

AMENDMENT NO. 3
to the MESA PUBLIC SCHOOLS
EMPLOYEE BENEFIT TRUST
Medical, Dental, Vision and Life Insurance Plans
PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION
Amended, restated and effective: October 1, 2004

Effective March 1 2008, the above Plan Document/Summary Plan Description is amended as follows:

Page 24 in the Schedule of Medical benefits, in the Drugs and Medicines row, the second column titled Explanations and Limitations, the following bullet point is amended to remove the text in strike-through and add the text in italics and a new bullet point is added as noted in italics:

- No coverage for: over-the-counter (OTC) medications (*except smoking/tobacco cessation products*), fertility/infertility, ~~and smoking cessation~~ products/medications. See also the Exclusions chapter of this document. See the definition of “Experimental and/or Investigational” in the Definitions chapter for more information.
- ***Tobacco/smoking cessation benefit:*** *Coverage is extended for over the counter or prescription tobacco/smoking cessation products (such as nicotine gum or patches) intended to assist an individual to stop smoking or using tobacco products. The drugs are payable only through the Prescription Drug Program using a network retail pharmacy at the Plan’s usual retail copay or coinsurance. You must present a written prescription from a physician for over the counter or prescription tobacco/smoking cessation products to the retail pharmacist. This benefit is not available as a reimbursement for products you purchase at a non-network location and is also not available through the plan’s mail order program. Benefits are payable as follows:*
 - *Chantix: maximum of 6 months of coverage in any 12-month period.*
 - *Zyban, Bupropion: maximum of 3 months of coverage in any 12-month period.*
 - *All other tobacco cessation products whether over the counter or prescription strength: maximum \$300 per person in any 12-month period.*

Page 39 in the Medical Plan Exclusions chapter, the plan is amended to remove the text in strike-through and add the text in italics:

Drugs, Medicines and Nutrition Exclusions

1. Pharmaceuticals requiring a prescription that have not been approved by the U.S. Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed; or are Experimental and/or Investigational as defined in the Definitions chapter of this document; or are prescribed in conjunction with a non-covered procedure or service.
2. Non-prescription (or non-legend or over-the-counter) drugs or medicines (*except smoking/tobacco cessation products*); or lost or stolen medicines.
3. Foods and nutritional supplements including, but not limited to, home meals, formulas, tube feedings, foods, diets, vitamins and minerals (whether they can be purchased over-the-counter or require a prescription), except when provided during a covered hospitalization or for prenatal vitamins or minerals requiring a prescription.
4. Naturopathic or homeopathic services and substances.
5. These drugs, medicines or devices: non-prescription contraceptives, cosmetic drugs, hair removal or hair growth; fertility and infertility; ~~smoking cessation~~; fluoride preparations for dental purposes; sexual dysfunction/inadequacy medications (e.g. Viagra); drugs (such as appetite suppressants/anorexiant) treating weight control.

Page 40 in the Medical Plan Exclusions chapter, the plan is amended to remove the text in strike-through and add the text in italics:

Smoking Cessation or Tobacco Withdrawal Exclusion

~~Expenses for nicotine gum or patches, or other products, services or programs intended to assist an individual to stop smoking.~~

Page 39 in the Medical Plan Exclusions chapter, the plan is amended to remove the text in strike-through and add the text in italics:

Family Planning (Fertility and Reproductive Care) Services Exclusions

1. Expenses *for certain types of services related to the diagnosis and treatment of infertility and complications thereof, including, but not limited to, services, outpatient retail/mail order drugs and procedures or devices to achieve fertility; in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, and adoption, cryostorage of egg, sperm or newborn cord blood, except as payable under Family Planning in the Schedule of Medical Benefits.*

Page 41 in the Medical Exclusions chapter, the following text is amended as noted by the addition of the text in italics and the deletion of the text in strike-through:

Weight Management and Physical Fitness Exclusions

1. Expenses for medical ~~or surgical~~ treatment of obesity, including but not limited to, ~~gastric restrictive procedures, and reversal procedures, gastric balloons, wiring of the jaw, jejunal bypass treatment,~~ weight loss programs, dietary instructions, and any complications thereof, ~~except gastric stapling and intestinal bypass surgery as provided by the Plan and described below: Refer to the Weight Management row of the Schedule of Medical Benefits for coverage of bariatric surgery.~~
 - ~~Charges for gastric stapling or intestinal bypass may be payable if all the following are met:~~
 - ~~(a) the Covered Person is morbidly obese with a Body Mass Index of 40kg/m² or 35kg/m² in conjunction with severe co-morbidities such as cardiopulmonary complications or severe diabetes, as confirmed by a minimum of two (2) legally qualified Physicians. Body Mass is calculated by converting pounds to kilograms (multiply pounds by 0.45) and then divide the patient's weight in kilograms by their height in meters squared; and~~
 - ~~(b) documented evidence person has failed physician supervised medical/dietary therapies; and~~
 - ~~(c) evidence of medical problems such as arthritis, hypertension, diabetes, or a strong family history of same which present a life threatening situation, and~~
 - ~~(d) the covered person is employed with the District on a continuous full time or part time basis for 5 or more years or if a dependent, the person is over the age of 18 and the employee/subscriber has met the 5 year continuous employment timeframe.~~
 - ~~Reversal/revision of gastric stapling or intestinal bypass payable only if there exists a complication of the original procedure.~~
 - ~~No coverage for skin reduction or skin revision procedures for individuals who lose weight after a bariatric surgical procedure or other weight management effort.~~
2. Expenses for medical or surgical treatment of severe underweight, as defined here, except in conjunction with Medically Necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by Physicians to determine normal body weight.
3. Expenses for memberships in or visits to health clubs, exercise programs, gymnasium, and/or any other facility for physical fitness programs.
4. Expenses for exercise equipment rental or purchase.

Page 34 in the Schedule of Medical Benefits chart a new row on Weight Management is added as noted below:

Benefit Description	Explanation and Limitations	Open Access “Choice EPO” Plan	Employee Benefit Trust (EBT) “Options PPO” Plan	
			In-Network	Out-of-Network
<p>Weight Management</p> <ul style="list-style-type: none"> Bariatric surgery (surgical weight management) is payable for individuals who meet the Plan’s criteria (noted to the right) including but not limited to gastrointestinal bypass and gastric restrictive procedures like gastric banding. 	<ul style="list-style-type: none"> Charges for bariatric surgery may be payable if all the following are met: <ul style="list-style-type: none"> (a) the Covered Person is morbidly obese with a Body Mass Index of 40kg/m,² or 35kg/m² in conjunction with severe co-morbidities such as cardiopulmonary complications or severe diabetes, as confirmed by a minimum of two (2) legally qualified Physicians. Body Mass is calculated by converting pounds to kilograms (multiply pounds by 0.45) and then divide the patient’s weight in kilograms by their height in meters squared; and (b) evidence of medical problems such as arthritis, hypertension, diabetes, or a strong family history of same which presents a life-threatening situation, and (c) the covered person is employed with the District on a continuous full-time or part-time basis for 5 or more years or if a dependent, the person is over the age of 18 and the employee/subscriber has met the 5 year continuous employment timeframe. Reversal/revision of gastric stapling or intestinal bypass is payable only if there exists a complication of the original procedure. No coverage for skin reduction or skin revision procedures for individuals who lose weight after a bariatric surgical procedure or other weight management effort. 	<p>Bariatric surgery is payable only when a network bariatric center of excellence is used. Contact the Claims Administrator for a list of approved network bariatric centers.</p> <p>See the Hospital and Physician services rows of this chart.</p>	<p>Bariatric surgery is payable only when a network bariatric center of excellence is used. Contact the Claims Administrator for a list of approved network bariatric centers.</p> <p>See the Hospital and Physician services rows of this chart.</p>	<p>No coverage</p>

Page 5 in the Eligibility chapter under the subheading “Enrollment and Start of Coverage” the language is amended by the addition of text in italics and the deletion of the text in strike-through. This section of this amendment amends Amendment #1 to the 2004 Plan as follows:

ENROLLMENT AND START OF COVERAGE

You and/or your Eligible Dependents may become covered under this Plan only upon submission of a properly completed enrollment form provided by the Plan. 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 walk into the Employee Benefits Department and indicate their desire to enroll in the Plan by signing up for a benefits enrollment meeting. (The address and phone number for the Employee Benefits Department is listed on the Quick Reference Chart in the front of this document.) *Attendance at a benefits enrollment meeting is required for proper enrollment in the Plan.*

(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 by signing up for a benefits enrollment meeting, you will be provided with the steps to properly enroll that include all of the following:

- a. attend a benefits enrollment meeting within 30 days of the start date of the employee's employment contract. To "attend a benefits enrollment meeting" means attendance at the entire benefits enrollment meeting (arrival at the meeting later than 15 minutes from the start time of the benefits enrollment meeting and leaving earlier than 15 minutes before the end of the meeting is not considered attendance at the entire meeting).

Failure to attend a benefits enrollment meeting as noted in this section means that the individual is not eligible to enroll at this time and must wait until the Plan's next enrollment opportunity in order to enroll.

All these steps must again be followed in order to properly enroll.

Enrollment forms will be provided at the benefits enrollment meeting.

If an employee is unable to attend the benefits meeting date they selected, the employee must contact the Employee Benefits Department to select another benefits enrollment meeting date.

- b. submit a completed written enrollment form (that may be obtained from and submitted to the Employee Benefits Department), and
- c. provide proof of Dependent status (as requested), and
- d. pay any required contributions for coverage, and
- e. 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. A person who has not properly enrolled by completing the above noted steps, in a timely manner, has no right to any coverage for Plan benefits or services under this Plan. Coverage may be subject to pre-existing condition limitations as described later in this chapter.

This Plan Document is amended as stated above, this _____ day of _____, 200__ :

Plan Administrator

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