

**AMENDMENT NO. 3**  
to the  
**Kyrene Employees Benefit Trust**  
**PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION**  
*Amended, Restated and Effective July, 1, 2008*

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**Effective April 1, 2009 the Plan Document/Summary Plan Description is amended as follows:**

**Page 9 in the Eligibility and Enrollment chapter under the section Special Enrollment, item “B”, the text is amended by the addition of the text in italics and the deletion of text in strike-through:**

**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 31 days after the date on which coverage under this Plan was previously offered because you or they had health care coverage under any other health insurance policy or program or employer plan (including COBRA continuation coverage, individual insurance, Medicare, Medicaid, or other public program); and you, 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 that spouse and/or dependent child(ren) within 31 days after the termination of their coverage under that other health insurance policy or plan, either as a result of:

- loss of eligibility for that other coverage resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in the number of hours of employment (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);
- termination of employer contributions toward that other coverage (an employer’s reduction but not cessation of contributions does not trigger a special enrollment right) ; or
- if that other coverage was COBRA Continuation Coverage, the 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 ceases to offer coverage to a group of similarly situated individuals; or
- the loss of dependent status under the other plan’s terms; or
- the termination of a benefit package option under the other plan, unless substitute coverage offered; or
- the loss of eligibility due to reaching the lifetime benefit maximum on all benefits under the other plan. For Special Enrollment that arises from reaching a lifetime benefit maximum on all benefits, an individual will be allowed to request Special Enrollment in this Plan within 31 days after a claim is denied due to the operation of a lifetime limit on all benefits.

***Effective April 1, 2009, you and your dependents may also enroll in this Plan if you (or your eligible dependents):***

- a. ***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; or***
- b. ***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.***

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 period of COBRA Continuation Coverage has expired.

C. When Coverage Begins Following Special Enrollment

- Coverage of an individual enrolling due to loss of other coverage or because of marriage: If the individual requests Special Enrollment within 31 days of the date of the event that created the Special Enrollment opportunity, (except for 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 Special Enrollment within 60 days of the date of the Special Enrollment opportunity related to Medicaid or a State Children's Health Insurance Program (CHIP), generally coverage will become effective on the first day of the month following the date event that allowed this Special Enrollment Opportunity.*
- Coverage of a newborn or newly adopted newborn Dependent Child: See the Newborn dependent children section below.
- Coverage of a newly adopted Dependent Child or Dependent Child Placed for Adoption who is properly enrolled more than 31 days after birth, but within 31 days after the child is adopted or placed for adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.

Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options at the same costs and the same enrollment requirements as are available to similarly situated employees at Initial Enrollment. See also the Enrollment Procedures section of this chapter for more information.

D. 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 31 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 them until the next Open Enrollment period.

**Page 19 in the COBRA Continuation Coverage chapter, under the section "Special Enrollment Rights" the text is amended by the addition of the text in italics:**

**Special Enrollment Rights**

You have special enrollment rights under federal law that allows 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.

**Effective July 1, 2009 the Plan Document/Summary Plan Description is amended as follows:**

**Page 75 in the Definitions Chapter the definition of "Dependent Child" text is amended by the addition of the text in italics:**

**Dependent Child:**

- A. For the purposes of this Plan, a Dependent Child is any of the employee's unmarried children who have the same principal place of abode as the employee, including a:
- natural child, stepchild, legally adopted child, or child placed for adoption with the employee; (proof of adoption or placement for adoption may be requested) or
  - child for whom the employee has legal guardianship under a court order (proof of guardianship may be requested); or
  - lawfully placed foster child for whom health coverage is not provided by the State (proof of foster child placement may be requested); or
- provided:
1. the Dependent Child depends on the employee for more than one-half of their support and is not a "qualifying child" of any other person. The term "qualifying child" is defined in the Internal Revenue Code (IRC) in Section 152 (c). *Note that a child will not be treated as the qualifying child of another person if that other person is not required by federal law to file an income tax return and that person either does not file an income tax return or files one solely to obtain a refund of withheld income taxes.* In addition, if a child (for whom the employee is the legal guardian) is not a "relative" as listed in IRC Section 152(d)(2)(A) through (G), the child must also have the

same principal place of abode as the employee for the entire year and be a member of the employee's household;  
AND

2. the child meets one of the following criteria:
  - a. The child has not reached his or her 19th birthday; OR
  - b. The child has reached his or her 19th birthday but has not reached his or her 25<sup>th</sup> birthday and is enrolled as a full-time student in high school or in an accredited and state licensed technical school or institution of higher education or is serving as a full-time missionary. If you have a dependent child who resides or attends school in a state other than Arizona, please contact the Human Resource Office for additional information. School vacation periods during any calendar year that interrupt but do not terminate a continuous course of study will be considered school attendance for those individuals who attend school on a full-time basis as long as the child has not reached their 25<sup>th</sup> birthday. The Plan may require initial and periodic proof of student status and full-time missionary status; OR
  - c. The child has reached his or her 19th birthday (and is not a full-time student or serving as a full-time missionary) or his or her 25<sup>th</sup> birthday and the child is mentally or physically Handicapped (as that term is defined in this Plan); the child is incapable of self-sustaining employment as a result of that handicap; and that handicap existed before the attainment of this Plan's age limit. This Plan may require initial and periodic proof of handicap. A Dependent Child who is not covered under the Plan but becomes handicapped after reaching the Plan's Dependent age limit is not eligible to enroll as a Dependent under this Plan.

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

- B. A child named in a qualified medical child support order (QMCSO) is also an eligible dependent under this Plan. See the Eligibility chapter for details on QMCSOs.
- C. See also the Proof of Dependent Status provisions in the Eligibility chapter.
- D. It is the employee's obligation to inform the Plan promptly if any of the requirements set out in this definition of a Dependent child are NOT met with respect to any child for whom coverage is sought or is being provided.
- E. Coverage of a Dependent Child ends at the end of the month in which that child:
  1. reaches his or her 19th birthday and does not meet the terms for fulltime student status described above, or
  2. reaches their 25<sup>th</sup> birthday; or
  3. is 19 to 25 years of age and voluntarily or involuntarily terminates full-time attendance at a high school, technical school or institution of higher education or graduates; or
  4. ceases to serve as a full-time missionary; or
  5. marries; or
  6. no longer meets the eligibility requirements of the Plan; or
  7. enters military or similar service anywhere; or
  8. becomes employed on a full-time basis by Kyrene School District or any other employer where coverage is elected and no longer depends on the employee for over half his/her support.

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

**Page 81 in the Definitions Chapter the definition of "Usual and Customary Charge" is deleted in its entirety and replaced by the definition of "Allowed Amount/Allowable Charge" text in italics as noted below:**

~~**Usual and Customary Charge:** Also known as usual, reasonable and customary (URC), usual and customary (U&C) or usual, customary and reasonable (UCR). Amounts that exceed usual and customary are not recognized by the plan for any purpose. Usual and Customary Charge is the allowed amount for medically necessary services or supplies as determined by the Plan Administrator or its designee to be the lowest of:~~

- ~~1. With respect to the PPO providers, the charge set forth in the agreement between the PPO providers and the PPO network; or~~
- ~~2. No more than the 80th percentile of Ingenix (formerly called HIAA, a national schedule of prevailing health care charges); or~~
- ~~3. The health care provider's actual billed charge; or~~
- ~~4. The usual charge by the health care provider for the same or similar service or supply.~~

~~The Plan will not always pay benefits equal to or based on the Health Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the Usual and Customary charge for health care services or supplies. Any amount in excess of the Usual and Customary~~

Charge does not count toward the Plan's annual Out of Pocket Maximums. Participants are responsible for amounts that exceed UCR allowances payable by this Plan.

**Allowed Amount/Allowable Charge:** means the amount this Plan allows as payment for eligible medically necessary services or supplies. The allowed charge amount is determined by the Plan Administrator or its designee to be the lowest of:

1. With respect to a network provider (PPO network Health Care or Dental Care provider/facility), the fee set forth in the agreement between the PPO network Health Care or Dental Care Provider/facility and the PPO network or the Plan; or
2. With respect to a non-network provider, allowed charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible medically necessary services or supplies performed by non-network providers. The Plan's allowed charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR) or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. See also the definition of Balance Billing in this chapter; or
3. For an In-Network health care provider/facility whose network contract stipulates that they do not have to accept the network discount for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the allowed charge amount under this Plan is the discounted fee that would have been payable by the Plan had the claim been processed as an In-Network claim; or
4. The Health Care or Dental Care Provider's/facility's actual billed charge.

The Plan will not always pay benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the "allowed charge" amount for health care services or supplies.

Any amount in excess of the "allowed charge" amount does not count toward the Plan's annual Out-of-Pocket Maximums. Participants are responsible for amounts that exceed "allowed charge" amounts by this Plan.