AMENDMENT NO. 1

to the Yuma Area Benefits Consortium (YABC) Medical, Dental, and Vision Plan Document

Effective July 1, 2015

Effective July 1, 2016, the Plan Document is amended as follows:

In the Eligibility chapter, the Employee Eligibility section and the Initial Enrollment section are amended to add the text in italics and delete the text in strike-through:

WHO IS ELIGIBLE FOR COVERAGE

EMPLOYEE ELIGIBILITY

The employers participating in the YABC plan reserve the right to use a **Monthly Measurement Method** and/or a **Look Back Measurement Method** to determine if an employee reaches the level of a **full-time employee**, in accordance with IRS regulations under the Affordable Care Act.

- The Monthly Measurement Method identifies full-time employees based on the hours of service achieved for each calendar month.
- The Look-Back Measurement Method determines the status of a new employee or an ongoing employee as full-time or not for a future period (called a stability period) based on the average number of hours of service per week the employee attained in a prior period (called a measurement period). See the definition of Look Back Measurement Method in the Definitions chapter.

The specific duration of periods under the Look Back Measurement Method (when used) are addressed in policies/procedures in the Human Resource/Payroll department of the participating employer, and can be changed on an annual basis as determined by the participating employer.

Employees, and former employees of a participating employer in the Yuma Area Benefit Consortium (called a Retiree), may be eligible for benefit coverage with this Plan as described below:

- **Crane Elementary School District No. 13:** Eligible employees include contracted and non-contracted employees who are full-time averaging at least 30 hours of service per week (at least 130 hours of service per month), as measured by the District.
- **Yuma School District No.1**: Full-time employees are eligible if they average a minimum of 30 hours of service or more per week, as measured by the District.
- **Arizona Western College:** Full-time employees averaging at least 30 hours of service per week (at least 130 hours of service per month), as measured by the College, are eligible for benefits.
- **City of Yuma:** Employees are eligible if they average at least 30 hours of service per week (at least 130 hours of service per month), as measured by the City. Employees participating in the City's job sharing program are also eligible. Critical Part-time "hard to fill" positions, as designated by the City Administrator, are also eligible for benefits.

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

Refer to the Initial Enrollment section in this chapter for information on any waiting period for coverage once an employee becomes eligible to enroll for coverage.

INITIAL ENROLLMENT

Enrollment: You must enroll within **30** days of the date on which you become eligible for coverage by submitting a completed written (or as applicable, online) enrollment form (that may be obtained from your Human Resource/Payroll

department), 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.

When Coverage Begins:

- **Crane Elementary School District No. 13:** For **contracted and non-contracted new full-time** employees, coverage becomes effective on the first day of the month following *30 days of continuous service with the District.* ~~your date of employment~~. ~~When the date of employment is the first day of the month coverage will be effective on the date of full-time employment~~.
- **Yuma School District No.1:** For **new full-time** employees, coverage becomes effective on the first day of the month following the date of employment in a benefits-eligible position.
- **Arizona Western College:** For **contracted and non-contracted new full-time** employees, coverage becomes effective on the first day of the month following the date of full-time employment. When the date of employment is the first day of the month coverage will be effective on the date of employment.
- **City of Yuma:** For **benefits eligible** City employees, coverage becomes effective on the first day of the month following one month of full-time employment. Retiree coverage becomes effective on the first of the month following the employee's retirement from the City.

Coverage of your enrolled Spouse and/or Dependent child(ren) begins on the date your coverage begins.

Failure To Enroll During Initial Enrollment: CAUTION: If you do not enroll yourself or your eligible dependents within 30 days of the date on which they first become eligible for coverage, unless your eligible dependent(s) qualify for Special Enrollment described in this chapter, you will have to follow the Subsequent (late) Enrollment procedure described later in this chapter.

In the Medical Expense Benefit chapter, the section on High Deductible Health Plan (HDHP) with Health Savings Account (HSA) is amended to add the text in italics and delete the text in strike-through:

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

The High Deductible Health Plan (HDHP) listed in this document is 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 as necessary to comply with 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. 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, contributing 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 fee 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 Plan both you and your employer can contribute to the 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 2015 the maximum is $3,350/individual or $6,650/family;~~ in 2016 the maximum is $3,350/individual or $6,750/family; *in 2017 the maximum is $3,400/individual or $6,750/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 (for example, in ~~2015 and 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."

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

- ✓ are enrolled in Medicare* *(Part A, Part B, Part C – Medicare Advantage Plans, Part D and Medigap, a Medicare supplemental insurance plan),*
- ✓ 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,
- ~~✓ are covered by VA or one of their facilities, including prescription drugs or covered by Indian Health Services (IHS) benefits and have used VA or IHS medical services within the previous 3 months, 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.

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.

Note that 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."

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.

The YABC 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

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 and Health Savings Accounts can be directed to your employer's Human Resource/Payroll Department.

In the Medical Expense Benefit chapter, the section on Coverage of Certain Over-the-Counter (OTC) Drugs, the aspirin row of the OTC chart is amended to add the text in italics:

OTC Drug Name	Who Is Covered for this Drug?	Cost-Sharing?	Payment Parameters in addition to a prescription:
Aspirin	• For men 45-79 years to reduce chance of a heart attack. • For women 55-79 years to reduce the chance of a stroke. • *For pregnant women who are at high risk for preeclampsia (a pregnancy complication).*	None, if payment parameters are met	Since dosage for non-pregnant adults is not established by USPSTF, plan covers up to one bottle of generic 100 tablets every 3 months. Daily low-dose aspirin (81 mg as preventive medication after 12 weeks' gestation in pregnant women who are at high risk for preeclampsia.

In the Schedule of Medical Benefits, in the row titled "Dietitian Services" the following bullet point is amended to add the text in italics and delete the text in strike-through:

- Services of a Registered Dietician or licensed or certified Nutritionist are payable as preventive services, to a maximum of 5 visits per person per year. *This visit limit does not apply to nutritional counseling services that are medically necessary for the treatment of an individual diagnosed with a mental health or substance abuse condition, such as an eating disorder.*

In the Schedule of Medical Benefits, in the row titled "Drugs and Medicines" the following text is amended (adding the text in italics) each time it appears in this row:

FDA-approved contraceptives for females, certain drugs to reduce the risk of breast cancer and certain OTC drugs mandated by Health Reform: No charge for generic drugs submitted with a physician prescription. *No charge for brand prescription contraceptives only if a generic contraceptive is unavailable or medically inappropriate. The attending provider determines medical necessity for FDA-approved female contraceptives.*

In the Schedule of Medical Benefits, in the row titled "Durable Medical Equipment" the following bullet point is amended to add the text in italics and delete the text in strike-through:

- ~~For the first 12 months following the birth of a child,~~ *While breastfeeding,* coverage is provided for ~~one~~ *a* standard manual or standard electric breast pump, (including hospital grade breast pumps when medically necessary) plus necessary breast pump supplies. Rental, purchase and repair is payable as outlined to the left. Coverage is available at no cost from in-network providers only. Standard cost-sharing applies to use of non-network providers. Reimbursement for a non-network provider is payable up the amount the Plan would have paid had an in-network provider been used.

In the Schedule of Medical Benefits, in the row titled "Maternity Services" the following bullet point is amended to add the text in italics and delete the text in strike-through:

- ~~In conjunction with birth,~~ *While breastfeeding,* the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) ~~by a trained provider during pregnancy and/or in the postpartum period,~~ at 100%, no deductible, when provided by an in-network provider *acting within the scope of his/her license. In-network providers are listed on the network directory described on the Quick Reference Chart.* ~~Under this plan a trained provider is a Breastfeeding/Lactation Educator, as defined in the Definitions chapter~~.

In the Schedule of Medical Benefits, in the row titled "Wellness Programs Well Child Examinations and Immunizations" the following bullet points are added to the Benefit Description columns:

- Preventive services are payable without regard to gender assigned at birth, or current gender status.
- For children age 6 years and older with obesity, the Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's in-network pediatrician.
- If there is no network a provider who can provide the Health Reform required wellness service, then the plan will cover the service when performed by an out-of-network provider without cost-sharing.
- Coverage is provided in primary care clinician visits for fluoride varnish applied to the primary teeth of children through age 5 years.
- Where the information in this document conflicts with newly released Affordable Care Act regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required.

The 2015 Yuma Area Benefit Consortium (YABC) Plan Document is amended by the YABC Trustees, as stated above, this _____ day of _____, 2016.

For the YABC Board of Trustees,

_____

YABC Trust Chairperson - Print Name

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YABC Trust Chairperson - Signature

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