

**AMENDMENT NO. 2**  
**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 October 1, 2005, the above Plan Document/Summary Plan Description is amended as follows:**

**Page 2 in the Quick Reference Chart, the row titled “Managed Dental Plan” is amended to add the text in italics and delete the text in strike-through as noted below:**

QUICK REFERENCE	
Information Needed	Contact
<p><b>Managed Preferred Provider Dental Plan</b></p> <p>(Note: Benefits are NOT described in this document. Refer to the Employee Benefits Department.)</p>	<p><del>Employers Dental Service (EDS)</del>  <del>P. O. Box 35760 – Tucson, AZ 85740-5760</del>  <del>1-800-722-9772</del>  <del><a href="http://www.mydentalplan.net">www.mydentalplan.net</a></del>  <i>Total Dental Administrators</i>  <i>1-888-422-1995</i>  <i><a href="http://www.totaldentaladmin.com">www.totaldentaladmin.com</a></i></p>

**Effective October 1, 2006, the above Plan Document/Summary Plan Description is amended as follows:**

**Page 2 in the Quick Reference Chart, the rows titled “Claims Administrator for the Choice EPO and Options PPO Plans” and “Flex Benefits Claim Administrator” are amended to add the text in italics and delete the text in strike-through as noted below:**

QUICK REFERENCE	
Information Needed	Contact
<p><b>Claims Administrator for the Choice EPO and Options PPO Plans</b></p> <ul style="list-style-type: none"> <li>• Medical Claims and claim appeals</li> <li>• Eligibility and Benefits</li> <li>• Choice EPO and Options PPO Network Administrator</li> <li>• Choice EPO and Options PPO Provider Directory</li> </ul>	<p>United Healthcare  <b>P. O. Box 30555 (for claims)</b>  <i>P.O. Box 30432 (for appeals)</i>  <b>Salt Lake City, UT 84130-0555</b>            Choice EPO Customer Service: 1-866-844-4867            Options PPO Customer Service: 1-866-527-9594  <i>Consumer Account Card Division: 1-866-755-2648</i>  <a href="http://www.mvuhc.com">www.mvuhc.com</a></p>
<p><b>Flex Benefits Claims Administrator</b></p>	<p><del>Sheakley UniService</del>  <del>100 Merchant St. – Cincinnati, OH 45242</del>  <del>Phone: 1-800-877-6630 Fax: 1-513-326-8082</del>  <del><a href="http://www.sheakley.com">www.sheakley.com</a></del>  <i>United Healthcare (UHC)</i>  <i>1-877-311-7849</i>  <i><a href="http://www.mvuhc.com">www.mvuhc.com</a></i></p>

**Page 24 in the Schedule of Medical Benefits Chart, the row titled “Drugs and Medicines” is amended to add the text in italics and delete the text in strike-through as noted below:**

**Schedule of Medical Benefits**

See also the Exclusions and Definitions chapters of this document for important information and limitations to these Plan benefits.

This table shows what the Plan pays.

Benefit Description	Explanation and Limitations	Open Access "Choice EPO" Plan	Employee Benefit Trust (EBT) "Options PPO" Plan	
			In-Network	Out of Network
<p><b>Drugs and Medicines</b></p> <ul style="list-style-type: none"> <li>• <b>Coverage is provided only</b> for FDA approved pharmaceuticals requiring a prescription and 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.</li> <li>• <b>Diabetic Supplies:</b> 30-day supply of insulin syringes, blood glucose monitor device, blood test strips, urine test strips, lancets, lancet devices and alcohol swabs.</li> <li>• <b>Coverage is provided for:</b> prenatal vitamins requiring a prescription, prescription contraceptives, and spacers for asthma inhalers.</li> <li>• <b>Drugs Needing Preapproval:</b> The following are examples of some of the drugs that must be preapproved: Growth hormones, Antifungal agents (e.g. Sporanox, Diflucan, Lamisil), Alzheimer therapy, Antiemetic Agents (e.g. Kytril, Zofran), Alfa Interferons, Flu Therapy (e.g. Tamiflu, Relenza), Skin Therapy (e.g. Retin-A, Regranex), etc. <b>Have your Physician contact the Prescription Drug Plan</b> whose phone number is listed on the Quick Reference chart in the front of this document.</li> <li>• <b>Drugs With Quantity Limits:</b> Certain drugs are payable up to a limit, such as migraine drugs. Contact the Prescription Drug Plan for more information.</li> <li>• <b>Preferred Drug List (Formulary):</b> The Preferred Drug List includes <del>generic Tier 1 and brand name drugs Tier 2 and Tier 3</del> that have been selected by the Prescription Drug Plan for their clinical effectiveness and safety.</li> <li>• <b>Direct Member Reimbursement:</b> If you obtain prescriptions at a non-network retail pharmacy, you must pay for the drugs and later, send the bills, along with a claim form, to the Prescription Drug Plan for reimbursement.</li> </ul>	<p><b>The Outpatient Prescription Drug benefits include:</b></p> <ul style="list-style-type: none"> <li>• <b>Deductible:</b> Under both Plan options, you must pay the first \$100 per person per calendar year for retail or mail order prescription drugs to satisfy your Outpatient Prescription Drug Deductible.</li> <li>• <b>In-Network Services:</b> Prescription drugs are provided through the Plan's Retail Prescription Drug Network for Choice EPO and Options PPO plan participants. Refer to the pharmacy network directory or contact the Prescription Drug Plan at the telephone number listed in the Quick Reference table in the Introduction chapter of this document. At in-network retail pharmacies, present your ID card and written prescription slip to receive up to a 30-day supply of medication.</li> <li>• <b>Non-Network Services:</b> There are no non-network pharmacy services for Choice EPO participants. For Options PPO plan participants, you may use any non-participating pharmacy. You must pay for the drug and then submit the receipt to the Prescription Drug Plan who will reimburse you at the negotiated prescription in-network price at the coinsurance noted under the Out-of-network column to the far right.</li> <li>• <b>Mail Order Home Delivery Services:</b> You may purchase (if your physician writes for this amount) up to a 90-day supply of maintenance or chronic condition medications. Some items may not be available through the mail order service. Contact the Prescription Drug Plan at the telephone number listed in the Quick Reference table in the Introduction chapter of this document. For more information about the mail order program, contact the Employee Benefits Department. Formulary drugs are those drugs listed as preferred by the vendor managing the Prescription Drug Plan (see also the Quick Reference table in the Introduction chapter of this document).</li> <li>• <b>No coverage for:</b> over-the-counter (OTC) medications, 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.</li> <li>• Deductibles, copayments and coinsurance associated with outpatient prescription drugs are not applied to meet the annual Out-of-Pocket maximum.</li> </ul>	<p><b>SEPARATE OUTPATIENT PRESCRIPTION DRUG DEDUCTIBLE:</b> \$100 per person per calendar year for retail or mail order drugs then the Plan pays as follows:</p>		
		<p align="center"><b>RETAIL:</b> <b>For up to a 30-day supply of <del>Generic Tier 1 or Brand name</del> Tier 2 or Tier 3 medication:</b></p> <ul style="list-style-type: none"> <li>• If drug costs less than \$15, you pay the actual cost of the drug;</li> <li>• If the drug costs \$15 to \$50, you pay a \$15 copay;</li> <li>• If the drug costs more than \$50, you pay 40% of the drug cost to a maximum of \$100.</li> </ul> <p align="center"><b>MAIL ORDER (Home Delivery):</b> <b>For up to a 90-day supply of medication:</b> <del>Generic Tier 1 =</del> \$30 copay <del>Preferred Tier 2 =</del> \$50 copay <del>Non-Preferred Brand Tier 3 =</del> \$70 copay</p>	<p><b>Options EPO:</b> No out-of-network coverage.</p> <p><b>Options PPO:</b> After the drug deductible is met, you may obtain up to a 30-day supply of medication at a retail pharmacy and this Plan pays: <del>Generic Tier 1 =</del> 70% <del>Brand Tier 2 or Tier 3 =</del> 70% of the allowed generic cost, plus you pay the difference between the cost of the generic and brand name drug.</p> <p><b>Mail Order:</b> Available only through the in-network benefits.</p>	

**Page 38 in the Medical Plan Exclusions Chapter under the “Cosmetic Exclusions” section the text of number 3 is amended to add the text in italics and delete the text in strike-through as noted below:**

**Cosmetic Services Exclusions**

Expenses for surgery or medical treatment to improve or preserve physical appearance, as determined by the Plan Administrator or its designee, including but not limited to removal of tattoos, breast augmentation, or breast reduction (*including treatment of benign gynecomastia in males*). However, the Medical Plan does cover Medically Necessary Reconstructive Surgery or treatment as outlined in the Reconstructive Services section of the Schedule of Medical Benefits. Covered individuals should use the Plan’s notification procedure (described in the Care Coordination chapter) to determine if a proposed Surgery will be considered Cosmetic or Reconstructive Surgery.

**Page 90 in the Definitions Chapter under the definition of “Surgery” section the text is amended to add the text in italics and delete the text in strike-through as noted below:**

**Surgery:** Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan Benefits.

When the procedures will be considered to be separate procedures, the following percentages of the Usual and Customary Charge will be allowed as the Plan’s Benefit:

1. Allowances for multiple surgeries through the **same incision** or operational field:

Primary procedure	100% of U&C Charge
Second procedure	50% of U&C Charge
Third and additional procedures	<del>25%</del> 50% of U&C Charge per procedure

2. Allowances for multiple surgeries through **separate incisions** or operative fields performed at the same operative session:

First site: primary procedure	100% of U&C Charge
First site: second procedure	50% of U&C Charge
First site: third and additional procedures	<del>25%</del> 50% of U&C Charge per procedure
Second site: primary procedure	100% of U&C Charge
Second site: second procedure	50% of U&C Charge
Second site: third and additional procedures	<del>25%</del> 50% of U&C Charge per procedure

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**This Plan Document is amended as stated above, this \_\_\_\_ day of \_\_\_\_\_, 200\_\_ :**

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**Signature**