# Pima County Community College District (PCCCD)

## Wrap Plan Document

**for Active Employees and their Eligible Dependents**

describing the Eligibility Provisions for the Medical and Dental Plan options, Life Insurance Benefits, Disability benefits, COBRA Continuation Coverage along with certain required Health Compliance Notices applicable to the Health Benefits sponsored by PCCCD.

**IMPORTANT NOTE**

**This wrap plan document, together with the separate Plan Documents, Booklets and/or Summary Plan Descriptions issued by the self-funded medical plan administrators and various Insurance Companies under contract to PCCCD, is your complete Plan Document.**

**Contact PCCCD's Employee Service Center for a copy of the benefit documents.**

**Amended, restated and effective November 1, 2019**

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# INTRODUCTION

**WHAT THIS DOCUMENT TELLS YOU**

This document describes some of the plan health benefits of Pima County Community College District (hereafter referred to as PCCCD).

**IMPORTANT NOTE**

This wrap plan document, together with the separate Plan Documents, Plan booklets and/or Summary Plan Descriptions issued by the medical plan claims administrators and various Insurance Companies under contract to Pima County Community College District, is your complete Plan Document.

Contact Pima County Community College District's Employee Service Center for a copy of the benefit documents.

The Plan described in this wrap document is effective November 1, 2019, and replaces all other wrap documents and applicable amendments to those documents previously provided to Plan participants.

- To determine if you are in a class of individuals who are eligible for benefits under this Plan, refer to the Eligibility chapter in this document. Coverage for eligible dependents will be conditioned on you providing proof of dependent status satisfactory to the Plan. If you have declined any of the coverages described in this document, the chapters pertaining to those declined coverages do not apply to you.
- Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment.
- No individual shall have accrued or vested rights to benefits under this Plan. Vested right refers to benefits that an individual has earned a right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed.

This document will help you understand and use the benefits provided by Pima County Community College District. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverages provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan. Be sure to read the Exclusions and Definitions chapters.

**While recognizing the many benefits associated with this Plan, it is also important to note that not every expense you incur for health care is covered by this Plan.**

**All provisions of this document contain important information.** If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears in this chapter.

**IMPORTANT INFORMATION**

Pima County Community College District 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 Administrator reserves the right to amend or terminate coverages at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

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 and outpatient prescription drugs benefits are self-funded by Pima County Community College District. The dental plan options, Employee Assistance Program (EAP), life insurance and short and long term disability benefits are fully insured with insurance companies whose names are listed on the Quick Reference Chart in this document.

**SUGGESTIONS FOR USING THIS DOCUMENT**

This document provides detail about your Plan. We suggest that you pay particular attention to the following:

- Read through this **Introduction** and look at the **Table of Contents** that immediately precedes it. If you don't understand a term, look it up in the Definitions chapter. The **Table of Contents** provides you with an outline of the chapters. The **Definitions** chapter explains many technical, medical and legal terms that appear in the text.
- The **Eligibility chapter** outlines who is eligible for coverage and when coverage ends while the **COBRA chapter** discusses your options if health coverage ends for you or a covered Spouse or Dependent Child.
- This document contains a **Quick Reference Chart** following this introductory text**.** This is a handy resource for the names, addresses and phone numbers of the key contacts for your benefits such as the Plan Administrator.
- Refer to the **General Provisions chapter** for important notices.

## IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Plan Administrator information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in Domestic Partnership status, change in status of a Dependent Child, birth, Medicare enrollment or disenrollment, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the Plan within 30 days after any of the above noted events.

**Failure to give this Plan a timely notice of the above noted events may:**

a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
c. cause claims to not be able to be considered for payment until eligibility issues have been resolved,
d. result in your liability to repay the Plan if any benefits are paid to an ineligible person.

**SPANISH LANGUAGE ASSISTANCE**:

Si usted no entiende la información en este documento, por favor de ponerse en contacto con personal del departamento de Beneficios en (520) 206-4945.

**QUESTIONS YOU MAY HAVE**

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Pima County Community College District Employee Service Center at their phone number and address located on the Quick Reference Chart in this document. As a courtesy to you, PCCCD's Employee Service Center staff may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. Your most reliable method is to put your questions into writing and fax or mail those questions to PCCCD's Employee Service Center and obtain a written response.

In the event of any discrepancy between any information that you receive from PCCCD's Employee Service Center, orally or in writing, and the terms of this document, the terms of this document will govern your entitlement to benefits, if any.

**FOR HELP OR INFORMATION**

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

| QUICK REFERENCE CHART | |
|---|---|
| **Information Needed** | **Whom to Contact** |
| **Medical Plan Benefits Network and Claims Administrator for the PPO, HDHP and EPO Medical Plans**<br>• Medical Plan Claims and Appeals<br>• Information on Eligibility for Coverage<br>• Plan Benefit Information<br>• ID cards<br>• Medical Network Provider Directory (in the US)<br>• Additions/Deletions of Network Providers<br>• (Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price)<br>• Summary of Benefits and Coverage (SBC)<br><br>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 Plans outside of Arizona. | **Blue Cross Blue Shield of Arizona (BCBSAZ)**<br>5285 E. Williams Circle, Suite 1000<br>Tucson, AZ 85711<br><br>**Customer service** (claims and benefits): 1-855-818-0236<br>(8 a.m. to 4:30 p.m. Arizona time)<br><br>**24 hour Nurse on Call:** 1-866-422-2729 or visit www.azblue.com/HealthyBlue<br><br>Claims Address:<br>Blue Cross Blue Shield of Arizona<br>P.O. Box 2924 Phoenix, AZ 85062-2924<br><br>**Web Site for Provider Directory**: www.azblue.com<br>Free mobile app to locate in-network providers at the Google Plan or App store (search for AZBlue)<br><br>Healthy Blue Website for Wellness Information:<br>www.azblue.com/healthyblue<br><br>**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. (See definition of "balance billing" in the Definition chapter of this document). **Your lowest out of pocket costs will occur when you use In-Network PPO providers**. |
| **Health Savings Account (HSA) with the High Deductible Health Plan (HDHP)** | **Health Equity**<br>Customer Service: 1-866-382-3510 |
| **Employee Assistance Program (EAP)**<br>• Professional, confidential information, support and referral to help individuals cope with personal problems that impact their home and work life. EAP counselors can help you with stress, marriage/family/work-related problems, substance abuse, financial and legal problems.<br>• No cost; up to **6 visits** per issue per year | **Jorgensen Brooks**<br>Phone: 520-575-8623 or 888-520-5400<br>Web Site: www.jorgensenbrooks.com<br>*Access code: jorgensenbrooks* |

| QUICK REFERENCE CHART | |
|---|---|
| **Information Needed** | **Whom to Contact** |
| **Prescription Drug Program administered by the Prescription Benefit Manager (PBM)**<br>• ID Cards<br>• Retail Network Pharmacies<br>• Mail Order (Home Delivery) Pharmacy<br>• Prescription Drug Information<br>• Diabetic supplies<br>• Formulary of Preferred Drugs<br>• Precertification of Certain Drugs<br>• Direct Member Reimbursement (for Non-Network retail pharmacy use)<br>• Specialty Drug Program: Precertification and Ordering | **MagellanRx**<br>Customer Service: (800) 424-0472<br>Website: www.magellanrx.com<br><br>MagellanRx free mobile app for medication information and options, location of retail network pharmacies, etc. Visit the MyPima Intranet at the website below: Website: https://www.pima.edu/administrative-services/human-resources/benefits/<br><br>Clinical appeal requests:<br>Magellan Rx Management Prior Authorization Program;<br>c/o Magellan Health, Inc.<br>Clinical Appeal<br>4801 E. Washington Street<br>Phoenix, AZ 85034<br>Call (800) 424-0472 or Fax (800) 424-3260<br>Administrative appeal requests:<br>Magellan Rx Management Prior Authorization Program;<br>c/o Magellan Health, Inc.<br>Administrative Appeal<br>4801 E. Washington Street<br>Phoenix, AZ 85034<br>Call (800) 424-0472 or Fax (800) 424-3260<br><br>Coverage review forms for faxing may be obtained online at https://magellanrx.com/member/external/commercial/common/doc/en-us/MRX_General_PA_form.pdf |
| **Dental Plan (Insured prepaid DMO)**<br>• Dental claims and appeals<br>• Dental network providers | **Employers Dental Service (EDS)**<br>Customer Service: (520) 696-4343<br><br>Email: EDSCS@mydentalplan.net<br><br>Website: www.mydentalplan.net |
| **Dental Plan (Insured PPO)**<br>• Dental claims and appeals<br>• Dental network providers | **Delta Dental of Arizona**<br>Customer Service: (800) 352-6132<br>Website: www.deltadentalaz.com |
| **Life and Accidental Death and Dismemberment (AD&D) Insurance**<br>• Basic term life insurance<br>• Employee AD&D insurance<br>• Beneficiary designation forms<br>• Optional Term Life Insurance for Employee, Spouse and Child(ren) | **Minnesota Life Insurance Company**<br>(800) 606-5433<br>Website: www.lifebenefits.com |
| **Short Term Disability Insurance** | **Sun Life Assurance Company of Canada**<br>800-247-6875<br>www.sunlife.com/us |
| **Long Term Disability Insurance** | **Sedgwick CMS**<br>Contact: 520-239-3100 or 800-495-9301 |

| QUICK REFERENCE CHART | |
|---|---|
| **Information Needed** | **Whom to Contact** |
| **Flexible Spending Accounts (FSA)**<br>• Flex plan claims and appeals | **ASI Flex**<br>Customer Service: (800) 659-3035<br>Website: www.asiflex.com |
| **COBRA Administrator**<br>• Information about COBRA coverage<br>• Cost of COBRA continuation coverage<br>• COBRA premium payments<br>• Second qualifying event and disability notification | **ASI COBRA**<br>Customer Service: (877) 388-8331<br>Website: www.asicobra.com |
| **Employee Benefits**<br>• Information about eligibility and enrollment for benefits<br>• Medicare Part D Notice of Creditable Coverage | **Pima County Community College District (PCCCD) Employee Service Center**<br>4905 E. Broadway Blvd. Suite C117 (DO-1235)<br>Tucson, AZ 85709-1235<br><br>**Phone Number: (520) 206-4945**<br>Fax: 520-206-4969<br>Email: ESC@pima.edu<br><br>The MyPima Intranet is available at the website below:<br>Website: https://mypima.pima.edu/ |
| **Plan Administrator** | **Pima County Community College District's Board of Governors**<br>4905 East Broadway Blvd.<br>Tucson, AZ 85709-1205<br>Phone: (520) 206-4971 or 1-800-860-7462 |
| **HIPAA Privacy Officer and HIPAA Security Officer**<br>• HIPAA Notice of Privacy Practices | **Director of the Employee Service Center**<br>4905 East Broadway Blvd.<br>Tucson, AZ 85709-1235<br>Phone: (520) 206-4945 or 1-800-860-7462<br>Confidential fax #: (520) 206-4969 |

# ELIGIBILITY

## HOW AND WHEN COVERAGE BEGINS, IS MAINTAINED AND ENDS

### WHO IS ELIGIBLE FOR COVERAGE AND START OF COVERAGE

Pima County Community College District (PCCCD) determines full-time employee status in compliance with IRS regulations under the Affordable Care Act.

**Employee Eligibility**: If you are a full-time regular classified staff, faculty or administrator of PCCCD averaging 30 hours of service or more each week, you are eligible for your own medical, dental, life and AD&D and disability benefits coverage. You must elect these benefits within 30 days of your eligibility date, usually your hire date. Your coverage will become effective on the first day of the month after you start work, or on the first day of the following month after you submit an online enrollment application or a completed written enrollment form that may be obtained from the PCCCD Employee Service Center.

Any required contributions for coverage will be deducted from your paycheck.

If you are one of these types of employees with PCCCD you are also eligible for benefits:

- a regular faculty who, by prior approval, have up to 2/5 unpaid release time
- faculty on a one-year administrative appointment
- probationary employee.

**Hours 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 to the extent the compensation for services performed constitutes income from sources without the United States.

**Employees who <u>do not</u> work an average of 30 hours of service/week (130 hours of service/month) as measured and determined by Pima County Community College District, are not eligible for coverage under this Plan.**

Pima County Community College District reserves the right to use a Look Back Measurement Method. Under the look-back measurement method, PCCCD 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 number of hours of service the employee attained in a prior period (called a measurement period).

PCCCD reserves 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 week the employee attained in a prior period (called a measurement period). The specific duration of periods under the Look Back Measurement Method (when used) are addressed in policies/procedures in the Human Resource department and can be changed on an annual basis as determined by PCCCD.

### DEPENDENTS' ELIGIBILITY

If you elect coverage for yourself, you are also eligible to elect medical and dental coverage for your Eligible Dependents on the later of the day you become eligible for your own medical and dental coverage or the day you acquire an Eligible Dependent, either by marriage, birth, adoption or placement for adoption, but only if you have submitted an online enrollment application or a completed written enrollment form (available on the MyPima Intranet or from the PCCCD Employee Service Center), with the Dependent's SSN, <u>and</u> if that medical coverage is in effect for you on that day <u>and</u> you provide the Plan's required proof of Dependent status <u>and</u> pay any required contribution for coverage of the dependent(s).

**A Dependent may not be enrolled for coverage unless the employee is also enrolled**. Specific documentation to substantiate Dependent status may be required by the Plan.

Your Eligible Dependents include your lawful Spouse and your 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 Plan benefits or services under this Plan, unless he or she is your Domestic Partner for whom you have elected coverage in accordance with the rules discussed below.

**Domestic Partners**:

- Individuals who qualify as a Domestic Partner, as that term is defined in this Plan, may be eligible to enroll for coverage as a dependent upon completion of a PCCCD Domestic Partnership Affidavit and completion of the PCCCD enrollment process.
- The employee will pay the full cost of premiums on a post-tax basis.
- A Domestic Partner and the children of a Domestic Partner may be enrolled during Initial Enrollment or during the Open Enrollment period and generally coverage of the Domestic Partner will become effective the first of the month after receipt and approval of the PCCCD Domestic Partnership Affidavit. Affidavits are available from and are to be returned to the PCCCD Employee Service Center.
- Note that temporary continuation of coverage under a benefit such as COBRA coverage is not available to Domestic Partners or children of Domestic Partners.

**PROOF OF DEPENDENT STATUS**

Specific documentation to substantiate Dependent status will be required by the Plan and may include a birth certificate, marriage certificate, proof of the dependent's age, the dependent's social security number (SSN), and other documents deemed necessary by the Plan. Below are other items the Plan may request to substantiate Dependent status.

**Note that failure to provide timely proof of dependent status means that claims submitted to the Plan for the dependents will not be able to be considered for payment until such proof is provided.**

- **Marriage:** the certified marriage certificate.
- **Birth:** the certified birth certificate showing biological child of employee.
- **Stepchild:** the certified birth certificate, divorce decree and marriage certificate.
- **Adoption or placement for adoption**: court order paper signed by the judge showing that employee has adopted or intends to adopt the child and birth certificate.
- **Foster Child:** court order documents signed by a judge verifying legal custody of the foster child (e.g. placement papers from a qualified state placement agency), or proof of judgment, decree or court order from a court of competent jurisdiction, plus the child's birth certificate.
- **Legal Guardianship:** the court-appointed legal guardianship documents and certified birth certificate.
- **Disabled Dependent Child:** Current written statement from the child's Physician indicating the child's diagnoses that are the basis for the Physician's assessment that the child is currently mentally or physically disabled (as that term disabled is defined in this document) and that disability existed before the attainment of the Plan's age limit and is incapable of self-sustaining employment as a result of that disability; and dependent chiefly on you and/or your Spouse for support and maintenance. The plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child including proof that the child is claimed as a dependent for federal income tax purposes.
- **Qualified Medical Child Support Order** (QMCSO): Valid QMCSO document signed by a judge or a National Medical Support Notice.
- **Domestic Partner**: PCCCD Domestic Partnership Affidavit signed by the employee and domestic partner that they meet the requirements of this Plan's domestic partner eligibility.

See also the section on Failure to Provide Proof of Dependent Status under the Initial Enrollment section of this chapter.

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

**ENROLLMENT PROCEDURE**

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.

**Procedure to request enrollment:** Generally, an individual must go online to MyPima, call, fax, e-mail or walk into the PCCCD Employee Service Center (ESC) and indicate their desire to enroll in the Plan (The address, phone number, fax and e-mail for the Benefits Department is listed on the Quick Reference Chart in the front of this document). Note that the Open Enrollment procedure can differ from this process and if so, the procedure 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, you will be provided with the steps to enroll that include all of the following:

a. submit an online enrollment application or a completed written enrollment form that may be obtained from PCCCD's Employee Service Center within 30 days of the date of eligibility for coverage (which includes providing the Dependent's social security number (SSN) or tax payer identification number (TIN)), and

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

c. pay any required contributions for coverage through payroll deduction, if available, and

d. perform steps a through c above in a timely manner according to the timeframes noted under the Initial, Special, or Open enrollment provisions of this Plan.

Proper enrollment is required for coverage under this Plan. If enrollment has been requested within the required time limit but proper enrollment including completion of either an online application for coverage or paper enrollment documents have not been completed and submitted, claims will not be able to be considered for payment and coverage will not be provided.

If you fail to complete enrollment for benefits within 30 days of eligibility, you will be **defaulted into the High Deductible Health Plan (HDHP) BASIC Plan with Health Savings Account (HSA) with employee-only coverage,** and no dental plan, optional life insurance coverage or FSA enrollment will be added**.** This HDHP plan is paired with a Health Savings Account, but only for those employees eligible to have contributions made to an HSA. Please review the IRS Health Savings Account (HSA) eligibility rules outlined in the "Health Plan Options" chapter. It is your responsibility to notify PCCCD's Employee Service Center if you are not eligible or no longer eligible to have a Health Savings Account.

**A person who has not properly enrolled by completing the Plan's enrollment procedures (noted above) including requesting enrollment in a timely manner, has no right to any coverage for Plan benefits or services under this Plan.**

**Failure to Provide Proof of Dependent Status**: See also the section on Proof of Dependent Status above. Claims for newly added dependents (e.g. Spouse, children) will not be considered for payment by this Plan until PCCCD's Employee Service Center receives verification/proof of dependent status.

**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 failure to 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.

## DECLINING/WAIVING COVERAGE

Benefits eligible employees may pass up the opportunity to enroll in (decline/opt out of) medical and dental benefits for themselves, but to do so, **you must submit to the Pima County Community College District Employee Service Center the completed portion of the online enrollment screens or enrollment form that pertains to declining coverage**. Remember that a Dependent may not be enrolled for coverage unless the employee is also enrolled.

The opportunity to decline coverage is only available at one of the Plan's initial and open enrollment times: If, at a later date, you want the coverage you declined for yourself you may enroll only under the Special Enrollment provisions (when applicable) described later in this chapter. Enrollment forms may be obtained from PCCCD's Employee Service Center.

There is additional compensation paid to you if you waive/decline benefit coverage and show proof of other group medical coverage, such as coverage under the spouse's medical plan. The form and manner of any additional compensation for declining coverage is announced by PCCCD at initial eligibility or open enrollment time. Proof of other group coverage is to be provided to the PCCCD Employee Service Center.

## DEFAULT ENROLLMENT

If a benefits eligible employee is offered the opportunity to enroll for coverage and either does not elect that coverage or does not waive/decline that coverage, then under this PCCCD plan, the **employee is defaulted into the base medical plan (the High Deductible Health Plan (HDHP) BASIC plan)** at the employee only level (no dependents will be added) and no dental plan, optional life insurance coverage or FSA enrollment will be added. Unless you and/or your Eligible Dependent(s) qualify for the Special Enrollment described in this chapter, you will not be able to enroll yourself and/or them until the next Open Enrollment period. Note too that the HDHP is paired with a Health Savings Account (HSA); however, the employee must be HSA-eligible in order to have any contributions made into the HSA by the employer or employee. It is your responsibility to notify PCCCD Employee Service Center is you are ineligible for HSA contributions.

Individuals ineligible for HSA contributions will not be owed any additional compensation nor will additional monies be set aside in an HSA on their behalf. Individuals who enroll in a Health Savings Account (HSA), but are later determined to be ineligible for that account, are subject to financial penalties from the IRS. Additionally, in these situations there are fees charged to PCCCD to cancel an HSA account. If these fees occur, PCCCD will pass on the HSA account cancellation fees to the applicable employee whose HSA account was required to be closed/cancelled. PCCCD will also not be liable for any associated IRS imposed financial penalties. For more information on HSA eligibility, see the HSA information in the "Health Plan Options chapter of this document. You may also contact PCCCD's Employee Service Center.

## INITIAL ENROLLMENT

Initial enrollment is the first time you, an employee, are eligible to enroll for benefits. You must enroll no later than 30 days after the date on which you are eligible for coverage by submitting a completed online enrollment application or a completed written enrollment form that may be obtained from PCCCD, providing proof of Dependent status (as appropriate) and paying any required contributions for coverage. If you want Dependent coverage, you must enroll your Eligible Dependents at the same time. See the Enrollment Procedure section of this chapter for more information.

**Start of Coverage Following Initial Enrollment:** Your coverage begins on the first day of the month following the day your employment in a benefit-eligible position begins. Coverage of your enrolled Spouse and/or Dependent Child(ren) begins on the date your coverage begins.

**Failure to Enroll During Initial Enrollment (Very Important Information):** If you fail to make an election during the Initial Enrollment period, you will be considered to have made an election to be **defaulted** into the High Deductible Health Plan (HDHP) with HSA medical plan option with employee only coverage (no dependents added) and no dental plan, optional life insurance coverage or FSA enrollment will be added. Unless you and/or your Eligible Dependent(s) qualify for the Special Enrollment described in the following section of this chapter, you will not be able to enroll yourself and/or them until the next Open Enrollment period (unless there is a Special Enrollment opportunity).

## 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:

**A. Newly Acquired Spouse and/or Dependent Child(ren)** (as these terms are defined under this Plan)

- **If <u>you are enrolled</u> for coverage** under this Plan and acquire a Spouse by marriage, or acquire any Dependent Child(ren) by birth, adoption or placement for adoption or marriage, you may request enrollment for your new Spouse and/or any Dependent Child(ren) no later than 30 days after the date of marriage, birth, adoption or placement for adoption. (Note: 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.)

- **If <u>you are eligible for coverage but not enrolled</u> for coverage** under this Plan and acquire a Spouse by marriage, or acquire any Dependent Child(ren) by birth, adoption or placement for adoption or marriage, you may request enrollment for yourself (if you are benefits-eligible) and/or your new Spouse and/or any Dependent Child(ren) no later than 30 days after the date of marriage, birth, adoption or placement for adoption. If you, the employee, are not already enrolled for coverage, you must request enrollment for yourself in order to enroll a new Dependent.

- **If you did not enroll your Spouse for coverage** within 30 days of the date on which he or she became eligible for coverage under this Plan, and if you subsequently acquire a Dependent Child(ren) by birth, adoption or placement for adoption or marriage, you may request enrollment for your Spouse and/or your new Dependent Child(ren) and/or any Dependent Child(ren) no later than 30 days after the date of your new Dependent Child(ren)'s birth, adoption or placement for adoption. If you, the benefits-eligible employee, are not already enrolled for coverage, you must request enrollment for yourself in order to enroll a new Dependent.

- **Under this Plan, Special Enrollment does not pertain to a Domestic Partner or a child of a Domestic Partner.**

To request Special Enrollment, follow the procedure described under "Enrollment Procedure" in this chapter. To obtain more information about Special Enrollment, contact PCCCD's Employee Service Center.

**B. Loss Of Other Coverage**

If, you did not request enrollment under this Plan for yourself, your Spouse and/or any Dependent Child(ren) within **30 days** after the date on which coverage under the Plan was previously offered because you or they had health care coverage under another group health plan or health insurance policy (including COBRA Continuation Coverage, certain types of individual health insurance, Medicare, or other public program) **and** you (if you are benefits-eligible) along with your Spouse and/or any Dependent Child(ren) **lose coverage** under that other group health plan or health insurance policy; you may request enrollment for yourself and/or your Spouse and/or any Dependent Child(ren) within **30 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 that was provided under COBRA Continuation Coverage, and such COBRA coverage was **"exhausted;"** 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

See also the Enrollment Procedures section of this chapter for more information. Proof of loss of coverage is 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 (as applicable) period of COBRA Continuation Coverage has expired.

**C. Medicaid Or A State Children's Health Insurance Program (CHIP):**

You (if you are benefits-eligible) and your dependents may also enroll in this Plan if you (or your eligible dependents):

- have coverage through **Medicaid or a State Children's Health Insurance Program (CHIP)** and you (or your dependents) **lose eligibility for that coverage**. However, you must request enrollment in this Plan within **60 days** after the Medicaid or CHIP coverage ends. Note that if the individual requests enrollment **within 60 days** of the date of the Special Enrollment opportunity related to **Medicaid or a State Children's Health Insurance Program (CHIP),** generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity; or
- become **eligible for a premium assistance program through Medicaid or CHIP**. However, you must request enrollment in this Plan within **60 days** after you (or your dependents) are determined to be eligible for such premium assistance.

**Start of Coverage Following Special Enrollment**:

**Coverage of an individual enrolling because of loss of other coverage or because of marriage:** If the individual requests Special Enrollment **within 30 days** of the date of the event that created the Special Enrollment opportunity, (except for a newborn and newly adopted child or on account of Medicaid or a State Children's Health Insurance Program (CHIP), (discussed below) generally coverage will become effective on the first day of the month following the date the Plan receives the request for Special Enrollment.

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

- **Coverage of a newborn child/adopted child/child placed for adoption:** Under the Medical plan options, a child is automatically eligible for coverage for the first 30 days after the date of birth, adoption or placement for adoption so long as the child's parent or guardian is covered under the medical plan and the parent/guardian remains eligible for medical plan coverage during that 30-day period. Then, medical plan coverage will continue for that child after the first 30-day period, and required contributions for coverage must be paid, unless the parent/guardian does not want such additional coverage. If coverage beyond the first 30 days after birth is no longer desired, the parent/guardian must contact PCCCD's Employee Service Center to disenroll the child from medical plan coverage.

  If the parent/guardian is not covered under the medical plan at the time of birth, adoption or placement for adoption, the child can be enrolled under the Special Enrollment provisions of this Plan.

  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.

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

**Failure to Enroll During Special Enrollment (Very Important Information):** If you fail to request enrollment for yourself and/or any of your Eligible Dependents within 30 days (or as applicable 60 days) after the date on which you and/or they first become eligible for Special Enrollment, you will not be able to enroll yourself or them until the next Open Enrollment period.

**OPEN ENROLLMENT**

**Open Enrollment Period**: Open Enrollment is the period of time each year to be designated by the Plan Administrator (prior to the July plan year) during which benefits-eligible employees and COBRA qualified beneficiaries may make the elections specified below. Enrollment forms and information may be obtained from PCCCD's Employee Service Center. Individuals enrolled during Open Enrollment should follow the procedures explained at the time of Open Enrollment or the procedures described under "Enrollment Procedure" in this chapter.

**Elections Available During Open Enrollment:** During the Open Enrollment period, you may elect, for yourself and your Eligible Dependents who are eligible for coverage, to:

- **enroll** in one of the medical and dental plans offered by PCCCD, or
- **add or drop** Eligible Dependents to the medical and/or dental plans, or
- **change** health plan options when options are available; or
- **add, drop or change** optional life insurance benefits.

**Restrictions on Elections During Open Enrollment:** No Dependent may be covered unless you are covered. You and all your covered Eligible Dependents must be enrolled for the same medical and dental coverages. All relevant parts of the enrollment form (or enrollment screens if enrolling online) must be completed and the form must be submitted before the end of the Open Enrollment period to PCCCD's Employee Service Center along with proof of Dependent status (as requested). See also the Enrollment Procedures section of this chapter for more information.

**Start of or Changes to Coverage Following Open Enrollment**:

- If you or your Spouse or Dependent Child(ren) are **enrolled for the first time during an Open Enrollment period**, that person's coverage will begin on the first day of the new Plan Year following the Open Enrollment.
- If you or your Spouse or Dependent 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.

**Failure to Make a New Election During Open Enrollment**:

- If you have been enrolled for coverage and you fail to make a new election during the Open Enrollment period, your current election will continue but no FSA enrollment will be added.
- Note, that for employees **to participate in the Plan's Flexible Spending Account for the next Plan Year** the employee must complete a new Flex Plan enrollment form, even if you were enrolled in the Flex plan the previous 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 Plan at the beginning of the Open Enrollment period.

**Failure to Enroll During Open Enrollment (Very Important Information):**

If you fail to enroll yourself and/or any of your Eligible Dependents within the Open Enrollment period (unless your Eligible Dependents qualify for Special Enrollment described in the previous section of this chapter), the following will occur:

a. Your eligible dependents cannot be enrolled until the next Open Enrollment period (unless you have a Special Enrollment opportunity); and

b. You (the employee) will be defaulted into the HDHP BASIC Plan with HSA medical plan with employee only coverage, and no dental plan, optional life insurance coverage or FSA enrollment will be added. It is your responsibility to assure that you are eligible for the HSA. PCCCD will not contribute to an HSA for an ineligible employee. To change medical plan options, you will need to wait until the next Open Enrollment period. Please review the IRS Health Savings Account (HSA) eligibility rules outlined in the "Health Plan Options" chapter. It is your responsibility to notify the PCCCD Employee Service Center if you are NOT eligible to have this Health Savings Account.

   Individuals not eligible for the HSA will not be owed any additional compensation nor will additional monies be set aside in an HSA on their behalf. Individuals who enroll in a Health Savings Account (HSA) but are later determined to be ineligible for that account, are subject to financial penalties from the IRS. Additionally, in these situations there are fees charged to PCCCD to cancel an HSA account. If these fees occur PCCCD will pass on the HSA account cancellation fees to the applicable employee whose HSA account was required to be closed/cancelled. PCCCD will also not be liable for any associated IRS imposed financial penalties.

**LATE ENROLLMENT**

This Plan does not offer a Late Enrollment provision. See the Special Enrollment or Open Enrollment provisions of this chapter.

**NEWBORN DEPENDENT CHILDREN (Special Rule for Coverage)**

**Coverage of a newborn or newly adopted newborn Dependent Child:** Under the Medical plan options, a child is automatically eligible for coverage for the first 30 days after the date of birth, adoption or placement for adoption so long as the child's parent or guardian is covered under the medical plan and the parent/guardian remains eligible for medical plan coverage during that 30-day period. Then, medical plan coverage will continue for that child after the first 30-day period, and required contributions for coverage must be paid, unless the parent/guardian does not want such additional coverage.

If coverage beyond the first 30 days after birth is no longer desired, the parent/guardian must contact PCCCD's Employee Service Center to disenroll the child from medical plan coverage.

If the parent/guardian is not covered under the medical plan at the time of birth, adoption or placement for adoption, the child can be enrolled under the Special Enrollment provisions of this Plan.

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.

Remember that you may not enroll a newborn Dependent Child for coverage unless you, the employee, are also enrolled for coverage. See also the Special Enrollment provisions and the Enrollment Procedure in this chapter.

**ADOPTED DEPENDENT CHILDREN (Special Rule for Coverage)**

Your newborn adopted Dependent Child can be covered from the date that child is adopted or "Placed for Adoption" with you, whichever is earlier, in accordance with the automatic coverage section described under Special Enrollment in this chapter.

- Under the Medical plan options, a child is automatically eligible for coverage for the first 30 days after the date of birth, adoption or placement for adoption so long as the child's parent or guardian is covered under the medical plan and the parent/guardian remains eligible for medical plan coverage during that 30-day period. Then, medical plan coverage will continue for that child after the first 30-day period, and required contributions for coverage must be paid, unless the parent/guardian does not want such additional coverage. If coverage beyond the first 30 days after birth is no longer desired, the parent/guardian must contact PCCCD's Employee Service Center to disenroll the child from medical plan coverage.

  If the parent/guardian is not covered under the medical plan at the time of birth, adoption or placement for adoption, the child can be enrolled under the Special Enrollment provisions of this Plan if the employee enrolls during the Special Enrollment period.

  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.

- **A Dependent Child adopted more than 30 days after the child's date of birth** will be covered from the date that child is adopted or "Placed for Adoption" with you, whichever is earlier, if you submit an online enrollment application or a completed written enrollment form that may be obtained from the PCCCD's Employee Service Center and provide of proof of Dependent status (if requested) and pay any required contribution for that Dependent Child's coverage, within 30 days of the child's adoption or placement for adoption.

If the adopted Dependent child is not properly enrolled in a timely manner, you must wait to enroll them at the next Open Enrollment period or Special Enrollment period, if applicable.

If a child is Placed for Adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child. Remember that you may not enroll an adopted Child or a Child Placed for Adoption for coverage unless you, the employee, are also enrolled for coverage. See also the Special Enrollment provisions and Enrollment Procedure in this chapter.

**WHEN YOU AND ANY OF YOUR DEPENDENTS BOTH WORK FOR PIMA COUNTY COMMUNITY COLLEGE DISTRICT: (Special Rule For Enrollment)**

1. No individual may be covered under this Plan both as an employee and as a Dependent, nor may any Dependent Child be covered as the Dependent of more than one employee.

2. **If both you and your Spouse or Domestic Partner are benefits-eligible employees of PCCCD**, one of you must be designated as the eligible employee who can file the medical coverage choices for the entire family, including the other employee as a Spouse, Domestic Partner and all Dependent Children. The Spouse or Domestic Partner who is **not** designated as the eligible employee may not make any independent coverage elections under the Plan.

   - If the Spouse who selected coverage as an employee terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, the benefits-eligible employee who was covered as Spouse will immediately be deemed to have employee coverage, and the employee who had employee coverage will immediately be deemed to be covered as a Spouse, and all Dependent Children will retain their coverage. Contributions for Dependent coverage will be deducted from the pay of the Employee-Spouse who is now deemed to be the eligible employee. As a result, neither employee will sustain a loss of coverage because of termination of employment or reduction in hours.

   - The Employee-Spouse who is then deemed to be the eligible employee will have the option to terminate the coverage of the Spouse or any Dependent Child or otherwise elect any alternative coverage available under the Plan for the family members provided such election is, in the judgment of the Plan Administrator or its designee, consistent with the change in the family's circumstances as a result of the termination of employment or reduction in hours.

3. **If, while your family coverage is in effect, any of your Dependent Children becomes a benefits-eligible employee of PCCCD and becomes eligible for coverage as an employee**:

   - That child may continue coverage as to be a Dependent Child, or enroll for coverage as an employee.

   - If the employee-child elects to continue coverage as an Employee and later terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, and still qualifies as a Dependent Child, the employee-child will immediately be deemed to be covered as a Dependent Child of the employee-parent. As a result, the employee-child will not sustain a loss of coverage because of termination of employment or reduction in hours. Contributions for Dependent coverage will be deducted from the pay of the employee-parent, and will be adjusted as may be required when a Dependent Child becomes an employee and ceases to have coverage as a Dependent Child, or when the employee-child ceased to be an employee and resumes coverage as a Dependent Child.

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

1. This Plan will provide benefits in accordance with a **National Medical Support Notice**. In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the Plan recognize the child as a dependent even though the child may not meet the Plan's definition of dependent. A QMCSO usually results from a divorce or legal separation and typically:
   - 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.
2. 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.
3. If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent Child of the employee, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the employee, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO, and if the employee is covered by the Plan, and advise them of the procedures to be followed to provide coverage of the Dependent Child(ren).
4. **Enrollment Related to a Valid QMCSO:** If the Plan has determined that an order is a valid QMCSO it will accept enrollment of the alternate recipient as of the earliest possible date following the date the Plan determined the order was valid, without regard to typical enrollment restrictions.
   a. **If the employee is already a 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 Special Enrollment 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 Special Enrollment request is received. Coverage will be subject to all terms and provisions of the Plan, including any requirements for authorization of services, as permitted by applicable law.
   b. **If the benefits-eligible employee is not a Plan Participant** when the QMCSO is received and if the QMCSO orders the employee to provide coverage for the alternate recipient, the Plan will accept a Special Enrollment of the benefits-eligible employee and the alternate recipient specified by the QMCSO. Coverage of the employee and the alternate recipient will become effective as of the date specified on the QMCSO, or if not specified, the first day of the month after the Special Enrollment request is received. Coverage will be subject to all terms and provisions of the Plan, including any requirements for authorization of services, as permitted by applicable law.
5. **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 of the Plan's requirements for enrollment and coverage of that alternate recipient have been satisfied. Contributions required for coverage under a QMCSO are the total employer contributions required for coverage of the employee and all members of the employee's family who are enrolled in the Plan, minus the contributions otherwise actually being paid by the employee.
6. **Termination of Coverage:** Generally, coverage 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. See also the COBRA chapter of this document.
7. **Additional Information:** For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact PCCCD's Employee Service Center.

**PAYMENT FOR YOUR COVERAGE**

A. If you are eligible for and wish to be covered for any of the following benefits, you may be required to make a contribution for each of the benefits you choose. These coverages include: medical, dental, life and AD&D insurance, short term disability and long term disability.

- Your employer pays the difference between the full cost of the entire benefits program and the amount contributed by employees. As a result, your contributions pay part of the cost of coverage for yourself and, where applicable, your Dependents. The amount that you and the other employees pay for this coverage is based on the cost of the Plan for all of the people who work at your location and also depends on the Plan Options selected by each employee.

The specific amount you must pay for coverage is announced annually during the Open Enrollment period or you can contact PCCCD's Employee Service Center for information.

Effective July 1, 2105, note that if you are an active Employee and enrolled in a medical plan option that is a High Deductible Health Plan (HDHP) with a health savings account (HSA), your employer may make a contribution to your Health Savings Account (HSA). The amount and frequency of that contribution is determined by PCCCD (within permissible government guidelines) and announced on an annual basis.

B. You pay your contributions for healthcare coverage and your contribution to the Flexible Spending Accounts on a **before-tax** (pre-tax) basis. This means that your payments for these coverages come from your pay before federal, and in most cases, state taxes are withheld. That way, you should pay less in taxes. However, before-tax contributions do not lower your pay-related benefits such as pension, life insurance and long term disability. The before-tax contributions you make toward your coverage may lower the annual pay used to determine your Social Security benefits if you retire or are disabled. However, because Social Security benefits are calculated on your annual income over the course of your career, with limits and adjustments made according to complex formulas, the effect (if any) of before-tax contributions is likely to be minimal.

C. If you elect coverage for a domestic partner (as defined in this Plan), the contributions you make toward the cost of this coverage and any children of the domestic partner must be deducted on an after-tax basis, in accordance with certain applicable tax law regulations. In addition, the amount your employer pays toward the cost of your domestic partner coverage and coverage for the children of domestic partners must be imputed as income and therefore is taxable to you. If you have questions about the state tax implications of covering a domestic partner or child or a domestic partner contact PCCCD's Employee Service Center.

D. In the case of all benefits insured under group insurance policies, the policies are fully combined for experience. This means that the cost of these insurance coverages is determined on a combined basis, and the costs also are accumulated from year to year. As a result, favorable experience on some insurance coverages in a particular year may be used to offset unfavorable experience on other insurance coverages in the same year, or offset unfavorable experience of insurance coverage in prior years.

**CHANGING YOUR COVERAGE DURING THE YEAR (Mid-Year Change of Status/Election Change)**

**Government regulations generally require that your Plan coverages remain in effect throughout the Plan Year** (from July 1 through June 30), but you may be able to make some changes during the year (mid-year) if the Plan Administrator or its designee determines that you have a permissible **change** in your status (as permitted by the IRS) affecting your benefit needs. Note that this Plan covers Domestic Partners and in order to allow a mid-year change related to a Domestic Partner, that Domestic Partner must meet the requirements of a Dependent under IRS Code Section 152 (d) (1) and (d) (2) (H) without regard to the gross income limit; that is, be a qualifying child or a qualifying relative of the employee. Proof of the change of status event will be required. The following changes are the only ones permitted under the Plan:

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 your, your Spouse's or Dependent Child's employment status or work schedule IF it impairs (or creates) your, your Spouse's or your Dependent Children's 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 or, other leave permitted by your 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.

5. **Change of residence or worksite that allows or impairs** your, your Spouse's 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 your former Spouse to provide that coverage.
7. **Change consistent with your right to Special Enrollment** as described in the section dealing with Special Enrollment in the Eligibility chapter of this document.
8. **Change consistent with entitlement to (or loss of eligibility for) Medicare or Medicaid** affecting you, your Spouse or Dependent Child (except for coverage solely under the program for distribution of pediatric vaccines), including prospective cancellation of coverage of the person entitled to Medicare/Medicaid following such entitlement or prospective reinstatement or election of coverage following loss of eligibility for Medicare/Medicaid.
9. **Automatic Change in the Cost of Coverage**. If the cost of a qualified benefits plan increases or decrease during the Plan year and under the terms of the Plan employees are required to make a corresponding change in their payments, the Plan may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the affected employees' elective contribution for the Plan.
10. **Significant Change in the Cost of Coverage**. If the cost charged to an employee for a benefit package significantly increases or significantly decreases during the Plan year, the Plan may permit the employee to make a corresponding change in election under the Plan. In such a case the employee may start coverage in the Plan option with the decreased cost; or, revoke coverage in the Plan option with an increased cost and elect, on a prospective basis, coverage under another plan option providing similar coverage, if one is available, or drop the coverage if no other such plan option is available.
11. **Significant curtailment without loss of coverage**. If the employee or employee's Spouse or Dependent child has a significant curtailment of coverage under a plan during the Plan year that is not a loss of coverage, the Plan may permit the employee who has been participating in the Plan to revoke his/her election for that coverage and elect to receive, on a prospective basis, coverage under another benefit package option providing similar coverage, or to drop coverage if no similar benefit package option is available. Coverage is significantly curtailed only if there is an overall reduction in coverage provided to participants under the Plan so as to constitute reduced coverage to participants generally.
12. **Addition or elimination of a benefit package option providing similar coverage**. If during a Plan Year, the Plan adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option) the Participant may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.
13. **Addition or significant improvement of any Plan option under the employer's Health Care Programs or the Spouse's employer's health care plans or programs**. In such a case, a Participant may revoke coverage in the current plan and either elect, on a prospective basis, coverage under a new or improved plan option.
14. **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, a Participant may elect, on a prospective basis, the same change in coverage under this Plan that was available under the other plan.
15. **Reduction of Hours.** An employee who was expected to average at least 30 hours of service per week may drop group health plan coverage midyear if the employee's status changes so that the employee is expected to average less than 30 hours of service, even if the reduction of hours does not result in loss of eligibility for the plan. However, the mid-year change must correspond to the employee's intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in other minimum essential coverage (MEC). The new MEC coverage must be effective no later than the first day of the second month following the month in which the original coverage is dropped.

**These rules apply to making changes to your benefit coverage(s) during the year:**

1. Any change you make to your 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. You must notify the Plan in writing within 30 days of the change in status, otherwise, the request will not be considered to be made on account of your change of status and you will have to wait until the next Open Enrollment period to make your 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 you have a permissible change in status, you are only allowed to make changes to your 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. If you will be adding a benefits-eligible individual to the Plan, **coverage changes associated with a mid-year change of status opportunity must be prospective** and are therefore effective the first day of the month following the change provided you submit a completed an online enrollment change application or an enrollment form to PCCCD's Employee Service Center, except for:
   - Newborns, who are effective on the date of birth and
   - Children adopted or placed for adoption, who are effective on the date of adoption or placement for adoption.

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

**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. Proof of the change of status event will be required. This chart is only a summary of some of the permitted medical plan changes and is not all inclusive. This chart should NOT be referenced for a Health FSA or Dependent Care Assistance Plan (DCAP).

| If you experience the following Event... | You may make the following change(s) within 30 days of the Event. | YOU MAY NOT make these types of changes... |
|---|---|---|
| ***REMINDER:*** *Failure to notify the Plan within 60 days of the date of a divorce or the date a child loses eligibility will cause the individuals losing coverage to forfeit the right to elect COBRA continuation coverage.* | | |
| ***Family Events*** | | |
| Marriage | • Enroll yourself, if applicable<br>• Enroll your new Spouse and other eligible dependents<br>• Drop health coverage (to enroll in your Spouse's plan)<br>• Change health plans, when options are available | • Drop health coverage and not enroll in Spouse's plan. |
| Divorce | • Remove your Spouse from your health coverage<br>• Enroll yourself (and your children) if you or they were previously enrolled in your Spouse's plan | • Change health plans<br>• Drop health coverage for yourself or any other covered individual |
| Gain a child due to birth or adoption | • Enroll yourself, if applicable<br>• Enroll the eligible child and any other eligible dependents<br>• Change health plans, when options are available | • Drop health coverage for yourself or any other covered individuals |
| Child requires coverage due to a QMCSO | • Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled)<br>• 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 Dependent's eligibility (*e.g.,* child reaches the maximum age for coverage) | • Remove the Dependent from your health coverage<br>• Dependent will be offered COBRA. You may pay for dependent's COBRA coverage on a pre-tax basis. | • Change health plans<br>• Drop health coverage for yourself or any other covered individuals |
| Death of a dependent (Spouse or child) | • Remove the dependent from your health coverage<br>• 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.<br>• Add the person who lost Medicare/Medicaid entitlement. | • Drop health coverage for yourself or any other covered individuals |
| ***Employment Status Events*** | | |
| Spouse becomes eligible for health benefits in another group health plan | • Remove your Spouse from your health coverage, with proof of Spouse's other new plan coverage<br>• Remove your children from your health coverage, with proof of children's other new plan coverage<br>• Drop coverage for yourself only with proof that Spouse added you to the Spouse's new group health plan | • Change health plans<br>• Add any eligible dependents to your health coverage |

| A Brief Summary of Common Change of Status Events and the Mid-Year Enrollment Changes Allowed Under the Medical Plan<br>Mid-year changes are only those permitted in accordance with Section 125 of the Internal Revenue Code. Proof of the change of status event will be required. This chart is only a summary of some of the permitted medical plan changes and is not all inclusive. This chart should NOT be referenced for a Health FSA or Dependent Care Assistance Plan (DCAP). | | |
|---|---|---|
| **If you experience the following Event...** | **You may make the following change(s) within 30 days of the Event.** | **YOU MAY NOT make these types of changes...** |
| 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<br>• Enroll yourself in a health plan if previously not enrolled because you were covered under your Spouse's plan<br>• 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<br>• 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.*** | | |

**RETURN TO WORK AND BENEFIT CONTINUATION ISSUES**

**If you cease to be a benefits-eligible Employee and then within thirty 30 days return to work in a benefits-eligible position,** you will be required to take the same benefit election for the remaining portion of the Plan year as you had before you terminated. Participation will be effective the first of the month following such election.

**If you cease to be a benefits-eligible Employee and return to work in a benefits-eligible position more than 30 days** following the termination you will be permitted to make a new benefit election for the remaining portion of the Plan year. Participation will be effective the first of the month following such election.

**WHEN COVERAGE ENDS**

**Employee coverage ends on the earliest** of the last day of the month in which:

- your employment ends; or
- you enter the Armed Forces (the military) on full-time active duty; or
- you are no longer eligible to participate in the Plan; or
- you cease to make any contributions required for your coverage; or
- the date the Plan is discontinued; or
- the date of your death.

**Dependent or Domestic Partner coverage ends on the earliest** of the last day of the month in which:

- the Employee's coverage ends; or
- your covered Spouse or Dependent Child(ren) or Domestic Partner or child of a Domestic Partner no longer meet the definition of Spouse or Dependent Child(ren) or Domestic Partner as provided in the Definitions chapter of this document; or
- you cease to make any contributions required for coverage of your Spouse or Dependent Child(ren) or Domestic Partner; or
- the date the Spouse, or Domestic Partner enters the Armed Forces on full-time active duty;
- the date Dependent coverage is discontinued under the Plan; or
- the date of the Dependent's or Domestic Partner's death.

**Note that this Plan does NOT extend COBRA-like temporary coverage to terminated domestic partners.**

**OPTIONS WHEN COVERAGE UNDER THIS PLAN ENDS**

**When coverage under this Plan terminates you may have** the option to:

1. Buy temporary continuation of this group health plan coverage by electing COBRA; or
2. For insured health plan options, convert your coverage to an individual insurance policy (when permitted by the insurance company); or
3. Look into your options to buy an individual insurance policy for health care coverage from 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.

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

**NOTICE TO THE PLAN**

You, your Spouse, your Domestic Partner or any of your Dependent Children **must notify the Plan preferably within 30 days but no later than 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 age 26 and older ceases to have any physical or mental disability);
- Domestic Partner ceases to meet the Plan's definition of Domestic Partner.

***Failure to give this Plan a timely notice (as noted above) may:** 1) cause your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage; 2) cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability; 3) cause claims to not be able to be considered for payment until eligibility issues have been resolved; or 4) result in a participant's liability to the Plan if any benefits are paid to an ineligible person.

For information regarding other notices you must furnish to the Plan, see the General Provisions chapter of this document.

**WHEN THE PLAN CAN END YOUR 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 60 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; 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.

   For example, you must immediately notify PCCCD's Employee Service Center, in writing, of any change in eligibility status for any Dependent enrolled for coverage under the Plan, such as divorce or other event resulting in a loss of eligibility. A failure to notify the Plan of such a change in status will be deemed an act of omission constituting fraud or an intentional misrepresentation of a fact by the Participant and ineligible Dependent.

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.

**LEAVE OF ABSENCE (Special Circumstances)**

**Family and/or Medical Leave (FMLA)**

If you have completed 12 months of employment with your employer in addition to completing at least 1,250 hours of work for your employer in the year preceding the start of leave, you are 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 your own serious illness. Under this Plan a FMLA leave cannot be used to care for a Domestic Partner or child of a Domestic Partner that is seriously ill. However, PCCCD's medical leave may be available for this purpose.

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

While you are officially on such a family or medical leave, you can keep medical and dental coverage for yourself and your Dependents and Domestic Partner or child of a Domestic Partner in effect during that family or medical leave period by continuing to pay your contributions during that leave period. Contact the PCCCD Employee Service Center to make arrangements to pay your employee contributions for coverage while on leave.

While you are on FMLA leave, PCCCD will continue to pay their usual monthly contributions toward your coverage. If you have dependent coverage, you are to pay your dependent contributions as they come due on the dates you would have been paid.

If you have exhausted your FMLA leave you will be offered COBRA continuation of benefits. If you elect to continue your coverage through COBRA, you will be responsible for paying the COBRA premiums directly to our COBRA administrator.

- Whether or not you keep your coverage while you are on family or medical leave, if you return to work promptly at the end of that leave, your health care coverage will be reinstated without any additional limits or restrictions imposed on account of your leave. This is also true for any of your Dependents and Domestic Partner or child of a Domestic Partner who were covered by the Plan at the time you took your leave.
- Of course, any changes in the Plan's terms, rules or practices that went into effect while you were away on that leave will apply to you and your Dependents and Domestic Partner or child of a Domestic Partner in the same way they apply to all other employees and their Dependents and Domestic Partner or child of a Domestic Partner.

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

**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 would otherwise 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 measured from the last day of the month in which the employee stopped working.
- If the employee goes into active military service for **up to 30 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 and provides a copy of the orders. 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 and that coverage will run simultaneously, not consecutively. Contact PCCCD's Employee

Service Center to obtain a copy of the COBRA or 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 **30 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 from the last day of the month in which the employee stopped working. 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 PCCCD's Employee Service Center.

## REINSTATEMENT OF COVERAGE AFTER LEAVES OF ABSENCE

- **If your coverage ends while you are on an approved leave of absence for family, medical or military leave**, your coverage will be reinstated on the first day of the month following your return to active employment in a benefits-eligible position, if you return immediately after your leave of absence ends, subject to all accumulated benefit maximum that were incurred prior to the leave of absence.
- **Special Administrative Leaves: If your coverage ends while you are on an approved leave of absence <u>other than</u> family, medical, or military leave**, your coverage will be reinstated on the first day of the month following your return to active employment in a benefits-eligible position, if you return immediately after your leave of absence ends.

Questions regarding your entitlement to an approved leave of absence and to the continuation of medical and dental coverage should be referred to PCCCD's Employee Service Center.

## CONTINUATION OF COVERAGE

See the COBRA chapter for information on continuing your health care coverage.

# HEALTH PLAN OPTIONS

**MEDICAL PLAN BENEFITS**

Pima County Community College District offers three self-funded medical plan options:

- PPO Plan with Health Reimbursement Account Plan (HRA)
- EPO Plan
- HDHP BASIC Option with Health Savings Account (HSA) Plan
- HDHP Buy-Up Option with Health Savings Account (HSA) Plan

Details about these medical plan options are described in the benefit booklets provided to plan participants by the medical plan claims administrator (whose contact information is contained within the Quick Reference chart of this wrap plan document). The benefit booklets describe the types of benefits, scope of coverage, prerequisites to being covered, and other details regarding the benefits not described within this wrap document.

When enrolled in the PPO Plan, individuals will be automatically enrolled in the Health Reimbursement Account (HRA). When enrolled in a High Deductible Health Plan (HDHP) option, individuals will be automatically enrolled in the Health Savings Account (HSA).Contact PCCCD's Employee Service Center for assistance.

**HIGH DEDUCTIBLE HEALTH PLAN (HDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)**

The High Deductible Health Plan (HDHP) options offered by PCCCD are intended to comply with Code §223(c)(2) to allow your employer (when applicable) and eligible employees to make contributions to a Health Savings Account (HSA). The High Deductible Health Plan has a specific design for the Deductible and Out-of-Pocket Limit and this design is adjusted annually in connection with applicable IRS rules, and as appropriate for Plan administration.

A Health Savings Account is an account owned by an employee. Money deposited into the health savings account can be used (tax-free) by the employee only for **qualified medical expenses**. Qualified medical expenses are those expenses that would generally qualify for the medical and dental expenses deduction for you, your Spouse and tax-qualified dependent children. To be reimbursed on a tax-free basis, qualified medical expenses must be incurred **after** the HSA has been established.

The IRS determines the types of eligible medical expenses that are permitted for tax-free withdrawals from the HSA and it is ultimately your responsibility to assure that you are complying with IRS rules. The account can also be used to buy non-qualified medical expenses but then the employee is required to pay applicable taxes and a financial penalty to the IRS.

The HSA Administrator (whose contact information including website is listed on the Quick Reference Chart in the front of this document) provides 24/7 toll-free access to HSA account services. Additionally, many questions about starting to contribute to an HSA and withdrawing funds from an HSA can be answered by going to the HSA Administrator's website.

**THREE TAX SAVINGS OF A HEALTH SAVINGS ACCOUNT (HSA)**

Health savings accounts (HSA) provide the HSA account owner with three tax savings:
(a) contributions to an HSA reduce their taxable income,
(b) earnings on the HSA account balance grows tax free and
(c) distributions from an HSA are not taxed for qualified expenses.

Note that the IRS code was not amended by PPACA Health Reform regulations to expand the definition of eligible dependents under Health Savings Accounts (HSA) to age 26. This means that employees may only be reimbursed from their tax-free HSA accounts for dependent children who meet the Internal Revenue Code definition of tax dependent (qualifying child or qualifying relative), which is a narrower definition than the applicable definition for federal Health Reform. Money withdrawn from the HSA account for dependent children who are not tax-qualified could cause the employee to be subject to income tax and a 20% penalty. The HSA participant is responsible for filing and payment of taxes on taxable amounts.

Under this HDHP Plan both you and your employer can contribute to the HSA account. However, your employer cannot begin to contribute to your HSA until you take the necessary steps to open a health savings account. Annually, your employer reserves the right to start, stop or adjust any contributions to a Health Savings Account. The amount of your employer's contribution, if any, will be in accordance with permissible government guidelines and is announced at the Open Enrollment period each year.

Each tax year the IRS announces the maximum amount of money that can be contributed to an individual's account (e.g. in in 2019 the maximum is $3,500/individual; $7,000/family)) and you can contact the HSA Administrator (noted on the

Quick Reference Chart in the front of this document) each year for the updated information. Individuals age 55 and older can make additional "catch-up" contributions each year (for example, in 2016 and 2017, the catch-up contributions cannot exceed $1,000). Unused money in the health savings account can grow the account balance because it can be rolled over year after year. The HSA is portable, meaning that the account belongs to you even if you change employers or leave the workforce.

**IMPORTANT:**

In order to open a Health Savings Account (HSA) and have tax-free contributions made to that account, you must be "HSA Eligible." IRS guidelines define an HSA Eligible individual as a person who:

- is covered under a HSA-qualified high deductible health plan (HDHP), and
- has "no other health coverage" (except what is permitted by the IRS), and
- is not enrolled in Medicare, and
- cannot be claimed as a dependent on someone else's tax return.

**By law, you are not eligible for HSA contributions if you:**

- ✓ are enrolled in any portion of Medicare (Part A, Part B, Part C -Medicare Advantage Plans, Part D, and Medigap, a Medicare Supplemental Insurance)*,
- ✓ are covered by another health care plan that is not a qualified high deductible health plan (HDHP),
- ✓ can be claimed as a dependent on someone else's tax return,
- ✓ are covered by a non-HDHP such as Medicaid, TRICARE and TRICARE For Life, or
- ✓ are enrolled in a general purpose Health Care Flexible Spending Account (or covered by a spouse's FSA).

*With respect to being enrolled in Medicare, HSA contributions generally should be discontinued at least six months prior to filing for Medicare benefits, because Medicare enrollment (called Medicare entitlement) can occur retroactively. If you do not stop HSA contributions six months before you apply for Social Security (applying for Social Security is a first step toward Medicare coverage), you may have a tax penalty. The penalty is because you were not supposed to put money into your HSA while you had Medicare coverage. So be sure to stop all contributions to your HSA up to six months before you collect Social Security benefits.

You cannot be covered under your spouse's medical plan or any general purpose Health Flexible Spending Account (Health FSA) that reimburses medical expenses before the deductible is met under the HDHP, a Health Reimbursement Arrangement (HRA) or covered by another plan that pays medical benefits. You could be enrolled in a Dental Plan, Vision Plan, a "limited purpose" Health Flexible Spending Account (Health FSA) that reimburses only dental and vision expenses, or a Dependent Care Flexible Spending Account Plan, and also could have automobile, disability or long-term care insurance coverage.

**Individuals who have a health savings account and are enrolled in Medicare can no longer contribute (or have employer contributions made) to the health savings account but can use the money they have accumulated in that HSA account when they were HSA eligible.**

In order to open a Health Savings Account (HSA) and have tax-free contributions made to that account, you must be "HSA eligible."

If you are defaulted into the HDHP because you failed to submit your medical election or your documentation waiving coverage within the enrollment deadlines, it is your responsibility to notify PCCCD Employee Service Center is you are ineligible for HSA contributions.

Individuals not eligible for the HSA will not be owed any additional compensation nor will additional monies be set aside in an HSA on their behalf. Individuals who enroll in a Health Savings Account (HSA) but are later determined to be ineligible for that account, are subject to financial penalties from the IRS. Additionally, in these situations there are fees charged to PCCCD to cancel an HSA account. If these fees occur PCCCD will pass on the HSA account cancellation fees to the applicable employee whose HSA account was required to be closed/cancelled. PCCCD will also not be liable for any associated IRS imposed financial penalties.

**Note about Use of an HSA Account for Dependent Child Expenses:** To use funds in a health savings account to reimburse eligible medical expenses for a dependent child, the IRS requires that a HSA account holder must be able to "claim" the child as a dependent on their tax return. If the account holder cannot claim the child as a dependent, then HSA dollars cannot be used to pay for/reimburse services provided to that child. This means that you could cover your 24-year-old child on the High Deductible Health Plan but not be able to use funds in your health savings account for that child if the child is not your tax-qualified dependent.

**HSA and Domestic Partners:** The federal tax rules governing HSAs and domestic partners vary depending on whether the domestic partner is a tax dependent. It is best to consult your tax advisor on whether your domestic partner is a tax dependent.

- **If your domestic partner is a tax dependent:** HSA disbursements from the employee's HSA account for your domestic partner's qualified medical expenses are tax-free. The domestic partner cannot contribute to his or her own HSA. Individuals who can be claimed as dependents on a tax return are not eligible to open their own HSA.
- **If your domestic partner isn't a tax dependent:** HSA disbursements from the employee's HSA account for their domestic partner's medical expenses would be taxable and would also generally be subject to the 20% excise tax. However, there may be situations where the domestic partner may open his or her own HSA and make contributions. IT is best to check with the HSA administrator.

**Information about Health Savings Account Contributions and Prorating the Maximum Yearly Contribution:** If you aren't certain you'll be enrolled in a HDHP during the entire next tax year, you can contribute a prorated amount for the months you're actually eligible in the current tax year. To do this, divide the yearly allowable maximum contribution by 12, then multiply the result by the number of months you're enrolled in a HDHP during that tax year.

Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your HDHP. If you are enrolled in the HDHP as of December 1, you are considered to be an eligible individual for HSA contributions for the entire tax year and you are not required to prorate your contributions to your health savings account. However, if you base an entire tax year's contribution on your status on December 1 and you cease to be an eligible individual before the end of the following year, any funding of the health savings account over the prorated amount (for December) is considered an excess health savings account contribution and the excess amount is subject to a penalty and income tax.

Note too that an employee cannot use money from the HSA to cover the medical expenses of a Domestic Partner without paying income taxes and a 10% penalty tax, unless the Domestic Partner is a tax-qualified dependent.

A few states (like California and New Jersey) do not conform their state tax laws with federal tax laws and contributions to the HSA may be taxed under these state laws. It is advisable to discuss with your tax advisor about joining a HDHP with HSA. Remember, **it is your responsibility to assure that you are an "HSA eligible" individual while contributions are made to your HSA account**.

Questions about the High Deductible Health Plan described in this document can be directed to the PCCCD Employee Service Center.

The plan administrator does not provide tax advice and no inference may be made that the information contained here constitutes tax advice. The tax information contained in this document is for general guidance only and is subject to change due to changes in IRS rules and regulations. You should consult a qualified tax advisor with regard to any questions you may have about the tax effects of an HSA on your individual circumstances. The plan administrator assumes no responsibility for the accuracy of tax statements expressed in this document in relation to an individual's tax situation.

**DENTAL PLAN BENEFITS**

Pima County Community College District offers two insured dental plan options:

- DMO Plan
- PPO Plan

Details about the Dental Plans are described in the booklets provided to plan participants by the dental plan insurance companies. Contact PCCCD's Employee Service Center for assistance.

**LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE**

Pima County Community College District offers a fully insured life insurance plan and a fully insured accidental death and dismemberment plan for employees. Details about these benefits is described in the booklet(s) provided to plan participants by the life insurance company. Contact PCCCD's Employee Service Center for assistance.

**SHORT TERM DISABILITY AND LONG TERM DISABILITY BENEFITS**

Pima County Community College District offers a fully insured short term disability (STD) plan and a fully insured long term disability (LTD) plan for employees. Details about these benefits is described in the booklet(s) provided to plan participants by the disability plan insurance company. Contact PCCCD's Employee Service Center for assistance.

# OUTPATIENT PRESCRIPTION DRUG BENEFITS: RETAIL & 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 the PCCCD-sponsored Medical plans. The outpatient prescription drug benefits are self-funded by PCCCD and administered by an independent Prescription Benefit Manager (whose name and contact information is listed on the Quick Reference Chart in the front of this document).

The Prescription Benefit Manager extends discounts on drugs purchased at network pharmacy locations to individuals enrolled in the PCCCD-sponsored Medical Plans and also processes prescription drug claims and appeals.

## 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. The outpatient prescription drug benefits also include certain over-the counter drugs in compliance with Health Reform.

- **Retail Drugs**: To obtain your discounted supply of medicine, for the copayment noted in the chart below, present your ID card to any In-Network retail pharmacy. Contact the Prescription Benefit Manager (whose name is listed on the Quick Reference Chart) for the location of In-Network retail pharmacies. You can purchase a 30-day supply of medication at the retail pharmacy.
- **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, arthritis, or diabetes unless the drug is considered a specialty drug. Note that not all medicines are available via mail order. Check with the Prescription Benefit Manager 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 Benefit Manager (whose address is listed on the Quick Reference Chart). Mail order forms may be obtained from the Prescription Benefit Manager. Allow up to 10 days to receive your order.
- **Specialty Drugs**: Specialty drugs are available on an outpatient basis by contacting the Prescription Benefit Manager. 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. Specialty drugs include treatment for certain chronic conditions such as multiple sclerosis, rheumatoid arthritis or hepatitis. Specialty drugs may need precertification, often require special handling, are date sensitive and are generally available only in a 30-day quantity.

## PRESCRIPTION DRUG PLAN DESIGN

If you are enrolled in the PCCCD-sponsored PPO Medical Plan, these are your Outpatient Prescription Drug Benefits. The Medical Plan deductible does not have to be met in order to start obtaining these drug benefits:

| OUTPATIENT DRUG BENEFITS FOR FOR THE PPO PLAN | | | | |
|---|---|---|---|---|
| **Outpatient Drug Benefits** | **In-Network Retail Pharmacy (up to a 30-day supply for the 1st and 2nd fill)** You pay the following | **In-Network Retail Pharmacy (up to a 30-day supply for the 3rd fill and thereafter)** 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)** |
| **Generic:** | $5.00 copay | $15.00 copay | $10.00 copay | You pay the same as if drug purchased at a Retail Pharmacy |
| **Preferred Brand Name:** | $25.00 copay | $60.00 copay | $55.00 copay | |
| **Non-Preferred Brand Name:** | $40.00 copay | $90.00 copay | $85.00 copay | |

Under the PPO medical plan option, outpatient prescription drugs accumulate to meet a separate outpatient drug annual Out-of-Pocket Limit of $3,800. The out-of-pocket limit is adjusted annually.
See also the section on Coverage of Certain Over-the-Counter Drugs on the pages that follow this chart.
A 30-day supply of diabetic supplies is available for a $10 copay for Generic and $20 for Brand at a Retail Pharmacy.
A 90-day supply of diabetic supplies is available for a $40 copay for Generic and $85 for Brand at Home Delivery Pharmacy.

If you are enrolled in the PCCCD-sponsored EPO Medical Plan, these are your Outpatient Prescription Drug Benefits. The Medical Plan deductible does not have to be met in order to start obtaining these drug benefits:

| OUTPATIENT DRUG BENEFITS FOR THE EPO PLAN | | | | |
|---|---|---|---|---|
| **Outpatient Drug Benefits** | **In-Network Retail Pharmacy (up to a 30-day supply for the 1st and 2nd fill)** You pay the following | **In-Network Retail Pharmacy (up to a 30-day supply for the 3rd fill and thereafter)** 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)** |
| **Generic:** | $10.00 copay | $30.00 copay | $10.00 copay | You pay the same as if drug purchased at a Retail Pharmacy |
| **Preferred Brand Name:** | $30.00 copay | $120.00 copay | $55.00 copay | |
| **Non-Preferred Brand Name:** | $45.00 copay | $180 copay | $85.00 copay | |
| Under the EPO medical plan option, outpatient prescription drugs accumulate to meet a separate outpatient drug annual Out-of-Pocket Limit of $3,400 per person. The out-of-pocket limit is adjusted annually.<br>See also the section on Coverage of Certain Over-the-Counter Drugs on the pages that follow this chart.<br>A 30-day supply of diabetic supplies is available for a $10 copay for Generic and $20 for Brand at a Retail Pharmacy.<br>A 90-day supply of diabetic supplies is available for a $40 copay for Generic and $85 for Brand at Home Delivery Pharmacy. | | | | |

If you are enrolled in a PCCCD-sponsored **HDHP BASIC Medical Plan**, these are your Outpatient Prescription Drug Benefits. The annual **Medical Plan deductible must be met before the Plan will start to pay for these drug benefits**:

| OUTPATIENT DRUG BENEFITS FOR THE HDHP PLAN | | | | |
|---|---|---|---|---|
| **Outpatient Drug Benefits** | **In-Network Retail Pharmacy (up to a 30-day supply for the 1st and 2nd fill)** You pay the following | **In-Network Retail Pharmacy (up to a 30-day supply for the 3rd fill and thereafter)** 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)** |
| **Generic:** | 20% coinsurance after the HDHP medical plan deductible has been met. | | | |
| **Preferred Brand Name:** | | | | |
| **Non-Preferred Brand Name:** | | | | |
| Under the HDHP BASIC medical plan, outpatient prescription drugs accumulate to meet the medical plan's annual Out-of-Pocket Limit of $6,550/person. The out-of-pocket limit is adjusted annually.<br>See also the section on Coverage of Certain Over-the-Counter Drugs on the pages that follow this chart.<br>A 30-day supply of diabetic supplies is available for a $10 copay for Generic and $20 for Brand at a Retail Pharmacy.<br>Not subject to deductible.<br>A 90-day supply of diabetic supplies is available for a $40 copay for Generic and $85 for Brand at Home Delivery Pharmacy.<br>Not subject to deductible. | | | | |

If you are enrolled in a PCCCD-sponsored **HDHP Buy-Up Medical Plan**, these are your Outpatient Prescription Drug Benefits. The annual **Medical Plan deductible must be met before the Plan will start to pay for these drug benefits**:

<table>
<tr><th colspan="5">OUTPATIENT DRUG BENEFITS FOR THE HDHP PLAN</th></tr>
<tr><th>Outpatient Drug Benefits</th><th>In-Network Retail Pharmacy (up to a 30-day supply for the 1st and 2nd fill)<br>You pay the following</th><th>In-Network Retail Pharmacy (up to a 30-day supply for the 3rd fill and thereafter)<br>You pay the following</th><th>Mail Order Service (up to a 90-day supply)<br>You pay the following:</th><th>Specialty Drug Program (up to a 30-day supply)</th></tr>
<tr><td>Generic:</td><td colspan="4" rowspan="3">There is no charge after the HDHP medical plan deductible has been met.</td></tr>
<tr><td>Preferred Brand Name:</td></tr>
<tr><td>Non-Preferred Brand Name:</td></tr>
<tr><td colspan="5">Under the HDHP Buy-Up medical plan, outpatient prescription drugs accumulate to meet the medical plan's annual Out-of-Pocket Limit of $3,000/person. The out-of-pocket limit is adjusted annually. See also the section on Coverage of Certain Over-the-Counter Drugs on the pages that follow this chart.<br>A 30-day supply of diabetic supplies is available for a $10 copay for Generic and $20 for Brand at a Retail Pharmacy.<br>Not subject to deductible.<br>A 90-day supply of diabetic supplies is available for a $40 copay for Generic and $85 for Brand at Home Delivery Pharmacy.<br>Not subject to deductible.</td></tr>
</table>

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.

When prescribed, coverage is provided for prenatal vitamins and self-administered injectables (such as Epipen and Glucagon).

**Diabetic Supplies:** Coverage includes insulin, pre-filed insulin syringes for the blind, oral agents for controlling blood sugar, injection aids (e.g. lancets and lancet devices, alcohol swabs), syringes, needles, glucose test strips, visual reading ketone strips and urine test strips. Present your drug ID card and prescription to a network pharmacy to obtain diabetic supplies for the copayments noted above. Blood glucose testing meter/devices are payable under the medical plan, not this outpatient prescription drug benefit.

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

The following chart outlines the current preventive care over the counter (OTC) and prescription drugs that are payable by the PCCCD-sponsored non-grandfathered medical plan options, in accordance with Affordable Care Act (ACA) regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations. To be **payable at no charge**, drugs must be:

a. obtained through the outpatient Prescription Drug Program at a participating network retail or mail order pharmacy, and

b. presented to the pharmacist along with a prescription for the OTC drug from your Physician or Health Care Practitioner.

Note that while these OTC drugs require a prescription, insulin is payable by the Plan without a prescription. Where the information in this document conflicts with newly released Affordable Care Act regulations affecting the coverage of preventive OTC 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 Preventive Drugs in addition to a prescription from your Physician or Health Care Practitioner: |
|---|---|---|---|
| Aspirin | • For pregnant women who are at high risk for preeclampsia (a pregnancy complication).<br>• 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 is not established by USPSTF, plan covers up to one bottle of generic 100 tablets every 3 months.<br>For pregnant women at high risk for preeclampsia: plan covers daily low dose aspirin (81mg) as preventive medication after 12 weeks' gestation.<br>The use of aspirin is recommended when the potential benefit outweighs the potential harm due to an increase in gastrointestinal hemorrhage. |
| 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 month's supply of FDA-approved contraceptives per purchase (or 3-month supply of certain 90-day dosed contraceptives like Seasonale) 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 when obtained from a network provider. Brand contraceptives are payable only if a generic alternative is medically inappropriate as determined by the patient's attending Physician or Health Care Practitioner, or is unavailable. |
| 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.<br>Plan covers generic folic acid up to one tablet per day. |
| Tobacco cessation products | 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 12-week courses of treatment per year, which applies to all products. No precertification or prior authorization is required. |
| Fluoride supplements | For children age 6 months 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 50-75 years. |

| Drug Name | Who Is Covered for this Drug? | Cost-Sharing? | Payment Parameters for ACA-Mandated Preventive 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 or raloxifene. |
| 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:<br>1) they are ages 40 to 75 years;<br>2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and<br>3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater.<br>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.<br>Brand statins are payable only if a generic alternative is medically inappropriate, as determined by the Physician or Health Care Practitioner. |

## 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. After purchasing, you may send your drug receipt to the Prescription Benefit Manager (PBM) following the Direct Member Reimbursement (DMR) process. For information on the DMR process and to obtain DMR forms, contact the Prescription Benefit Manager whose information is listed in the Quick Reference Chart of this document.

For eligible prescriptions 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.

## MANAGEMENT OF THE PRESCRIPTION DRUG BENEFIT

Contact the Prescription Benefit Manager (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 Pharmacy Benefit Manager's (PBM) **National Preferred drug formulary**
- Information on **drugs needing preapproval** by the clinical staff of the PBM (such as sleeping pills, certain pain medication and compounded drugs costing $300 or more).
- Information on which **drugs have a limit to the quantity** payable by this Plan (such as anti-migraine drugs and erectile dysfunction 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.
- The **Compound Drug Management Program** where certain substances added to compound drugs are not covered by the Plan. If your provider orders a compound drug with one of these non-covered substances (like flurbiprophen powder), the pharmacy will contact your provider to discuss an alternate FDA-approved substance.

## 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 medications, except insulin and products listed under the section titled "Coverage of Certain Over the Counter (OTC) Preventive Care Drugs Mandated By the Affordable Care Act (ACA)" that the Plan must cover in compliance with ACA regulations.
2. cosmetic drugs such as to promote hair growth or to promote hair loss, anti-wrinkle cream
3. non-prescription contraceptives for males such as condoms
4. fertility products or agents
5. weight management drugs
6. 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.
7. 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.

## 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 all of the PCCCD medical plan options is "creditable."** "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan Participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Because this Plan's prescription drug coverage is as good as Medicare, 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.

> **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.

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.

For more information about creditable coverage or Medicare Part D coverage see the PCCCD Notice of Creditable Coverage (a copy is available from the PCCCD Employee Service Center). See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

## OUTPATIENT PRESCRIPTION DRUG CLAIM APPEAL PROCEDURES

**TIME LIMIT FOR INITIAL FILING OF OUTPATIENT PRESCRIPTION DRUG CLAIMS**

All post-service outpatient prescription drug claims must be submitted to the Prescription Benefit Manager 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, you may appeal that denial by following the steps in this Claim Appeal section. PCCCD has delegated final claims and appeal authority for the outpatient prescription drug benefits of this Plan to the independent Prescription Benefit Manager. This section discusses the claim appeal process (also referred to as the coverage review).

**Coverage Review Description**

You have the right to request that a medication be covered or be covered at a higher benefit (e.g. lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. The Prescription Benefit Manager reviews both clinical and administrative coverage review requests:

- **Clinical coverage review request**: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.
- **Administrative coverage review request**: A request for coverage of a medication that is based on the Plan's benefit design.

The contact information for where to submit a coverage review (an appeal) is located on the Quick Reference Chart in the front of this document.

**How To Request An Initial Coverage Review**

The preferred method to request an initial clinical coverage review is for the prescriber or dispensing Pharmacist to call the Prescription Benefit Manager's Coverage Review Department at the phone number listed on the Quick Reference Chart in the front of this document. Alternatively, the prescriber may submit (via fax) a completed coverage review form. Coverage review forms may be obtained online at the website listed on the Quick Reference Chart. Coverage review requests may also be mailed to the Prescription Benefit Manager's address noted on the Quick Reference Chart.

Home Delivery coverage review requests are automatically initiated by the Prescription Benefit Manager's Home Delivery pharmacy as part of filling the prescription.

To request an initial administrative coverage review, you or your authorized representative must submit the request in writing to the Prescription Benefit Manager.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by the provider by contacting the Prescription Benefit Manager by phone (contact information on the Quick Reference Chart).

**How A Coverage Review Is Processed**

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to the Prescription Benefit Manager for review. For an administrative coverage review request, the member must submit information to the Prescription Benefit Manager to support their request.

**The initial determination and notification to the patient and prescriber will be made within the specified timeframes as follows:**

| Type of claim | Decision Timeframe<br>Decisions are completed as soon as possible from receipt of request but no later than: | Notification of Decision | |
|---|---|---|---|
| | | Approval | Denial |
| **Standard Pre-Service*** | 15 days (Retail)<br>5 days (home delivery) | Patient: automated call (letter if call not successful)<br>Prescriber: Fax (letter if fax not successful) | Patient: letter<br>Prescriber: Fax (letter if fax not successful) |
| **Standard Post-Service*** | 30 days | Patient: automated call (letter if call not successful)<br>Prescriber: Fax (letter if fax not successful) | Patient: letter<br>Prescriber: Fax (letter if fax not successful) |
| **Urgent** | 72 hours | Patient: automated call and letter<br>Prescriber: Fax (letter if fax not successful) | Patient: live call and letter<br>Prescriber: Fax (letter if fax not successful) |

*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

**How To Request A Level 1 Appeal Or Urgent Appeal After An Initial Coverage Review Has Been Denied**

When an initial coverage review has been denied (adverse benefit determination), a request for appeal may be submitted by the member or authorized representative within **180 days** from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests (contact information on the Quick Reference Chart):

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax (contact information on the Quick Reference Chart).

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

**How A Level 1 Appeal Or Urgent Appeal Is Processed**

The Prescription Benefit Manager completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by a Prescription Benefit Manager's Pharmacist, Physician, panel of clinicians, trained prior authorization staff member, or independent third party utilization management company. Appeal decisions and notifications are made as follows:

| Type of Appeal | Decision Timeframe<br>Decisions are completed as soon as possible from receipt of request but no later than: | Notification of Decision | |
|---|---|---|---|
| | | Approval | Denial |
| **Standard Pre-Service** | 15 days | Patient: automated call (letter if call not successful)<br>Prescriber: Fax (letter if fax not successful) | Patient: letter<br>Prescriber: Fax (letter if fax not successful) |
| **Standard Post-Service** | 30 days | Patient: automated call (letter if call not successful)<br>Prescriber: Fax (letter if fax not successful) | Patient: letter<br>Prescriber: Fax (letter if fax not successful) |
| **Urgent** | 72 hours | Patient: automated call and letter<br>Prescriber: Fax (letter if fax not successful) | Patient: live call and letter<br>Prescriber: Fax (letter if fax not successful) |

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

**How To Request A Level 2 Appeal After A Level 1 Appeal Has Been Denied**

When a level 1 appeal has been denied (adverse benefit determination), a request for a level 2 appeal may be submitted to the Prescription Benefit Manager by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination

Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax (contact information on the Quick Reference Chart).

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

**How A Level 2 Appeal Is Processed**

The Prescription Benefit Manager completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by the Prescription Benefit Manager's Pharmacist, Physician, panel of clinicians or independent third party utilization management company.

Appeal decisions and notifications are made as follows:

| Type of Appeal | Decision Timeframe<br>Decisions are completed as soon as possible from receipt of request but no later than: | Notification of Decision | |
|---|---|---|---|
| | | Approval | Denial |
| **Standard Pre-Service** | 15 days | Patient: automated call (letter if call not successful)<br>Prescriber: Fax (letter if fax not successful) | Patient: letter<br>Prescriber: Fax (letter if fax not successful) |

| Type of Appeal | Decision Timeframe<br>Decisions are completed as soon as possible from receipt of request but no later than: | Notification of Decision | |
|---|---|---|---|
| | | Approval | Denial |
| **Standard Post-Service** | 30 days | Patient: automated call (letter if call not successful)<br>Prescriber: Fax (letter if fax not successful) | Patient: letter<br>Prescriber: Fax (letter if fax not successful) |
| **Urgent** | 72 hours | Patient: automated call and letter<br>Prescriber: Fax (letter if fax not successful) | Patient: live call and letter<br>Prescriber: Fax (letter if fax not successful) |

**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.
- **Claim** – A request for a Plan benefit that is made in accordance with the Plan's established procedures for filing benefit claims.
- **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 Benefit Manager 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.

**Voluntary 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" related to medical necessity, appropriateness, health care setting, level of care, experimental/investigational or effectiveness for outpatient prescription drug benefits under this Plan may be permitted to further appeal that denial using the **voluntary external review process**. The external review process provides individuals with another option (a voluntary option) for protesting the denial of their claim.

PCCCD pays for the cost of an external review. The Prescription Benefit Manager contracts with at least three Independent Review Organizations (IRO) and when an external review is requested, will rotate the case among the IROs.

**Definitions Pertinent To The External Review Process Provided By The Prescription Benefit Manager**

- **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 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 Benefit Manager 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 Benefit Manager will conduct a "preliminary review" to ensure that the request qualifies for External Review. In this preliminary review, the Prescription Benefit Manager will determine whether:

- The individual is or was covered under the Plan at the time the prescription drug benefit at issue was requested, or in the case of a retrospective review, was covered at the time the prescription drug 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 Benefit Manager 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 Benefit Manager will assign the request to one of the IROs with which the Prescription Benefit Manager 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 Benefit Manager (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 Benefit Manager, 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 Benefit Manager, 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 Benefit Manager 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.

**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 Benefit Manager 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 Benefit Manager will determine whether the request meets the reviewability requirements described above for standard External Review. Immediately upon completing this review, the Prescription Benefit Manager 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 Benefit Manager will assign an IRO to review the individual's Claim. The Prescription Benefit Manager 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 Benefit Manager, 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 Benefit Manager, on behalf of the Plan, with written confirmation of its decision.

**Authority for Review**

The Prescription Benefit Manager 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 Benefit Manager 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.

## 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

## CONTINUATION OF COVERAGE (COBRA)

### Entitlement to COBRA Continuation Coverage

In compliance with a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly called COBRA), eligible employees, and their covered Dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

A Healthcare Reimbursement Arrangement (HRA) is a group health plan subject to COBRA's continuation requirements. Under this Plan, the HRA is combined with the medical plan when you elect COBRA continuation coverage for the HRA. If an individual elects COBRA coverage for the HRA, the HRA contribution will continue at the same time and at the same increment as exists for similarly situated non-COBRA beneficiaries.

### 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 of losing coverage under this Plan, even if that plan generally does not accept late enrollees.

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

**NOTE:** Domestic Partners and children of Domestic Partners (as defined in this Plan) **are NOT** offered the ability to elect "COBRA-like" temporary continuation of benefits when coverage ends.

**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.**

**COBRA Administrator**: 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 in the front of this document.

*IMPORTANT:*
*This chapter summarizes your rights and obligations under the COBRA Continuation Coverage law. It is provided to all covered employees, and their covered Spouses and is intended to inform them (and their covered dependents, if any) in a summary fashion about COBRA coverage, when it may become available and what needs to be done to protect the right to receive COBRA coverage. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that you and your Spouse take the time to read this chapter carefully and be familiar with its contents.*

### 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. Covered employees may elect COBRA on behalf of their spouses and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment and Open Enrollment.

1. **"Qualified Beneficiary"**: Under the law, a Qualified Beneficiary is any Employee or the Spouse or Dependent Child of an employee who is 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 who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.
    - A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a

"Qualified Beneficiary." This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

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 individual LOSES health care coverage under this Plan**. If a covered individual has a Qualifying Event but, as a result, **does not lose** their health care coverage under this Plan, (*e. g.* employee continues working even though entitled to Medicare) then COBRA is not available.

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] | | |
|---|---|---|---|
| | Employee | Spouse | Dependent Child(ren) |
| Employee terminates (for other than gross misconduct), including retirement. | 18 months | 18 months | 18 months |
| Employee's reduction in hours worked (making employee ineligible for health care 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 |

[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.*

**Special Enrollment Rights**

You have special enrollment rights under federal law that allow you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days (or as applicable 60 days) after your group health coverage ends because of the Qualifying Events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

**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 (making a total of 29 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.

**Medicare Entitlement**

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

**Procedure for Notifying the Plan of a Qualifying Event (Very Important Information)**

In order to have the chance to elect COBRA Continuation Coverage after loss of coverage due to a divorce or legal separation, or a child ceasing to be a "dependent child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that Qualifying Event occurs.**

That written notice should be sent to the COBRA Administrator whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your 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 not received by the COBRA Administrator within the 60-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.**

Officials of the employee's own employer should notify the COBRA Administrator of an employee's death, termination of employment, reduction in hours, or entitlement to Medicare. However, **you or your family should also promptly notify the COBRA Administrator in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

**Notices Related to COBRA Continuation Coverage**

When:

a. **your employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to health care coverage under the Plan, you died, have become entitled to Medicare, or

b. **you notify the COBRA Administrator** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

**then** the COBRA Administrator will give you and/or your covered Dependents notice of the date on which your coverage ends and 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, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice to elect COBRA Continuation Coverage.

**NOTE: If you and/or any of your covered dependents do not choose COBRA coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.**

**The COBRA Continuation Coverage That Will Be Provided**

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you 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 you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families that same change will apply to your COBRA Continuation Coverage.

When COBRA Continuation Coverage of your participation in the health care flexible spending account (Health FSA) is available, it will be on the same terms outlined above for group health 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.

If you are participating in a **health flexible spending account (Health FSA)** at the time of the Qualifying Event, you will only be allowed to continue that Health FSA until the end of the current flex plan year in which the Qualifying Event occurred.

- Continuation of the Health FSA under COBRA is offered only when the employee's Health FSA is underspent when the qualifying event occurs (meaning that the underspent amount in the Health FSA exceeds the COBRA premium for that period).
- COBRA coverage is not offered to a Qualified Beneficiary who has exhausted their Health FSA, or whose Health FSA does not exceed the COBRA premium, at the time of the qualifying event.
- A Qualified Beneficiary's participation in the Health FSA will cease at the earlier of the end of the plan year in which the qualifying event occurs or if the COBRA premium payment is not made.
- When COBRA Continuation Coverage of your participation in the health care flexible spending account (Health FSA) is available, it will be on the same terms as for group health coverage, but since the person who elects COBRA will generally 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)**

Any person who elects COBRA Continuation Coverage must 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. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

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

**IMPORTANT**

**There may not be invoices or payment reminders for COBRA premium payments. You are responsible for making sure that timely COBRA premium payments are made to the COBRA Administrator.**

**Grace Period**

The **initial payment** for the COBRA Continuation Coverage is due to the COBRA Administrator **no later than 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 30-day 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 COBRA Continuation Coverage**

If a Health Care Provider requests confirmation of coverage and you, your 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** you, your 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.

**HIPAA Special Enrollment and COBRA**

- **Addition of Newly Acquired Dependents**

  If, while you (the employee) are enrolled for COBRA Continuation Coverage, you have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that child for COBRA Continuation Coverage if you do so within 30 days after the birth, adoption, or placement for adoption. The child will be entitled to the full duration of COBRA.

  If you marry while you are enrolled for COBRA, your spouse is not a Qualified Beneficiary, but the spouse can be added for the remainder of the duration of your existing COBRA coverage.

  Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the COBRA Administrator to add a dependent.

- **Loss of Other Group Health Plan Coverage**

If, while you (the employee) are enrolled for COBRA Continuation Coverage your Spouse or dependent loses coverage under another group health plan, you may enroll the Spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The Spouse or dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the Spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the Spouse or dependent within 30 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

**Notice of Unavailability of COBRA Coverage**

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 the COBRA Administrator an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

**Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period**

A Spouse and Dependent Child who already have COBRA coverage, and then experience a second qualifying event, may be entitled to extend their COBRA from 18 or 29 months, to a total of 36 months of COBRA coverage. Second qualifying events may include the death of the covered employee, divorce [or legal separation] from the covered employee, the covered employee becoming entitled* to Medicare benefits (under Part A, Part B or both), or a Dependent Child ceasing to be eligible for coverage as a dependent under the group health plan.

NOTE: Medicare entitlement is not a Qualifying Event under this Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for Spouses and dependents who are Qualified Beneficiaries.

**Notifying the Plan:** To extend COBRA when a second Qualifying Event occurs, you 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 your 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 your Spouse 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 you (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.

**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 you or a covered Spouse or Dependent Child is 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 at some time before the 60th day of COBRA Continuation Coverage; **and**

- the disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.

**Notifying the Plan**: you or another family member need to follow this procedure (to notify the Plan) by sending a written notification to the COBRA Administrator of the Social Security Administration determination within 60 days after that determination was received by you 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 name of the disabled person, 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. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage may be 50% higher than the cost for coverage during the first 18-month period.
3. The COBRA Administrator must also be notified within 30 days of the determination by the Social Security Administration that you are 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 premium payment amount due for COBRA coverage is **not paid in full and on time**;
2. The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;
3. The date, after the date of the COBRA election, on which the Qualified Beneficiary first becomes covered under another group health plan. IMPORTANT: The Qualified Beneficiary must notify this Plan as soon as possible once they become aware that they will become covered under another group health plan, by contacting the COBRA Administrator. COBRA coverage under this Plan ends on the date the Qualified Beneficiary is covered under the other group health plan.
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;
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);
6. The date the employer no longer provides group health coverage to any of its employees.

Once COBRA coverage terminates early it cannot be reinstated.

**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.

Once COBRA coverage terminates early it cannot be reinstated.

**COBRA Questions or To Give Notice of Changes in Your Circumstances**

If you have any questions about your COBRA rights, please contact the COBRA Administrator whose address is listed on the Quick Reference Chart in the front of this document.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit their website at www.dol.gov/ebsa. The addresses and phone numbers of Regional and District EBSA offices are available through this website.

**Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you must notify the COBRA Administrator:**

1. within 30 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 you or a covered dependent Spouse or 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 health 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 (or in some cases 26 week) period, a loss of coverage could occur earlier.

- **Leave of Absence (LOA) and COBRA**

  If an employee is offered alternative health care coverage while on LOA, and this alternate coverage is **not identical** in cost (increase in premium), or benefits to the coverage in effect on the day before the LOA, then such alternate coverage does not meet the COBRA requirement, and is considered to be a loss in coverage requiring COBRA to be offered. If a Qualified Beneficiary rejects the COBRA coverage, the alternative plan is considered to be a different group health plan and, as such, after expiration of the LOA, no COBRA offering is required. If the alternative coverage is identical in cost and benefits but the coverage period is **less than** the COBRA maximum period (18, 29, 36 months), the lesser time period can be credited toward covering the 18, 29, or 36-month COBRA period. For example, if an employee is allowed to maintain the same coverage and premium for six months while on an LOA, the six months can be credited toward the COBRA maximum period.

# GENERAL PROVISIONS

## NAME OF THE PLAN

Pima County Community College District (PCCCD)

## NAME AND ADDRESS OF EMPLOYER MAINTAINING THE PLAN

Pima County Community College District
4905D East Broadway Blvd.
Tucson, Arizona 85709-1235
Phone: (520) 206-4945
TTY: (520) 206-4530
Fax: (520) 206-4969
Email: ESC@pima.edu

## TYPE OF ADMINISTRATION/TYPE OF FUNDING

- Various independent claims administrators (whose name and address are listed on the Quick Reference Chart in the front of this document) administer the self-funded benefits of this Plan and provide payment of claims with claim appeal decisions associated with these benefits. Benefits under the following programs are **self-insured/self-funded** out of the Pima County Community College District's reserve account: medical plans, outpatient prescription drug benefits, health reimbursement account, health savings account, flexible spending account administration and COBRA administration.
- Pima County Community College District contracts with independent insurance companies (as noted on the Quick Reference Chart in the front of this document) to manage their insured benefit programs. Benefits under the following programs are **fully-insured** with various insurance companies: dental plan options, life insurance, accidental death and dismemberment insurance, short term disability and long term disability benefits.

## PLAN ADMINISTRATOR/PLAN SPONSOR

Pima County Community College District Board of Governors
4905D East Broadway Blvd.
Tucson, Arizona 85709-1005
Phone: (520) 206-4971

## AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made on the Plan Administrator or on the Plan's General Counsel:

Pima County Community College District
Office of the Chancellor
District Office
4905C E. Broadway
Tucson, AZ 85709-1005

For disputes arising under those portions of the Plan that are insured, service of legal process may be made upon the appropriate insurance company at their address listed on the Quick Reference Chart in the front of this document, or upon the supervisory official of the State Insurance Department.

## PLAN'S REQUIREMENTS FOR ELIGIBILITY AND BENEFITS

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility or denial or loss of benefits are described in the Eligibility chapter in this document. Questions about eligibility and benefits should be referred to the PCCCD's Employee Service Center.

## CONTRIBUTION SOURCE

The employer/plan sponsor and the employees share the cost of contributions for the benefits provided by this Plan. A portion of the contributions related to health care (medical and dental) benefits are made by the employer/plan sponsor pursuant to salary reduction agreements between plan participants and the employer/plan sponsor. The remainder of the contributions related to health care benefits are made by the employer based on the Plan participant's benefit selection/purchase.

A small portion of contributions for benefits are made entirely by plan participants, such as through optional Life Insurance, self-pay COBRA benefits or through the optional election of flexible spending accounts.

**PLAN YEAR**

The Plan's fiscal records are kept on a 12-month basis beginning on July 1 and ending on June 30.

**PLAN AMENDMENTS OR TERMINATION OF PLAN**

The Plan Administrator reserves the right to amend or terminate this Plan, or any part of it, at any time without advance notice to participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan.

- Amendments to the Plan may be made in writing by the Plan Administrator and become effective on the date approved by the Plan Administrator, or on such other date as may be specified in the document amending the Plan.
- The Plan or any coverage under it may be terminated by the Plan Administrator. Upon termination, discontinuance or revocation of participation in the Plan, all elections and reductions in compensation related to the Plan will terminate.

**ALLOCATION AND DISPOSITION OF ASSETS UPON TERMINATION**

In order for Pima County Community College District to carry out its obligation to provide the maximum possible benefits to all Participants within the limits of its resources, the Plan Administrator has the right to take any of the following actions, even if claims that have already accrued are affected:

- To terminate any benefits provided by these Plan Rules.
- To alter or postpone the method of payment of any benefit.
- To amend or rescind any provision of these Plan Rules.

In addition, the Plan may be terminated by the Plan Administrator, provided that the termination is not effective until 60 days after the mailing of such notice. In the event the Plan terminates, the Plan Administrator, by unanimous agreement and in their full discretion, will determine the disposition of any assets remaining after all expenses of the Plan have been paid; provided that any such distribution will be made only for the benefit of former participants and for the purposes set forth in the Plan. Upon termination of the Plan, the Plan Administrator (with full power) will continue in such capacity for the purpose of dissolution of the Plan.

**DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES**

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate/designee, 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. The Plan Administrator also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder. 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. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Any interpretation or determination by the Plan Administrator or its delegate/designee, made in good faith which is not contrary to law, is conclusive on all persons affected.

**STATEMENT OF PIMA COUNTY COMMUNITY COLLEGE DISTRICT'S RIGHTS**

A. Pima County Community College District makes no representation that employment with it represents lifetime security or a guarantee of continued employment. Further, your 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 PCCCD's rules and policies; or
   - because an individual's services become excess to PCCCD's staffing needs.

B. An individual's employment may also be terminated whenever Pima County Community College District, in its sole judgment, deems that to be in its best interest.

C. Pima County Community College District, as Plan Administrator/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.

D. Any written or oral statement other than a written statement signed by the Plan Administrator that is contrary to the provisions of this subchapter **is invalid**, and no prospective, active or former employee 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 you 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 to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

**RIGHT OF PLAN TO REQUIRE A PHYSICAL EXAMINATION**

The Plan reserves the right to have the person, who is totally disabled or who has submitted a claim for benefits and is undergoing treatment under the care of a Physician, to be examined by a Physician selected by the Plan Administrator or its designee at any time during the period that benefits are extended under this Plan. This right extends to the right and opportunity to request an autopsy or other forensic exam in case of death where it is not forbidden by law. The cost of such an examination will be paid by the Plan.

**WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA) AND NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT (NEWBORNS' ACT) REGULATIONS**

**Women's Health and Cancer Rights Act (WHCRA):** The medical plans offered by Pima County Community College District 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 will be provided in a manner determined in consultation with the attending Physician and the patient, including:

- 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.

**Newborns' and Mothers' Health Protection Act:** Under federal law, group health plans, like the medical plans offered by Pima County Community College District, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). Plan participants may be required to obtain precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section.

**INFORMATION YOU OR YOUR DEPENDENTS MUST FURNISH TO THE PLAN (Very Important Information)**

In addition to information you must furnish in support of any claim for Plan benefits under this Plan, you or your covered Dependents must furnish information you or they may have that may affect eligibility for coverage under the Plan.

> **IMPORTANT: Failure to give this Plan a timely notice (as noted above) may cause your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage, or may cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability, or may cause claims to not be able to be considered for payment until eligibility issues have been resolved, or may result in a participant's liability to the Plan if any benefits are paid to an ineligible person.**

Submit such information in writing to the Pima County Community College District's Employee Service Center at the address shown in the Quick Reference Chart in the front of this document. The information needed and timeframes for submitting such information are outlined below. See also the COBRA chapter for special timeframes applicable to those benefits:

| Type of Information Needed | Date Information is to be Submitted to the Plan as Soon as Possible and: |
|---|---|
| • Change of name or address or the existence of other health care coverage for any covered person. | No later than 30 days after the change or addition of other coverage. |
| • Marriage, divorce, legal separation, addition of a new Dependent, death of any covered person. | Within 30 days |
| • Covered Dependent (Spouse or child) becomes disabled or is no longer disabled. | Within 30 days of the date the person becomes disabled or is no longer disabled. |
| • An individual meets the termination provisions of this Plan. | Within 30 days of the termination event |
| • Covered child ceases to be a Dependent as defined by this Plan (*e.g.* over the limiting age of the Plan, etc.) | Within 30 days of the date the child is no longer considered a Dependent. |
| • Employee receives a determination of disability from the Social Security Administration (SSA) or is no longer disabled according to SSA.<br>• Medicare enrollment or disenrollment. | See the COBRA chapter for timeframe. |

## 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**.

## 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 like the Pima County Community College District self-funded medical plans, outpatient prescription drug benefits, health reimbursement account (HRA) flexible spending account administration and COBRA administration (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- **PHI does not include** health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical leave (FMLA), life insurance, dependent care FSA, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment in the Plan and is also available from the Pima County Community College District Employee Service Center and PCCCD's intranet at www.MyPima.edu.

For the insured dental plans in which you are enrolled, the insurance company distributes their Notice of Privacy Practices to you. Information about HIPAA in this document is not intended to and cannot be construed as a Notice of Privacy Practices.

The Plan, and the Plan Sponsor (Pima County Community College District), 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 your 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 your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the 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 of your 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, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and
    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, 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;
    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 you sign a valid authorization form (available from PCCCD's Employee Service Center) in order for the Plan to use or disclose your PHI **other than** when you request your 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 you will be given the opportunity to agree or disagree before the Plan uses and discloses your 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, including their subcontractors, 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 of 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; and
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. Employee benefits administration staff designated by the Plan Administrator,
   3. Business Associates under contract to the Plan including but not limited to the flexible spending account claims 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.

   If you are a minor and have concerns about the Plan releasing PHI to your parents or guardian, please contact the Privacy Officer.

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 health benefits, COBRA administration and Health Flexible Spending Account (FSA) administration.

**GENERAL STATEMENT OF NONDISCRIMINATION: (DISCRIMINATION IS AGAINST THE LAW)**

Effective July 1, 2017, PCCCD complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PCCCD does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. PCCCD:

a) Provides free aids and services to people with disabilities to communicate effectively with us, such as:
   - Qualified sign language interpreters
   - Written information in other formats (large print, audio, accessible electronic formats, other formats)

b) Provides free language services to people whose primary language is not English, such as:
   - Qualified interpreters
   - Information written in other languages

If you need these services, contact the PCCCD Civil Rights Coordinator located in the PCCCD Employee Service Center.
If you believe that PCCCD has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the PCCCD Civil Rights Coordinator, Mailing Address:

PCCCD Employee Service Center 4905 E. Broadway Blvd. Suite C117 (DO-1235) Tucson, AZ 85709-1235. Phone Number: (520) 206-4945. Fax: 520-206-4969 Email: ESC@pima.edu. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the PCCCD Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

**Free Language Assistance:** The following chart displays the top 15 languages spoken by individuals with limited English proficiency in the state of Arizona.

| **ATTENTION: FREE LANGUAGE ASSISTANCE**<br>This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency. | |
|---|---|
| **Language** | **Message About Language Assistance** |
| 1. Spanish | ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-818-0236. |
| 2. Chinese | 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-818-0236 |
| 3. French | ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-818-0236. |
| 4. German | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-818-0236. |
| 5. Vietnamese | CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-818-0236. |
| 6. Persian | **هجوت** :رگا هب نابز یسراف وگتفگ م ینکی،د هستیتلا نابز یتروصب ارینگ ارب یامش مهارف م یدشاب .اب 1-855-818-0236 تماس بگیرید |
| 7. Tagalog | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-818-0236. |
| 8. Navajo | Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-855-818-0236. |
| 9. Arabic | مقر (855-818-0236-1 مقرب لصتا .ناجملاب كل رفاوتت ةيوغللا ةدعاسملا تامدخ نإف ،ةغللا ركذا ثدحتت تنك اذإ :مكيلاو مصلا فتاهِ 1-0236-818-855.( ةظوحلم |
| 10. Korean | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-818-0236 번으로 전화해 주십시오. |
| 11. Thai | เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-818-0236. |
| 12. Russian | ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-818-0236 (телетайп: 1-855-818-0236). |
| 13. Serbo-Croatian | OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-818-0236 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-855-818-0236). |
| 14. Japanese | 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-818-0236）まで、お電話にてご連絡ください。 |
| 15. Assyrian (Syriac) | ܫܡܘܥ :ܐ1-855-818-0236 |

# DEFINITIONS

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

**Affordable Care Act (ACA):** a comprehensive federal health care reform law enacted in March 2010 (sometimes known as ACA, 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.

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

**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.

**Coinsurance:** That portion of Eligible Medical and Prescription Drug Expenses for which the covered person has financial responsibility to pay. In most instances, the Covered Individual is responsible for paying a fixed percentage of covered expenses after the Plan's deductible has been met.

**Coordination of Benefits (COB):** The rules and procedures applicable to determination of how Plan benefits are payable when a person is covered by two or more health care plans.

**Copayment, Copay:** The fixed dollar amount you are responsible for paying when you incur an Eligible Medical or Prescription Drug Expenses for certain drugs or services.

**Cost-sharing:** A term to mean the amount of money a plan participant is to pay toward a service or item, versus the amount of money the Plan is to pay. Plans typically have three different types of cost-sharing provisions: Deductibles, Copayments/Copays and Coinsurance, although not all plans feature each of these types of cost-sharing. It is common to have a Plan change the amount of its cost-sharing provisions at least once each 12 months (more often if necessary).

**Covered Individual:** Any employee, and that person's eligible Spouse or Dependent 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. A covered individual is also referred to as a Plan Participant.

**Deductible:** The amount of Eligible Medical or Prescription Drug Expenses you are responsible for paying before the Plan begins to pay benefits. The amount of deductibles as applicable to Prescription Drug benefits is discussed in the Outpatient Prescription Drug Benefits chapter of this document.

**Dependent:** Any of the following individuals: Dependent Child(ren) or Spouse as those terms are defined in this document. See also the definition of Eligible Dependent. Note that the daughter-in-law, son-in-law, grandchild of an eligible employee or spouse, a Domestic Partner and a child of a Domestic Partner are not eligible dependents under this Plan.

**Dependent Child(ren):** For the purposes of this Plan, a Dependent Child is any of the employee's/participant's children listed below who are under the age of 26 (whether married or unmarried):

- **Biological son or daughter** (proof of relationship and age may be required).
- **Stepson or stepdaughter** (proof of relationship and age may be required).
- **Legally adopted child or child placed for adoption** with the employee/participant (proof of adoption or placement for adoption and age may be required). Placed for adoption means the assumption and retention by the employee/participant of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement for adoption terminates upon the termination of such legal obligation.
- A child named as an "alternate recipient" under a **Qualified Medical Child Support Order (QMCSO)**.
- **Foster child**, lawfully placed with the employee/participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction (proof of relationship, age and foster child placement may be required).
- A child for whom the employee has **legal guardianship** under a court order (proof of guardianship and age may be required).

**Additional Dependent Children:** In addition to the Dependent Children defined above, the following individuals are eligible for coverage under the Plan:

- **For the medical plans, a disabled dependent child means** a child who has reached age 26 and has been covered under the medical plan up to the day he or she is no longer eligible for coverage based on the age 26 limit, is

continuously incapable of self-sustaining employment because of mental or physical disability on the date the dependent reaches age 26 and is dependent on the employee for maintenance and support as determined by the medical plan claims administrator. Initial proof of incapacity and status as a disabled dependent child must be submitted to the medical plan claims administrator within 30 days of the date such child reaches age 26. Continued coverage under the medical plan is subject to periodic review by the medical plan claims administrator. Cessation of the child's disability or dependency will terminate the child's coverage under the medical plan.

- **For non-medical benefits, a Disabled dependent child means:** An **unmarried** Dependent Child (as defined above) age 26 or older who is **permanently and totally disabled with a disability that existed prior to the attainment of the Plan's age limit**, and who will be claimed as a dependent on the employee's/participant's federal income tax return for each plan year for which coverage is provided. The Plan will require initial and periodic proof of disability. Employees have 30 days from the date of the request to provide this proof of disability before the child is determined to be ineligible. Cessation of the child's disability or dependency will terminate the child's coverage under the non-medical portion of the plan.

See also the termination provisions for Dependent Children listed in the Eligibility chapter of this document.

**The following individuals are not eligible under the Plan:** a spouse of a Dependent Child (e.g. employee's son-in-law or daughter-in-law) or a child of a Dependent Child (e.g. employee's grandchild) unless the employee has legal guardianship.

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

- A Domestic Partner is a person of the same or opposite gender who has the same principal place of abode as the employee; and
- The employee and domestic partner have completed the PCCCD Domestic Partnership Affidavit.

A domestic partner is not also considered a Spouse under this Plan. Coverage of a Domestic Partner ends in accordance with the section of "When Coverage Ends" as noted in the Eligibility chapter of this document.

**Eligible Dependent:** Your lawful Spouse and your Dependent Child(ren), Domestic Partner, and Domestic Partner's child, 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 their 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 Pima County Community College District in Tucson, Arizona who is on the payroll of Pima County Community College District and is eligible to enroll for coverage under the Plan. An employee does not refer to leased employees, contract workers, and independent contractors. See the Eligibility provisions in the Eligibility chapter of this document.

**Enroll, 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.

**Food and Drug Administration (FDA):** The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

**Formulary:** A list of outpatient prescription drug products, including strength and dosages, approved by the Prescription Drug Program, and available for use by Plan participants. The formulary approval process considers factors such as drug safety, effectiveness, cost-effectiveness, side effects and therapeutic outcome. A formulary is also called a Preferred drug list.

**Non-Network, Non-Participating Provider:** A retail or mail order pharmacy that does not contract with the Plan's selected Pharmacy Benefit Manager. Non-participating is also referred to as Non-PPO, Non-EPO, Out-of-Network or Non-Network.

**Open Enrollment Period:** The period during which an employee may add coverages of dependents, drop coverages or 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.

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

**Plan Administrator:** The Pima County Community College District's Board of Governors, who has the responsibility for overall Plan administration.

**Plan Participant:** See the definition of Covered Individual.

**Plan Sponsor**: The Plan Administrator as defined above.

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

**Prescription Drugs:** For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend Drug:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. **Compound Drug/Compounding:** Any drug that has more than one ingredient and at least one ingredient is a drug that requires a prescription under state law. Some compound drugs are only available at a retail pharmacy location, not mail order. Pharmacy compounding is a practice in which a pharmacist combines, mixes, or alters ingredients in response to a prescription to create a medication tailored to the medical needs of an individual patient.
3. **Generic drug**: means a generic version of a brand-name drug (basically a copy of an FDA approved brand-name drug that contains the same active ingredients as the brand-name drug and is the same in terms of dosage, safety, purity, strength, how it is taken, quality, performance and intended use). Generic drugs work in the same way and in the same amount of time as brand-name drugs. The generic drug must be the same (or bio-equivalent) in several respects: the active ingredients (those ingredients that are responsible for the drug's effects), the dosage amount, the way in which the drug is taken must be the same as the brand name drug, the safety must be the same and the amount of time the generic drug takes to be absorbed into the body must be the same as the brand name drug. A generic drug has been approved by the U.S. Food and Drug Administration (FDA). Generic drugs can have different names, shapes, colors and inactive ingredients than the original brand name drug.
4. **Brand drug:** means a drug that has been approved by the U.S. Food and Drug Administration (FDA) and that drug has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company who holds the patent has the right to sell that brand drug. A brand drug cannot have competition from a generic drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.
5. **Specialty drug**: Refers to high-cost, biotechnology-engineered FDA approved, non-experimental medications used to treat complex, chronic or rare diseases. These medications may also have one or more of the following qualities: are injected, infused, taken oral or inhaled, may need to be administered by a Health Care Practitioner, have side-effects or compliance issues that need monitoring, require substantial patient education/support before administration, and/or have unique manufacturing, handling, distribution and administration issues that make them unable to be purchased from a retail and/or mail order service. Examples of specialty drugs can include medications (and the supplies necessary to administer them) to treat hemophilia, multiple sclerosis, rheumatoid arthritis, Crohn's disease, psoriasis, hepatitis, cancer or immunity disorders. [Specialty drugs are managed by a specialty drug pharmacy that is part of the Prescription Drug Program under contract to the Plan.

**Preventive services/Preventive Care Benefits:** are defined under the Patient Protection and Affordable Care Act (Affordable Care Act, ACA or Health Care Reform) and include recommended services rated as "A" or "B" by the U.S. Preventive Services Task Force (USPSTF) with respect to the individual involved.

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

**Spouse:** An employee's Spouse means a person of the opposite gender or same gender who is legally married under State law. The Plan follows the IRS guidance that a same gender couple is married for federal tax purposes if the couple was married in a state that allows same gender marriage, regardless of the laws of the state in which the married couple resides or the foreign jurisdiction in which the individuals' marriage was entered into. The Plan may 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 domestic partner, a civil union, or a divorced former Spouse of an employee, a common law marriage, or a spouse of a Dependent Child.

**Total Disability, Totally Disabled:** The inability of a covered employee to perform all the duties of his or her occupation with the County as a result of a non-occupational illness or injury, or the inability of a covered Dependent to perform the normal activities or duties of a person of the same age and gender. See also the definition of Disabled.

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