals are **not eligible** under the Plan: a spouse of a Dependent Child of a Domestic Partner (e.g., employee/retiree/Domestic Partner's son-in-law or daughter-in-law).

Domestic Partner Child(ren) for the Insured Dental Plan, Vision Plan and Life Insurance Benefits: If a Domestic Partner is enrolled in the Plan, the Employee may also apply for coverage for the Domestic Partner's Child(ren) who meet the requirements set out below:

A. For the purpose of this Plan, a Domestic Partner's Child is any of the Domestic Partner's unmarried Children who have the same principal place of abode as the Employee and Domestic Partner, including a:

- natural child, stepchild, legally adopted Child, or Child Placed for Adoption with the Domestic Partner (proof of adoption or placement for adoption may be requested); or
- Child for whom the Domestic Partner has legal guardianship under a court order (proof of guardianship may be requested); or
- foster Child who meets the following criteria: a Child the Domestic Partner is raising as their own, or a Child who lives in the Domestic Partner home, or a Child who is chiefly Dependent on the Domestic Partner for support, or a Child for whom the Domestic Partner has taken parental responsibility and control. A foster Child is not eligible if a Child is temporarily living in the Domestic Partner's home or is a Child placed with the Domestic Partner in their home by a social service agency which retains control of the Child or a Child whose natural parent is in a position to exercise or share parental responsibility and control (proof of foster Child status may be requested;

provided:

1. The Domestic Partner's Child depends on the Domestic Partner and/or the Employee for **more than one-half** of their support, and

   For All NAPEBT Employers for the Insured Dental, Vision, and Life Insurance: the Domestic Partner's Child meets one of the following criteria:

   a. The Child has not reached his or her 26th birthday; **OR**

   b. The Child has reached his or her 26th birthday and is disabled. A **disabled Dependent Child** may continue coverage under this benefit Plan if the Child is otherwise eligible for the benefit Plan and meets **all** of the following criteria: (1) has been covered under this benefit Plan up to the day he/she is no longer eligible for coverage based on the age limits specified in this benefit Plan; and (2) is continuously incapable of self-sustaining employment because of mental retardation or mental or physical disability; and (3) is chiefly Dependent upon the Employee or Retiree for maintenance and support (meaning the child is claimed as a dependent on the participant's tax return for each plan year for which coverage is provided).

Proof of the same principal place of abode may be requested by the Plan.

B. See also the Proof of Dependent Status provisions in the Eligibility chapter.

C. **It is the Employee's obligation to inform the Plan promptly if any of the requirements set out in this definition of a Domestic Partner or Domestic Partner's Child are NOT met with respect to any Child for whom coverage is sought or is being provided**.

D. Coverage of a Domestic Partner ends in accordance with the termination provisions outlined in the section titled "When Coverage Ends" in the Eligibility chapter in this document.

E. **For All NAPEBT Employers the** Domestic Partner's Child meets one of the following criteria:

F. Coverage of a Domestic Partner's Dependent Child(ren) ends at the **end of month** in which that Child

1. reaches his or her 26th birthday; or
2. no longer meets the eligibility requirements of the Plan; or
3. enters military or similar service anywhere; or
4. **on the date** the Child becomes enrolled for coverage as an Employee of any other Employer.

- Note that if the Domestic Partner loses benefits under the Plan the Children of a Domestic Partner also lose coverage.

G. The following individuals are **not eligible** under the Plan: a spouse of a Domestic Partner's Dependent Child.

Eligible Dependent: Your lawful Spouse, your Dependent Child(ren), your Domestic Partner and a Child(ren) of a Domestic Partner, as those terms are defined in this Plan. An Eligible Dependent may be enrolled for coverage under the Plan by following the procedures required by the Plan. See the Eligibility chapter for further information. Once an Eligible Dependent is duly enrolled for coverage under the Plan, coverage begins in accordance with the terms and provisions of the Plan, as described in the Eligibility chapter, and that person is a covered Dependent, and remains a covered Dependent until his or her coverage ends in accordance with the terms and provisions of the Plan.

Employee: Unless specifically indicated otherwise, when used in this document, Employee refers to a person employed by a participating Employer of NAPEBT, who is on the payroll of a participating Employer of NAPEBT and is eligible to enroll for coverage under the Plan. An Employee does not refer to leased Employees and independent contractors.

Employer: An Employer who participates in NAPEBT.

Enroll(ed), Enrollment: The process of completing and submitting a written enrollment form indicating that coverage by the Plan is requested by the Employee. An Employee may request coverage for an Eligible Dependent only if he or she is or will be covered by the Plan. See the Eligibility chapter for details regarding the mechanics of enrollment.

Exhausted (in reference to COBRA Continuation Coverage): For the definition of Exhausted in connection with COBRA Continuation Coverage as it relates to entitlement to Special Enrollment for coverage, see the section on Special Enrollment in the Eligibility chapter.

Experimental and/or Investigational: The Plan Administrator or its designee has the discretion and authority to determine if a drug, service, or supply is or should be classified as Experimental and/or Investigational. A drug, service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee,

1. The drug, service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the drug or supply;
2. The prescribed drug, service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;

3. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative health care or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized health care or scientific experts: classify the drug, service or supply as experimental and/or investigational; or indicate that more research is required before the drug, service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to drugs, services or supplies regulated by the US Food and Drug Administration (FDA), FDA approval is required in order for the drug, service and supply to be lawfully marketed; and it has not been granted at the time the drug, service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA.
5. Under the NAPEBT-sponsored medical plans, experimental, investigational, or unproven does not include **routine costs associated with a certain "approved clinical trial" related to cancer or other life-threatening illnesses.** The routine costs that are covered by this Plan are discussed below:
   a. "**Routine costs**" means services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered for a participant or beneficiary who is not enrolled in a clinical trial. However, the plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
   b. An "**approved clinical trial**" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial's study or investigation must be (1) federally-funded; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. "Federally funded" clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
   c. A participant or beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual's referring physician is a participating health care provider in the plan who has determined that the individual's participation in the approved clinical trial is medically appropriate, or the individual provides the plan with medical and scientific information establishing that participation in the trial would be medically appropriate.
   d. The plan may require that an eligible individual use an in-network provider as long as the provider will accept the patient. This plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.
   e. The plan may rely on its Medical Plan Claims Administrator, Utilization Management Company, or other medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process. To appeal an adverse decision related to routine care, contact the Medical Plan Claims Administrator (see the Quick Reference Chart in the front of this document). Additionally, external review is available for an adverse determination related to coverage of routine costs in a clinical trial.

In determining if a drug, service, or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the drug, service or supply was performed, provided, or considered for Precertification under the Plan:

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed drug, service or supply;
3. Protocols of the Health Care Provider that renders the prescribed drug, service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed drug, service, or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";
5. The published opinions of the American Medical Association (AMA), or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or clinical/pharmaceutical policy bulletins of major insurance companies in the U.S. such as Blue Cross Blue Shield, Aetna, or CIGNA.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed drug, service, or supply.

Health Reform: refers to the Affordable Care Act (ACA) which is a comprehensive federal health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, Health Reform, or "Obamacare"). The law has 2 parts: the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (the Reconciliation Act). The Affordable Care Act (ACA) includes requirements for coverage of certain health care services that impact medical plans.

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".

Medically Necessary/Medical Necessity:

A. A drug, service or supply will be determined to be **"Medically Necessary"** by the Plan Administrator or its designee if it:
   1. is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it; and
   2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical, pharmaceutical, or dental standards; and
   3. is determined by the Plan Administrator or its designee to meet <u>all</u> the following requirements:
      - It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
      - It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or Health Care Facility; and
      - It is an **"Appropriate"** service or supply given the patient's circumstances and condition; and
      - It is a **"Cost-Efficient"** supply or level of service that can be safely provided to the patient; and
      - It is safe and effective for the illness or injury for which it is used.

B. A drug, service or supply will be considered to be **"Appropriate"** if:
   1. It is a diagnostic procedure that is called for by the health status of the patient and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative drug, service, or supply, both with respect to the illness or injury involved and the patient's overall health condition.
   2. It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative drug, service, or supply, both with respect to the illness or injury involved and the patient's overall health condition.

C. A drug, service or supply will be considered to be **"Cost-Efficient"** if it is no more costly than any alternative appropriate drug, service or supply when considered in relation to all health care expenses incurred in connection with the drug, service, or supply.

D. The fact that your Physician or Dentist may provide, order, recommend or approve a drug, service or supply does not mean that the service or supply will be considered to be Medically Necessary for the coverage provided by the Plan.

E. Under the prescription drug benefits of the Plan, medications, health care services or products are considered Medically Necessary if:
   - Use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
   - Use of the medication, service, or product is based on recognized standards for the health care specialty involved;
   - Use of the medication, service, or product represents the most appropriate level of care for the individual, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed; and
   - Use of medication, service or product is not solely for the convenience of the individual, individual's family, or provider.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

NAPEBT: refers to the Northern Arizona Public Employees Benefit Trust. Website: www.napebt.org

Open Enrollment Period: The period (determined by NAPEBT) during which an Employee or Retiree may add coverages for Dependents, drop coverages for Dependents or select among the alternate health benefit programs that are offered by the Plan. The Plan's annual Open Enrollment Period is described in the Eligibility chapter of this document.

Participant(s): When used in this document, these words refer to the Employee or Retiree who is covered by the Plan. The term Participant does **not** refer to any Dependent of the Employee or Retiree even though that Dependent may have completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan.

Placed for Adoption: For the definition of Placed for Adoption as it relates to coverage of adopted Dependent Children, see the definition in the section on Adopted Dependent Children in the Eligibility chapter.

Plan, This Plan: The programs, benefits and provisions described in this document.

Plan Administrator: The Board of Trustees of NAPEBT has designated a Third Party Plan Administrator and who has the responsibility for overall Plan administration. The Board of Trustees of NAPEBT also designates Plan Administrators for medical, prescription drugs, outpatient prescription drug benefits, dental, vision, life, COBRA administration, flexible spending account administration, health savings account administration, etc.

Plan Sponsor: NAPEBT Board of Trustees.

Plan Year: The twelve-month period from July 1 to June 30 designated to be the Plan Year.

Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an Employee to provide health care coverage for a Dependent Child(ren) and requiring that benefits payable on account of that Dependent Child(ren) be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child(ren). See also the Eligibility chapter of this document.

Retiree: Retiree is defined as a former Employee of an Employer participating in NAPEBT. See the information on "Eligibility for NAPEBT Retiree Benefits" in the Eligibility chapter of this document or the Employer's Department using the Quick Reference Chart for more information.

Spouse: The Employee's or Retiree's Spouse under a legally valid existing marriage. The Plan will require proof of the legal marital relationship. The following are not defined as a Spouse under this Plan: a legally separated Spouse (when legal separation is permitted by state law), a civil union, or a divorced former Spouse of an employee or retiree, a common law marriage not recognized as a valid marriage under state law, or a spouse of a Dependent Child.

You, Your, Yourself: When used in this document, these words refer to the Participant who is covered by the Plan. They do **not** refer to any Dependent of the Employee or Retiree.