The Cochise Combined Trust

Plan Document
and Summary Plan Description Amendments
and Federal Notices

Exclusive Provider Organization (EPO) Plan
Buy-Up Exclusive Provider Organization (Buy-Up EPO) Plan

Effective July 1, 2018
The Cochise Combined Trust
Plan Document
and Summary Plan Description
Exclusive Provider Organization (EPO) Plan
Amendment No. 1

Effective July 1, 2018, The Cochise Combined Trust hereby amends the Plan Document and Summary Plan Description, Exclusive Provider Organization (EPO) Plan effective July 1, 2017, as follows:

Under SECTION III—SCHEDULE OF BENEFITS, B. Pre-Certification, ADD and RENUMBER all subsequent items:
7. home health care

Under SECTION III—SCHEDULE OF BENEFITS, J. Schedule of Medical Benefits-EPO, Hearing Aid, DELETE:

<table>
<thead>
<tr>
<th>Hearing Aids</th>
<th>Benefit maximum: Limited to one (1) aid every three (3) years, per plan participant. Subject to a maximum benefit payable of $1,000.</th>
</tr>
</thead>
</table>

And REPLACE with:

<table>
<thead>
<tr>
<th>Hearing Aids</th>
<th>Benefit maximum: Limited to two (2) aids every three (3) years, per plan participant. Subject to a maximum benefit payable of $2,000.</th>
</tr>
</thead>
</table>

Under SECTION III—SCHEDULE OF BENEFITS, J. Schedule of Medical Benefits-EPO, Home Health Care, DELETE:

<table>
<thead>
<tr>
<th>Home Health Care</th>
<th>Therapy provided in the home will apply to the home health care plan year maximum. Plan year maximum: Sixty (60) visits per plan participant. Pre-certification is required for injectable medications in excess of $1,000 in billed charges.</th>
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<th>Home Health Care</th>
<th>Therapy provided in the home will apply to the home health care plan year maximum. Plan year maximum: Sixty (60) visits per plan participant. Pre-certification is required for home health care and injectable medications in excess of $1,000 in billed charges and for health care.</th>
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Under SECTION III—SCHEDULE OF BENEFITS, J. Schedule of Medical Benefits-EPO-Buy-Up, Maximum Out-of-Pocket Limit, per Plan Year, DELETE:

<table>
<thead>
<tr>
<th>Maximum Out-of-Pocket Limit, per Plan Year</th>
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<tbody>
<tr>
<td>The out-of-pocket limit includes deductibles, co-insurance, and Medical co-payments.</td>
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<tr>
<th>Per plan participant</th>
<th>$2,000</th>
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<tbody>
<tr>
<td>Per family unit</td>
<td>$4,000</td>
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</table>

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Under SECTION III—SCHEDULE OF BENEFITS, J. Schedule of Medical Benefits-EPO-Buy-Up, Hearing Aids, DELETE:

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<th>Hearing Aids</th>
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<tr>
<td>50% after deductible</td>
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And REPLACE with:

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<th>Hearing Aids</th>
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<tr>
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<td></td>
</tr>
</tbody>
</table>
Under SECTION V—MEDICAL BENEFITS, A. Covered Medical Charges, Hearing Aids, DELETE:

22. Hearing Aids. The charge for one (1) hearing aid will be is subject to the hearing aid limits shown in the applicable Schedule of Medical Benefits. Also covered under this benefit are hearing implants in lieu of a hearing aid.

And REPLACE with:

22. Hearing Aids. The charge for two (2) hearing aids will be subject to the hearing aid limits shown in the applicable Schedule of Medical Benefits. Also covered under this benefit are hearing implants in lieu of a hearing aid.

Under SECTION V—MEDICAL BENEFITS, A. Covered Medical Charges, Home Health Care, DELETE:

24. Home Health Care. Charges for home health care/home infusion services rendered by a licensed home health care agency which a physician has prescribed and which is determined by the Plan or its designee to be medically necessary and the most appropriate care. Mileage charges may be eligible if the plan participant resides in a remote area that does not have a local home health care agency. Benefits are payable as shown in the applicable Schedule of Medical Benefits. A visit by a representative of a home health agency of four (4) hours or less shall be considered as one (1) home health care visit. Charges for custodial care, mental health care, or substance abuse or chemical dependency treatment would not be eligible under this provision. Pre-certification is required for injectable medication over one thousand dollars ($1,000) in billed charges, administered in conjunction with home health care services (refer to the Medications provision listed below). Please also see the applicable Schedule of Medical Benefits.

And REPLACE with:

24. Home Health Care. Charges for home health care/home infusion services rendered by a licensed home health care agency which a physician has prescribed and which is determined by the Plan or its designee to be medically necessary and the most appropriate care. Mileage charges may be eligible if the plan participant resides in a remote area that does not have a local home health care agency. Benefits are payable as shown in the applicable Schedule of Medical Benefits. A visit by a representative of a home health agency of four (4) hours or less shall be considered as one (1) home health care visit. Charges for custodial care, mental health care, or substance abuse or chemical dependency treatment would not be eligible under this provision. Pre-certification is required for home health care and injectable medication over one thousand dollars ($1,000) in billed charges, administered in conjunction with home health care services (refer to the Medications provision listed below). Please also see the applicable Schedule of Medical Benefits.

Under SECTION VI—MEDICAL REVIEW/PRE-CERTIFICATION PROGRAM, A. Utilization Review, What Services Must Be Pre-Certified (Approved before they are Provided), ADD and RE-ALPHABETIZE all subsequent items:

g. home health care

All other terms and conditions of this Cochise Combined Trust hereby amends the Plan Document and Summary Plan Description which are not affected by this amendment remain unchanged.

Cochise Combined Trust hereby adopts the provisions of this amendment of the Cochise Combined Trust- EPO Plan, and its duly authorized officer has executed this amendment.
FEDERAL NOTICES

A. Women’s Health and Cancer Rights Act (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. all stages of reconstruction of the breast on which the mastectomy was performed
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses
3. treatment of physical complications of the mastectomy, including lymphedema

This coverage is subject to the same deductibles and co-insurance consistent with those established for other benefits under this Plan.

B. Non-Discrimination Policy

This Plan will not discriminate against any plan participant based on race, color, religion, national origin, disability, gender, sexual orientation, or age. This Plan will not establish rules for eligibility based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, genetic information, or disability.

This Plan intends to be nondiscriminatory and to meet the requirements under applicable provisions of the Internal Revenue Code of 1986. If the Plan Administrator determines before or during any plan year that this Plan may fail to satisfy any non-discrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated individuals, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated covered employees, to assure compliance with such requirements or limitation.

C. Notice of Prescription Drug Coverage and Medicare

Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Cochise Combined Trust (hereafter CCT) and about your options under Medicare’s Prescription Drug coverage. It also tells you where to find more information to help you make decisions about your prescription drug coverage. You may ask for another copy of this notice from the CCT at any time.

Key points for you to remember:

1. Medicare Prescription Drug coverage (sometimes called Medicare Part D) is available to everyone with Medicare.
2. The prescription drug coverage offered to you by CCT is generally better than the standard Medicare Prescription Drug coverage.
3. If you decide to keep your coverage through CCT’s Plan, you do not have to do anything.
4. If you keep your prescription drug coverage through CCT and then later decide to buy prescription drug coverage through Medicare, you will not have to pay a penalty (that is, pay a higher Medicare premium).
5. If you have questions about this Notice or would like more information about your coverage options, please contact your Personnel Office or Human Resources Department.

For the upcoming year, you have several coverage options:

1. You may stay with your current plan offered by CCT. Because CCT’s coverage is, on average for all plan participants, expected to pay out more than standard Medicare Part D Prescription Drug coverage will pay, you can keep this coverage and not pay a higher premium (that is, there is no penalty) if you later decide to enroll in a Medicare Part D plan. If you decide to keep your existing coverage through CCT’s Plan, you do not have to do anything. You will continue to be enrolled in CCT’s Plan and receive the same benefits you currently have.
2. You may enroll in a stand-alone Medicare Prescription Drug plan to obtain Medicare Part D coverage. All Medicare Prescription Drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

If you want to enroll in a Medicare Prescription Drug plan, open enrollment for the Medicare Prescription Drug plans runs from October 15th through December 7th of each year. Before enrolling in a Medicare Prescription Drug plan, please contact your Human Resources Department to discuss what health insurance coverage you have through CCT to avoid duplicate coverage.

You should also know that if you drop or lose your prescription plan with CCT and don’t enroll in a Medicare Prescription Drug plan or another plan that is at least as good within sixty-three (63) days after your coverage with CCT ends, you will pay more (that is, pay a penalty) to enroll in Medicare Prescription Drug coverage. When you enroll in a Medicare Prescription Drug plan, your monthly premium will be increased at least 1% for every month you did not have coverage. For example, if you go nineteen (19) months without coverage, your premium for a Medicare Prescription Drug plan will always be at least 19% higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare Prescription Drug coverage. In addition, you may have to wait until the next November to enroll and until the next January to receive benefits.

3. You may decide not to have any prescription drug coverage from either CCT’s plan or from a Medicare Prescription Drug plan. If you decide not to have any prescription drug coverage, you will have to pay a higher premium later (that is, pay a penalty), when you decide to enroll in a Medicare Prescription Drug plan. Later when you enroll in a Medicare Prescription Drug plan, your monthly premium will be increased at least 1% for every month you did not have coverage. For example, if you go nineteen (19) months without coverage, your premium for Medicare Prescription Drug plan will always be at least 19% higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare Prescription Drug coverage. In addition, you may have to wait until next November to enroll and until next January to receive benefits.

For more information about your current prescription drug coverage, please call the Prescription Customer Service number on your health insurance card.

If you have questions about this notice or would like more information about your options, please contact your Personnel Office or Human Resources Department.

More detailed information about Medicare plans that offer Prescription Drug coverage is available in the Medicare & You handbook, which is published annually by Medicare. You will get a copy of the handbook in the mail from Medicare. You can also get more information about Medicare Prescription Drug plans from:

- Call (800) MEDICARE (800-633-4227). TTY users should call (877) 486-2048.

For people with limited income and resources, extra help paying for Medicare Prescription Drug plans is available. Information about this extra help can be obtained from the Social Security Administration (SSA) online at www.socialsecurity.gov, or call (800) 772-1213 (TTY 800-325-0778).

Keep this notice. If you enroll in a Medicare Prescription Drug plan in the future, you may need to give a copy of this notice to the Plan to show that you are not required to pay a higher monthly premium. You may ask for another copy of this notice from CCT at any time.

D. Newborns’ And Mothers’ Health Protection Act Statement of Rights

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not do any of the following:
1. restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section.

2. set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) or ninety-six (96) hours, as applicable, stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

3. require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) or ninety-six (96) hours, as applicable.

However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., the participant’s physician, nurse midwife, or physician’s assistant), after consultation with the mother, discharges the mother and/or newborn earlier. Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48)-hour or ninety-six (96)-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48)-hour or ninety-six (96)-hour.

Pre-certification is still required for the delivery and for newborn placement in an intensive care nursery. Pre-certification is also required for any length of stay period in excess of the minimum forty-eight (48)-hour or ninety-six (96)-hour, even though not required for the minimum length of stay period.

E. Mental Health Parity

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits state and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is self-funded by the employer, rather than provided through a health insurance policy. The Cochise Combined Trust (CCT) has elected exemption from the following requirement:

**Parity in the Application of Certain Limits to Mental Health Benefits**

Group health plans [of employers that employ more than fifty (50) employees] that provide both medical and surgical benefit and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the Plan.

The exemption from this Federal requirement will be in effect for the plan year beginning July 1, 2018 and ending June 30, 2019. This election may be renewed for subsequent plan years.

If you have any questions regarding CCT’s election to exempt the Trust from the requirements of mental health parity, please feel free to contact the Pool Administrator, Stephanie Moore with Erin P. Collins & Associates, Inc., at (928) 753-4700 ext. 303.
COMPLIANCE WITH HIPAA PRIVACY STANDARDS

A. Compliance with HIPAA Privacy Standards

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996.

Certain members of the employer’s workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the Privacy Standards), these employees are permitted to have such access subject to the following:

1. General. The Plan shall not disclose Protected Health Information to any member of the employer’s workforce unless each of the conditions set out in this Compliance with HIPAA Privacy Standards section is met. Protected Health Information shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

2. Permitted Uses and Disclosures. Protected Health Information disclosed to members of the employer’s workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan’s administrative functions shall include all Plan payment and health care operations. The terms payment and health care operations shall have the same definitions as set out in the Privacy Standards, but the term payment generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. Health care operations generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.

3. Authorized Employees. The Plan shall disclose Protected Health Information only to members of the employer’s workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this Compliance with HIPAA Privacy Standards section, members of the employer’s workforce shall refer to all employees and other persons under the control of the employer.

   a. Updates Required. The employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

   b. Use and Disclosure Restricted. An authorized member of the employer’s workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

   c. Resolution of Issues of Noncompliance. In the event that any member of the employer’s workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

      i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and whether the Protected Health Information was compromised

      ii. applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment

      iii. mitigating any harm caused by the breach, to the extent practicable

      iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages

      v. providing notification in accordance with HIPAA requirements

4. Certification of Employer. The employer must provide certification to the Plan that it agrees to:
a. Not use or further disclose the Protected Health Information other than as permitted or required by the plan documents or as required by law.

b. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the employer with respect to such information.

c. Not 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 employer.

d. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

e. Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards.

f. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards.

g. Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards.

h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards.

i. If feasible, return or destroy all Protected Health Information received from the Plan that the employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible.

j. Ensure the adequate separation between the Plan and member of the employer’s workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

5. The following members of the Cochise Combined Trust are designated as authorized to receive Protected Health Information from the Cochise Combined Trust (the Plan) in order to perform their duties with respect to the Plan:

   a. Account Manager (brokerage firm)
   b. Group Benefits Analyst (brokerage firm)
   c. Assistant Vice President - Human Resources
   d. Human Resources Director
   e. Benefits Analyst or Benefits Manager

B. Compliance with HIPAA Electronic Security Standards

   Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the Security Standards), the employer agrees to the following:

   1. The employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the employer creates, maintains or transmits on behalf of the Plan. Electronic Protected Health Information shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

   2. The employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

   3. The employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in the Authorized Employees and Certification of Employers provisions, described above.